YALE SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

YALE SCHOOL OF PUBLIC HEALTH
Health Policy and Management
60 College St
New Haven, CT 06510

Andrew R. Olenski, PhD
Assistant Professor of Health Policy and Management
andrew.olenski@yale.edu

November 12, 2026

Via Electronic Submission

Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard Baltimore, MD 21244

Re: CMS-3484-P

Medicare and Medicaid Programs; Cutting Administrative Requirements for Excellence in Patient Care

Dear Madam or Sir:

Thank you for the opportunity to comment on proposed rule CMS-3484-P "*Cutting Administrative Requirements for Excellence in Patient Care.*"

I am an Assistant Professor of Health Policy and Management at the Yale School of Public Health and a Faculty Research Fellow at the National Bureau of Economic Research. I am an economist who studies how nursing home ownership, payment, and regulation affect resident care. My research draws on quasi-experimental methods meant to understand the conditions under which relationships drawn from observational data can have a causal interpretation. I write in response to CMS's request for comment on reimbursement strategies to address direct care worker shortages in nursing facilities, as well as the proposed rescission of the Medicaid institutional payment transparency reporting requirements.

Summary

I recommend that CMS update its guidance to states to encourage Medicaid payments that are conditioned on staffing, targeted to facilities where payments will have the highest impact, and tied directly to tenure or wages if the goal is to lower turnover. I also recommend that CMS improve the accuracy of existing nursing home financial reporting, including through targeted audits of Medicare cost reports, before relying on these data as an alternative to new transparency requirements.

1) Reimbursement Should Be Tied to Staffing Rather Than Raised Unconditionally

In 2022, Illinois began paying nursing facilities a bonus of up to $38.68 per Medicaid resident-day based on their acuity-adjusted staffing levels. My coauthors and I find a sharp and sustained increase in staffing after these payments took effect. The reform increased staffing at the average facility by about 5 percent

of the clinical target, equivalent to roughly 100 hours of staffing per week for the typical facility. Among facilities serving a large share of Medicaid residents, the increase was as large as 9 percent.[1] We contrast this change against a 2019 reform in the same state that raised Medicaid rates without tying payment to staffing or quality. We find no effect of the 2019 reform on staffing in the short term.

The structure of Medicaid payments, rather than just their level, appears to determine whether the additional spending translated into more staff.

2) Payments Should Be Targeted to Facilities Where They Raise Staffing

The Illinois payments were not equally effective everywhere. At facilities with many Medicaid patients, the pass-through of Medicaid spending to staffing hours was high: each dollar of incentive payments generated $0.86 of additional staffing at market wages. At facilities with low Medicaid shares, however, each dollar generated only $0.04 additional staffing. This was in part because low-Medicaid facilities tended to have higher staffing before the reform, and therefore received large per-patient payments with negligible staffing increases. Therefore, many dollars went to facilities that were already well-staffed and thus did not increase staffing rates.

CMS should encourage states to direct staffing incentive payments toward facilities where they are likely to buy additional staffing, such as those serving a high share of Medicaid residents. Alternative approaches, such as larger payments for facilities with low baseline staffing, may give facilities a reason to cut staffing before the baseline is measured. By contrast, the natural strategic response to targeting payments based on Medicaid share – facilities admitting more Medicaid residents – is one policymakers should welcome, given known access limitations faced by Medicaid patients.[2,3]

3) Staffing Payments Improved Resident Health, but Payment Measures Should Be Verifiable

In a companion study, we found that the reform reduced 90-day hospitalization rates among long-stay residents by 0.51 percentage points, approximately 4.1 percent of the mean. A similar reform adopted nationally would imply nearly 6,000 fewer hospitalizations each year.[4] We also find improvements in residents' independence in activities of daily living. However, these changes should be interpreted cautiously: because bonus payments depended on acuity-adjusted staffing, facilities could increase their payments by reporting residents as lower acuity. Payment formulas would therefore ideally rely on measures that facilities cannot influence.

4) Reducing Turnover Requires Payments Tied to Retention

Most facilities have annual turnover among certified nursing assistants exceeding 100 percent. Our study of the Illinois Medicaid reform concluded that staffing incentive payments did not reduce it; rather, facilities increased staffing by hiring new workers. Our results may be interpreted that "you get what you pay for:" payments for staffing hours do buy more staffing hours. Other objectives, such as maintaining a more stable workforce, may require other tools, such as payments tied to tenure or wages directly, for

---

[1] Gandhi, Ashvin D., Andrew Olenski, Krista Ruffini, and Karen Shen. Alleviating Worker Shortages Through Targeted Subsidies: Evidence from Incentive Payments in Healthcare. *Review of Economics and Statistics*, forthcoming. https://doi.org/10.1162/rest_a_01530

[2] Gandhi, Ashvin. Picking Your Patients: Selective Admissions in the Nursing Home Industry. SSRN Working Paper 3613950, 2023. https://doi.org/10.2139/ssrn.3613950.

[3] Einav, Liran, Amy Finkelstein, Jesse Gubb, Neale Mahoney, and James Okun. Selective Admissions in Nursing Homes: Evidence from a Randomized Audit Study. NBER Working Paper 35944, 2026. https://doi.org/10.3386/w35944

[4] Olenski, Andrew, Karen Shen, Krista Ruffini, and Ashvin Gandhi. Health Impacts of Nursing Home Staffing. *JAMA Health Forum* 2026;7(1):e256272. https://doi.org/10.1001/jamahealthforum.2025.6272

example through support for wage scales that rise with experience. Evaluating the effectiveness of such approaches should be a priority.

5) Transparency Requires Reliable Financial Data

CMS proposes to rescind requirements for reporting the share of Medicaid payments spent on staff compensation. I recognize CMS's concern that nursing homes serve residents covered by multiple payers, making it difficult to attribute staffing expenditures specifically to Medicaid beneficiaries. CMS suggests that existing administrative data, including Medicare cost reports (HCRIS), could provide a less burdensome alternative. However, these data have serious accuracy problems.

In separate research with Ashvin Gandhi, we document that federal nursing home cost reports contain implausible reported values and that nursing homes can substantially understate profits by reporting inflated payments to commonly owned real estate and management companies as costs. Using Illinois Medicaid cost reports, we estimate that 68 percent of the state's nursing home profits were hidden through such transactions.[5] Motivated by these findings, we argue for greater scrutiny and auditing of related-party transactions.[6] These concerns are shared by the HHS Office of Inspector General, which identified more than $1.7 million in overstated related-party costs among seven nursing homes in a sample of 14 and recommended incorporating reviews of related-party costs into routine cost-report oversight.[7]

CMS itself acknowledged concerns about SNF cost-report accuracy in its July 2026 payment rule, noting that it would continue exploring spot audits to improve the reliability of these data for developing a SNF-specific wage index.[8] I encourage CMS to pursue such audits, particularly targeting related party transactions. If CMS intends to rely on existing cost reports as an alternative to new reporting requirements, ensuring that those reports are accurate should be an essential part of its transparency strategy.

6) CMS Should Update Its Guidance to States

The population aged 85 and older is projected to double by 2040, from roughly 6 million to more than 12 million. In recent work, I project a shortage of approximately 3.3 million long-term care workers by 2040, roughly the size of the entire current workforce.[9] Because long-term care is largely publicly financed, wage increases – which will likely be necessary to grow the workforce – require corresponding increases in reimbursement. How those increases are structured will determine what they accomplish.

---

[5] Gandhi, Ashvin, and Andrew Olenski. *Tunneling and Hidden Profits in Health Care.* NBER Working Paper 32258, September 2025. https://doi.org/10.3386/w32258

[6] Fuse Brown, Erin C., Andrew R. Olenski, and Ashvin D. Gandhi. Pleading Poverty — Related-Party Payments and Health Care Entities' Financial Health. New England Journal of Medicine 2026;394(4):317–319. https://doi.org/10.1056/NEJMp2512845

[7] U.S. Department of Health and Human Services, Office of Inspector General. Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs. Report A-07-21-02836, December 2024. https://oig.hhs.gov/reports/all/2024/some-selected-skilled-nursing-facilities-did-not-comply-with-medicare-requirements-for-reporting-related-party-costs/

[8] Centers for Medicare & Medicaid Services. Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program for Federal Fiscal Year 2027. Final Rule, 91 FR 48588, 48597–48598, July 31, 2026. https://www.govinfo.gov/content/pkg/FR-2026-07-31/html/2026-15562.htm

[9] Olenski, Andrew R., and David C. Grabowski. Caring for an Aging America — The Looming Crisis of the Long-Term–Care Workforce. *New England Journal of Medicine* 2026;395(2):107–110. https://doi.org/10.1056/NEJMp2604122

In 2022, CMS issued an informational bulletin encouraging states to tie nursing facility payments to staffing and cited Illinois as an example.[10] There is now evidence on exactly how well that approach performs, and CMS should update the bulletin to reflect it. More broadly, as CMS considers how to improve transparency while reducing administrative burdens, it should ensure that the existing financial data on which it relies are accurate and reliable enough to inform reimbursement policy.

Thank you again for the opportunity to submit these comments. I would be glad to answer any questions or provide further detail on the research described here.

Sincerely,



Andrew Olenski, PhD
Assistant Professor of Health Policy and Management
Yale School of Public Health
Faculty Research Fellow, National Bureau of Economic Research

The views expressed here are my own and do not necessarily represent those of Yale University or the National Bureau of Economic Research.

[10] Center for Medicaid and CHIP Services. Medicaid Nursing Facility Payment Approaches to Advance Health Equity and Improve Health Outcomes. CMCS Informational Bulletin, August 22, 2022. https://www.medicaid.gov/federal-policy-guidance/downloads/cib08222022.pdf