Diversified Reporting Services, Inc.

RPTS O'CONNOR

HIF121140

LEGISLATIVE PROPOSALS TO INCREASE MEDICAID ACCESS AND IMPROVE PROGRAM INTEGRITY

TUESDAY, APRIL 30, 2024

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:03 a.m., in Room 2123 Rayburn House Office Building, Hon. Brett Guthrie [Chairman of the Subcommittee] presiding.

Present: Representatives Guthrie, Burgess, Latta, Griffith, Bilirakis, Bucshon, Hudson, Carter, Dunn, Pence, Crenshaw, Joyce, Balderson, Harshbarger, Miller-Meeks,

Obernolte, Rodgers (ex officio); Eshoo, Sarbanes, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Craig, Schrier, and Pallone (ex officio).

Also present: Representatives Pfluger; and Schakowsky.

Staff present: Sarah Burke, Deputy Staff Director; Seth Gold, Professional Staff Member; Grace Graham, Chief Counsel; Sydney Greene, Director of Operations; Nate Hodson, Staff Director; Calvin Huggins, Staff Assistant; Tara Hupman, Chief Counsel; Alex Khlopin, Staff Assistant; Emily King, Member Services Director; Chris Krepich, Press Secretary; Karli Plucker, Director of Operations (shared staff); Emma Schultheis, Clerk; Lydia Abma, Minority Policy Analyst; Tiffany Guarascio, Minority Staff Director; Mackenzie Kuhl, Minority Digital Manager; Una Lee, Minority Chief Health Counsel; Gayle Mauser, Minority Health Advisor; Katarina Morgan, Minority Health Fellow; and Andrew Souvall, Minority Director of Communications, Outreach and Member Services.

*Mr. Guthrie. The subcommittee will come to order. The chair recognizes himself for an opening statement.

I would like to welcome everyone to today's hearing. Today we are here for Dr. Daniel Tsai _ Mr. Daniel Tsai, the Director of Center for Medicaid and CHIP Services, about some of the most pressing challenges facing the Medicaid program. Over 75 million Americans are covered by Medicaid, a number that approached nearly 100 million during the pandemic.

According to Congressional Budget Office, federal spending on Medicaid is expected to increase from around 550 billion in fiscal year 2023 to almost 800 billion in 2033, and that does not include state spending. Continued unchecked growth in the program will inevitably lead to decreased spending on other important priorities such as education or increases in taxes at the state and federal level.

During an Oversight Investigation Subcommittee hearing two weeks ago, we heard about the increases in improper payments and the risks they pose to the program, which total more than 50 billion last fiscal year. In the hearing we

heard from the Department of Health and Human Services Inspector General who stated there is a compelling need to prioritize program integrity to protect against improper payments.

As a former state legislator, I know the work it takes to ensure Medicaid beneficiaries maintain access to high quality healthcare services or maintaining vigilance over the program. Part of that work is engaging with CMS to improve state plan amendments in 1115 waivers, or 1115 waivers, in a timely manner so that states can administer the program. However, according to the National Association of Medicaid Directors in a recent Health Affairs article, CMS has taken more than 15 months to approve new waivers which is a breach in the state and federal relationship in running this program. Yet instead of addressing these backlogs and working to ensure that the program is better managed, CMS has chosen to impose new sweeping regulations on states that will lead to increased spending and a decrease in services to beneficiaries.

I am extremely concerned about two of these rules in particular, the nursing home minimum staffing rule and the

Medicaid access rule, both of which threaten access to long-term care services for Medicaid beneficiaries by setting arbitrary staffing and pay standards. While I agree that we need to do more to ensure our frontline caregivers and clinical care providers are compensated commensurately with the care they are providing and offer a better quality of life for our most vulnerable, this approach simply won't work. These rules come at a time when we have seen more than 500 nursing home facilities close since the start of the pandemic and where we have 150,000 fewer long-term care workers than we did before 2020.

That is further evidenced by a collection of red and blue states suggesting in their comment letter to CMS that the rule "threatens to make these critical programs so expensive that states will need to seriously consider controlling costs by serving fewer people, growing more slowly, providing fewer services, or cutting back on other aspects of the Medicaid program.'' This echoes concerns I have raised with these concerns alongside my Energy and Commerce Republican colleagues in a letter to CMS in September opposing the access rule.

Today we are preparing to act by considering Representative Pence's bill, H.R. 7513, which would block the minimum staffing rule, and Representative Cammack's legislation, H.R. 8114, to block the access rule's 80 percent passthrough policy. I will note that Representative Pence's bill already advanced out of the Ways and Means Committee with a bipartisan vote and hopefully we will see similar bipartisanship on these issues here.

Of course the subcommittee is not just reacting to the administration's flurry of bad regulations but we are also being proactive in finding constructive solutions. Today's hearing includes a number of bipartisan bills to support long-term care and reduce program integrity for the Medicaid program. In particular, I would ask that my colleagues work with me on passing my bill, H.R. 468, the Building America Healthcare Workforce Act. This legislation will permit temporary nurse aides to work and support while _ nursing home residents while they work to become certified nursing assistants, filling a critical shortage in the workforce. This is a balanced approach that won't put new burdens on nursing home facilities like the minimum staffing rule while

also protecting our Nation's seniors.

Thanks to our witness for being here, we appreciate your time, and to my colleagues for their leadership on the bills before us today.

[The prepared statement of Mr. Guthrie follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. I yield back and recognize the ranking member, the gentlelady from California, for five minutes for her opening statement.

*Ms. Eshoo. Thank you, Mr. Chairman, and good morning, colleagues.

Today on the last day of Care Workers Recognition Month, we are going to discuss 19 proposals to improve Medicaid Home and Community-Based Services and ensure funding for Medicaid is well spent. Medicaid is the largest payor of long-term support services in our country providing health coverage to more than, as the chairman said, more than 77 million low-income adults, children, parents, and individuals with disabilities nationwide.

The American Rescue Plan Act, which Democrats passed in March 2021 without a single Republican vote, increased funding for Medicaid HCBS by over 37 billion dollars. Every state, every single state took advantage of this funding to retain, expand, and train direct care workers who are the backbone of our long-term care workforce. We have to continue to build on that progress.

President Biden recently said that, "If we want the

best economy in the world we have to have the best caregiving economy in the world.'' Several of the proposals before us today I think get us closer to that goal. The Money Follows the Person Permanency Act of 2024, introduced by Representatives Dingell and Balderson, makes permanent the Money Follows the Person demonstration. It is a critical program to provide enhanced federal funds to states to help seniors and people with disabilities move from institutions to the community.

The Stop Unfair Medicaid Recoveries Act introduced by Representative Schakowsky, and the Protecting Married Seniors from Impoverishment Act of 2024 introduced by Reps. Dingell and James, and the outdated systems that keep Medicaid beneficiaries who need long-term care and their families in poverty. Representative Schakowsky's legislation stops states from going after family' homes for repayment of Medicaid long-term services. Again, Reps. Dingell and James' legislation protects spouses from having to deplete their financial resources to qualify for Medicaid coverage for long-term care.

Some of the bills being considered today are partisan

and would roll back recent progress to improve the quality of long-term care. For example, the Biden administration recently finalized a solution to the lack of staff providing care in nursing homes. Hire more staff. The new rule requires a registered nurse to be on site 24 hours a day, seven days a week instead of the current minimum of eight straight hours a day. The rule also requires nursing homes to have enough nurses and nursing assistants to be able to give each resident at least three-and-a-half hours of care per day. I don't know about all of you, but I think if I were in a nursing home I would want those standards.

These requirements phase in for most facilities over three years but give rural facilities five years to come into compliance. It also provides 75 million dollars in grants to train nurse aides. The Protecting America's Senior Access to Care Act by Representative Fischbach and Pence prohibits this policy and it stops any similar rule from ever going into effect.

The Biden administration also recently required at least 80 percent of home and community-based payments to go directly to care worker pay. This will help raise the pay

for the home health workers our loved ones rely on. H.R. 8114 by Rep. Cammack prohibits this policy and stops any similar rule from ever going into effect. I support the administration's recent rulemaking to improve nursing home quality and raise the wages of care workers and oppose both of the aforementioned bills.

Today's hearing is about the hardest questions a family can face. How do we take care of a family member at home? If that is not possible, can we trust a nursing home? How are we going to afford this care? I hope we can work together to find solutions to make the answers to those questions a little easier.

[The prepared statement of Ms. Eshoo follows:]

**********COMMITTEE INSERT**********

*Ms. Eshoo. And with that, Mr. Chairman, I yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back, and I now recognize the chair of the full committee, Chair Rodgers, for five minutes for an opening statement.

*The Chair. Good morning, everyone. Thank you, Mr. Chairman.

Many in this committee are familiar with my son, Cole, and his story. For those unfamiliar, Cole was born with Down Syndrome and just yesterday we celebrated his 17th birthday. Over the past 17 years I have had the privilege of meeting with countless families with kids just like Cole, and they all want the same thing, for their kids to have every chance in this world to succeed and live up to their God-given potential.

I have dedicated much of my career here in Congress to being an advocate for people with disabilities. We are all a product of our experiences, and that is why I am grateful for today's hearing where we will discuss solutions to support access to long-term care for people with disabilities.

The Medicaid program was designed as an important

safety net for those who truly need assistance and otherwise might not get the vital care that they deserve. Unfortunately, Medicaid doesn't always live up to this mission. States have waitlists for home and community-based services, key long-term care services to empower people with disabilities to live independently in their communities, allowing them to reach their full potential. I have met with too many people over the years who have struggled to get off these waitlists or who have been afraid to pursue jobs out of state and risk being moved to the back of a new state's waitlist.

So I am pleased that we are discussing potential solutions to start making sure Medicaid is best serving those who need it most. For example, my bipartisan legislation with Ranking Member Pallone will increase flexibility for states to offer more care by reducing these waitlists and making sure each state is tracking and reporting waitlist statistics uniformly.

We will also discuss bipartisan legislation from Representatives Kiggans and Kaptur that would ensure coverage of home and community-based services for Medicaid

eligible dependents of active duty military families. As co-chair of the Military Families Caucus, I am proud to support this legislation, which would mean individuals won't lose coverage when their families move for a new assignment.

There is over a dozen other important pieces of legislation that will be discussed today. We are working closely with the ranking member and his team on these bills, the majority of which are bipartisan. And I recognize that not all of them are perfect in their current form. For example, I have concerns with H.R. 8115 and how it would upend the shared state/federal partnership of the Medicaid program. It is important, though, that we discuss and debate the merits of each bill today through regular order and continue to work in a bipartisan manner to find solutions that we can agree on and today we get the chance to do that.

Unfortunately, while we continue to develop bipartisan legislative solutions, the Biden administration is making it more difficult in some instances for people with disabilities to access care. By setting unattainable staffing requirements, I fear that the minimum staffing rule

will force nursing homes to close or reduce the number of seniors served. And the Medicaid access rule so-called 80/20 policy will lead to home care agencies reducing the amount of care that they can provide.

Lastly, the recently finalized Medicaid eligibility and enrollment rule is estimated by CMS's own actuary to increase federal spending by tens of billions of dollars over the next five years, all without Congress taking a single vote on any of the policies and in the face of widespread opposition from disability advocates and states. In contrast, today we will begin reasserting our role, Congress' Article I authority, by taking back control of the policy making process. We will consider legislation from Mr. Pence and Mrs. Cammack that repeal these rules and hopefully avoid the negative consequences that I have already mentioned.

This hearing is a great example of Energy and Commerce plowing the hard ground necessary to legislate with proposals to make sure that the Medicaid program is working as and _ as intended. And as I mentioned, many of these have bipartisan support. I look forward to today's hearing

and continuing to work together to advance these solutions so important to the people that we serve.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. I yield back.

*Mr. Guthrie. The chair yields back, and I now recognize the ranking member of the full committee, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

Our Nation faces an ongoing long-term care crisis that is impacting millions of American seniors, people with disabilities and chronic conditions, and the growing need for long-term care continues to be one of the greatest threats to retirement security for American seniors and the adult children who care for them. Today Medicaid is the Nation's primary payor for long-term care services but significant reform is needed to support a sustainable system.

I have also long believed that we must move forward with bold solutions within both Medicaid and Medicare. This has been a priority of mine for years and it is particularly important since demand for long-term care is expected to increase substantially as our Nation's population ages. And this committee has long worked to expand access to long-term care for people who need it while also improving the quality

of care and promoting better pay for providers.

We are continuing some of that work today by considering the Stop Unfair Medicaid Recoveries Act, bills to make the Money Follow the Person demonstration program and spousal impoverishment protections permanent, and bills to improve access to Medicaid home and community-based services for some of the many additional Americans who need it. And while I appreciate the modest improvements these policies would make, much more significant long-term care reform is needed.

Last Congress I was proud to cosponsor the Better Care Better Jobs Act which would have increased funding for Medicaid home and community-based services, ensured those funds were used to improve the quality and availability of such services, and strengthen the direct care workforce by addressing insufficient payment rates and high turnover rates. And I have also previously released a proposal to establish a long-term care benefit in the Medicare program so that millions of seniors and people with disabilities no longer have to face financial ruin before they get assistance. And these are the types of sweeping reforms

that we need to be thinking about in order to address the long-term care crisis.

Unfortunately, we will not be considering proposals to make those types of changes today. Instead we will consider several Republican bills that would worsen access to quality long-term care for the millions of Americans who depend on it. Some of the Republican bills that we will consider today go after the rules the Biden administration just finalized last week that lay the groundwork for necessary systematic long-term care reform. The administration's action establishes minimum staffing standards for nursing homes, requires that at least 80 percent of Medicaid payments for home care services go to caregiver pay, and expands nursing home oversight. These are important steps, but Republicans have proposed bills that would prevent them from taking effect and would ban any similar initiatives in the future.

We will also consider Republican legislation to rollback protections that ensure nurse aides working in nursing homes meet minimum training requirements and that their training is provided in settings that meet minimum

quality standards. Now if we want to improve the quality of long-term care, we need to ensure there are enough qualified workers, and to ensure there are enough qualified workers, we have to pay them adequately and provide a safe place for them to work, and these rules by the Biden administration take steps to do just that. They also balance the unique challenges that some nursing homes and home and community-based service providers may face by phasing in certain requirements over time and allowing hardship exemptions where they are truly needed.

And while I have concerns about these Republican bills that would undermine the Medicaid program, I am pleased we will consider several proposals aimed at improving its integrity. To promote program integrity we must acknowledge a system to which most Medicaid beneficiaries receive their care. More than 80 percent of Medicaid enrollees are covered by managed care programs and increasingly states are turning to managed care plans to administer Medicaid long-term services and supports.

The HHS Office of the Inspector General and the Government Accountability Office have long raised concerns

about instances of waste, fraud, and abuse, low quality of care, and poor access to care in Medicaid managed care, yet the Federal Government lacks practical means to ensure plan compliance with federal rules. So H.R. 8115 would give the government basic and necessary tools for Medicaid managed care oversight and enforcement, and there is no reason this legislation should not garner strong bipartisan support.

So I know, Mr. Chairman, we have a lot to discuss today as some of the bills are definitely, you know, positive and bipartisan, other _ others are not and efforts to rollback good things from the Biden administration. But this is certainly an important hearing and I certainly am pleased that we are having it today.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. Thank you, Mr. Chairman. I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back, and our _ now it is time to _ that has concluded members' opening statements and move into our witness statement.

So today our witness it Mr. Daniel Tsai, the Deputy Administrator and Director of the Center for Medicaid and CHIP Services. So, Ms. Tsai, you said you have testified before, so you know the light system. After four minutes, you will have a yellow light, and if you see red, it is time to wrap up. But we appreciate you for being here and, Mr. Tsai, you are now recognized for five minutes for your opening statement.

STATEMENT OF DANIEL TSAI, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES, CENTER FOR MEDICARE & MEDICAID SERVICE (CMS)

STATEMENT OF DANIEL TSAI

*Mr. Tsai. Thank you to the chair and good morning. Chairs Rodgers and Guthrie, Ranking Members Pallone and Eshoo, and members of the subcommittee, good morning. Thank you for the opportunity to testify before you about what we at CMS are doing to administer, protect, and strengthen the Medicaid program.

Medicaid and the Children's Health Insurance Program provides access to critical healthcare services to more than one in four Americans. We cover almost half of kids in this country. We are the largest payor for home and community-based services, or HCBS services, as well as nursing home care, and we are the largest payor for mental health and substance use disorder treatment.

Our goal for Medicaid is simple. We want to make sure all eligible kids and adults, eligible kids and adults are

covered with as little red tape as possible. We want to make sure people can access critical healthcare services in a timely way in such a manner that any of us would find acceptable. We want to improve health outcomes and the cost effectiveness of care and we want to ensure strong program integrity.

Let me first spend a minute outlining what we are doing to strengthen HCBS, which we just heard some very important comments on. First, I want to thank Congress for making really important investments in this area. HCBS services are critical, as you know, to helping to be able to continue living at home or in the community, for people's independence and dignity. This includes children with medically-complex conditions or intellectual and developmental disabilities, adults with disabilities, and older adults who need support to be able to age in place.

This administration's goal is to make sure Medicaid enrollees who need HCBS services receive them timely and with high quality. The President's budget calls for a 150 billion dollar investment or downpayment to further strengthen HCBS and we hope to work with Congress on these

critical investments. And as you know, we recently finalized a historic rule for Medicaid access which, among other things, enacts a systematic and multifaceted set of changes to strengthen home and community-based services.

For example, we emphasize the need for states to pay sufficient rates to home care and HCBS providers and we require transparent into what states are paying HCBS providers in a way that we never had before. And at the same time, as this committee just noted, we require that at least 80 percent of Medicaid HCBS rates got to direct care workers and not to administrative overhead or profit.

We also require states to measure timeliness of access to HCBS services. For example, how long does it take for someone who needs home care to actually receive the services, and we require states to track how long waitlists are for HCBS, and for the first time, we established a consistent set of quality measures for HCBS across the country.

I would like to turn briefly now to our efforts at CMS on strong program integrity for the Medicaid program. We and our staff take our responsibility for oversight and

fiscal stewardship incredibly seriously and states, healthcare providers, and managed care plans have certainly been feeling this intensity of focus. I know I hear about it all the time from our stakeholders.

First, we have taken significant steps to strengthen program integrity and Medicaid managed care plans, including through our recently finalized managed care rule. For example, we established maximum appointment wait time standards to make sure managed care plans are delivering services to their enrollees.

You have heard much about state-directed payments. We strengthen federal standards for the supplemental payments, including requiring that states and managed care plans report actual spending on these payments to CMS. And beyond the rule, we have also increased our audits and reviews of managed care plans and we have taken firm action.

We are also committed to continuing to measure and reduce the rate of improper payments across state Medicaid programs. It is important to note that the vast majority of improper payments result from clerical or documentation errors by a state or provider for covered services delivered

to eligible people. However, any level of improper payment is unacceptable, full stop, and we have substantively engaged with states to take necessary steps to remedy and therefore reduce improper payments.

We are committed to continuing to build a stronger Medicaid program and we look forward to continuing to work with Congress to advance this goal. Thank you for the opportunity to testify and I look forward to dialogue with this committee.

[The prepared statement of Mr. Tsai follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Thank you. That concludes the opening statements, and we will now begin questions, and I will recognize myself for five minutes for an _ for questions.

So, Mr. Tsai, your agency also appears to be finalizing a rule for May 2023 that will require manufacturers participating in the Medicaid drug re-rate program to stack or add up all the rebates they offer in the entire channel to determine their best price, and this is in direct contrast to 30 years of precedent and clear legal reading of the statute that says the best price is the single lowest price a manufacturer gives. Can you share what steps HHS has taken to determine how manufacturers and others in the supply chain could even comply with this rule as well as steps you have taken to protect patient information?

*Mr. Tsai. Thank you, Mr. Chairman. I appreciate that question. We want to make sure Medicaid enrollees have access to life-saving medication and we want to make sure as fiscal stewards we are paying a _ an effective rate and making sure that we are implementing the full effect of the Medicaid drug rebate program, as you are well aware of. And so as you noted, we proposed a rule on a range of things for

ensuring there is access to drugs in the Medicaid program. On the stacking provision, we _ that you referenced, we certainly heard many comments and _

*Mr. Guthrie. So I don't _ I got a couple more questions. Have you _ I understand that _ what you are talking about and I absolutely having been at state level and here want to pay the lowest price as well, but you want to pay a price that is going to guarantee the access to the drug. Have you looked at the price being so low that manufacturers won't supply the drug to the Medicaid program?

*Mr. Tsai. So, the _

*Mr. Guthrie. Are you concerned about that?

*Mr. Tsai. We want to make sure people have access to drugs and that we are being good fiscal stewards.

*Mr. Guthrie. Are you concerned that the stacking price may get so low that they won't have access?

*Mr. Tsai. As you know, we are in notice and comment rulemaking, and I can assure you we are thoroughly considering I would say the voluminous set of comments that we've received _

*Mr. Guthrie. Mm-hmm.

*Mr. Tsai. _ on this provision.

*Mr. Guthrie. Okay. Let me move on. So I just went through, unfortunately, a family situation trying to find long-term care, and it is incredibly expensive, and said many times going how does average families deal with this. And one of the big problems is labor, and so now you are going to increase the cost of labor, and you _ so the nursing homes would say, or the care homes, that they have an increase labor without any reimbursement costs coming for it so they are kind of being pinched and so it has pushed off to the private sector moving forward.

So I have a provision to try to increase the access to good labor because that is what we want, and I _ one _ it was from a waiver from a _ from COVID about allowing _ so it was a [indiscernible] waiver, and before _ and I will tell you what it is, but before I decided to offer the bill, I will ask the question, were there any reports during the waiver of any negative incidents because of this program, and I received none.

So we know we have a program that is safe and I want to try to move this forward. And what it does, it allows

temporary nurses aides to provide bedside care for as long as it takes them to reach 75 hours of training requirements to become a certified nurse assistant, and we believe this is the right approach to create a pipeline moving forward. And since we had a waiver and it was successful, there is no incidents that we know of, so it is safe. Would you support my legislation or a similar framework to commit _ and commit working with us to get this signed into law?

*Mr. Tsai. Thank you for that, and I am sorry to hear about your recent experiences, and thank you for your focus on making sure there is sufficient access to workforce in long-term care settings. As you know, I can't comment on any specific legislation, but we deeply support making sure there is sufficient access to all sorts of long-term care and also that we are considering a range of creative solutions to think about how to make sure we can address the pressing workforce challenges, and so we would be happy to work on anything that is helpful.

*Mr. Guthrie. Yeah, I didn't know you couldn't comment on legislation, but okay. I think you are going to comment on some later, so we will see what _ where we go with that.

So on the access rule, it is going to force states to control costs and we think provide fewer of these services to a smaller number of patients. So my concern is that we want a safe place for these _ for people to go, we absolutely want that, but we are worried about we are getting to a point where people are going to leave the marketplace or it is going to be so expensive people can't provide, and we just want a comment, can you guarantee that your rule won't lead to patients getting less access?

*Mr. Tsai. So I assume from the access rule you are talking about the _

*Mr. Guthrie. The access rule, the 80/20, yeah.

*Mr. Tsai. For _ on home case. So we want to make sure people have access to home care and that it is quality, and we know that staffing is, as you have noted, is _

*Mr. Guthrie. It is a big problem.

*Mr. Tsai. It is both a challenge and it is critical to making sure there is quality care that can be delivered, and that is really why we _

*Mr. Guthrie. Do you think this particular provision would hurt access?

*Mr. Tsai. It affirms that people can have access to quality care because the workforce is critical. And we received a tremendous amounts of comments on this, as you are indicating, and the rule we finalized is substantively different from what we proposed to account for longer timeframes, to create exceptions for say small providers or rural providers and the like. And we also emphasized that states have an obligation to pay a sufficient rate for home care and HCBS services.

*Mr. Guthrie. Thanks. Well, my time has expired, and I will yield back, and recognize the gentlelady from California for five minutes for questions.

*Ms. Eshoo. Thank you, Mr. Chairman, and thank you very much, Mr. Tsai, for being here with us. You have an incredible _ incredibly important portfolio that you oversee. One in four Americans in your care.

On April 22nd, as we all know, the administration finalized the policy to require states to spend 80 percent of Medicaid payments for home care services on compensation for workers. I am glad the administration has taken the steps that they have taken. There are many groups that

support the policy. Opponents of the policy argue that 20 percent of payments isn't enough to cover administrative costs, so I want to give you the opportunity to tell us why you chose this approach to improve the HCBS workforce, why is the 80/20 proposal so important, and what do you have to say to the opponents?

*Mr. Tsai. Thank you to the ranking member for that question and your support for home care, HCBS services. We _ as part of making sure people could have access to quality care, we need to make sure that there is a sufficient workforce available which requires sufficient funding for the workforce. And importantly, one of the reasons why we finalized this rule is to make sure that Medicaid payments for direct care, for home and community-based services should go to direct care workers versus administrative overhead and profit. And we did have very clear data points that pointed us to the 80 percent.

And in addition, the American Rescue Plan, which I thank Congress for as well, and those investments, that 37 billion dollars, the vast majority of states that _ every state utilized that funding. The vast majority, almost to a

T, used that on workforce, and many of them, as they made investments in workforce, also had requirements that a sufficient portion of those investments would go to the direct care workforce. So we are seeing that interest and appetite and policy direction from states across the continuum as well.

*Ms. Eshoo. Mm-hmm. I would note that the Republican Study Committee, which in my understanding is they represent a majority of the Republican conference, released its budget for fiscal year 2025. That budget endorses gutting funding for federal healthcare programs by four-and-a-half trillion dollars, including the Affordable Care Act, the Children's Health Insurance Program, and of course, Medicaid. What would that do? What would the ground look like if that were to be the case, and what does the President propose in his budget to strengthen Medicaid?

*Mr. Tsai. I appreciate that question, and I haven't seen the Study Committee's report so I can't comment on that, but relative to the impact of any large budget cuts for the Medicaid and Children's Health Insurance Program, it would be devastating for the health, and mortality, and

morbidity for kids, adults, individuals with disabilities, others all across the country.

*Ms. Eshoo. Yeah. We are not talking about systems that are rich systems to begin with, and I think that it is very important to have, you know, balanced policies. We can't afford to do without nursing homes in our country, in rural areas the stress is even greater. But I don't think we are going to attract a _ and keep a workforce unless they can live on what they make.

And so in your considerations, where _ did you have like 10 or 20 options that you examined and then landed on this one, taking all of these things into consideration? Because there is a real bone of contention here, obviously. You could hear it in the chairman's opening statement, and then in mine, and the others.

*Mr. Tsai. I appreciate that. I would say one really important thing to emphasize is in part of supporting stronger access to home and community-based services, the rule hit on many different pieces. The 80/20 was only one piece. There were many other provisions from quality to transparency of rates to waitlists, which Chair Rodgers

discussed, and so it is a multifaceted, systematic way of getting at how do we make home care stronger and more accessible.

And we also think that investments are really important downpayments, and the Pres _ you asked about the President's commitment. The President's budget includes a proposal for 150 billion dollar investment into home and community-based services.

*Ms. Eshoo. Well, my time is expired, and I thank you for being here today and the such important work that you do day in and day out.

*Mr. Tsai. Thank you.

*Ms. Eshoo. I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back, and the chair will now recognize the chairman of the Rules Committee, Chair Burgess, for five minutes for questions.

*Mr. Burgess. Thank you, Chair Guthrie.

Thanks for being with us here today. In your written testimony, one of the footnotes is _ deals with the amount of improper payments, and although you don't list it out specifically in your testimony, the improper payment rate

for Medicaid for an aggregate of years, 2023, 2022, 2021, is listed as 8.5 percent. One of those years it was as high as 15 percent, the improper payment rate. And let me stipulate, improper payment rate is not fraud, the _ but improper payment is money that was paid that possibly was not correct.

Just as a point of reference, do we know what the improper payment rate for Visa and MasterCard is?

*Mr. Tsai. I appreciate the question. I _ we take our fiscal responsibility very seriously and we want to make sure that we are reducing that rate of improper payments.

*Mr. Burgess. Well, and I want you take it seriously. 50 billion dollars is a figure that is given in the _ in your footnoted report. I am also on the Budget Committee. You know the massive amount of deficit that this country is running right now. Interest rates have been jacked up the last three years. So that 50 billion dollars costs _ I mean, there is a lot of carrying costs in that 50 billion dollars. It is not just that we spent 50 billion dollars more than we should have based on the bills that came in, but now we have got to do the debt service on that 50

billion dollars, and with the size of your agency and the size of the Federal Government, you begin to get an idea of how that can snowball and why it is so important that we stay focused on it.

Still at the same time I am concerned that it does seem that the scrutiny placed upon a state like Texas, a state like Florida may be higher than what you would expect from other states. And, in fact, there was a newspaper article that openly suggested Florida, because it may be producing a political rival to the President, Florida came under increased scrutiny during that time. Can you comment to that?

*Mr. Tsai. So I appreciate the question. I just want to first agree wholeheartedly, fiscal integrity, reducing the rate of improper payments, making sure that every Medicaid dollar, both federal dollars and state dollars, are wisely and prudently spent because we have just talked about how many priorities there are and how much there is to make sure there's investment in, we couldn't agree more. We are very focused on that. And, in fact, in our discussions with states, I think we are so focused on it that in every

discussion we have around X or Y, states are raising to us, how are you auditing us, what is our _ what is going to be the impact on your improper payment reviews.

And so I think that increased scrutiny and that strong, firm approach we are taking is having an effect and our goal is to make sure that there are as few improper payments in the Medicaid program as possible.

*Mr. Burgess. So no one wants the improper payments. At the same time there is also a cost to not spending money that you perhaps should have spent, and one of the things that has concerned me greatly over the last three or four years and now has been corrected, Texas as of the first of March of this year is now covering postpartum care, post-delivery care for a full year rather than two months, which had been the standard in Medicaid. It took a while to get that done.

One of the interim steps was Texas agreed to cover six months of care after delivery in the previous legislative session, but you all stopped that. And water under the bridge, and you can't go back and redo that, and now the problem is at least in theory solved, but why would you make

a decision like that? The state is meeting you halfway, coming halfway to where you want, why would you deny them for that, recognizing that you have got a two-year legislative session, why would you do that?

*Mr. Tsai. I appreciate that and we I think share a common goal of wanting to make sure that there is as much postpartum coverage, the 12-month option that Congress put forward, as possible. And I would note we have 46 states plus territories that have now taken that 12-month postpartum option, the state plan option outlined by statute by Congress. Thank you all for that _

*Mr. Burgess. You are welcome. And the option was I thought important because some states like Texas react differently if you tell them it is something they have to do and then there are court cases filed and you actually delay getting the good policy in effect. But again, I don't understand why the agency itself held that up. The two years where it could have been six months of coverage, I don't know what number to put on that as to the number of lives that could have been saved, but it seemed meaningless, and it seemed arbitrary, and it seemed capricious, and I

wish you wouldn't do stuff like that.

*Mr. Tsai. Appreciate that.

*Mr. Burgess. Mr. Chairman, I yield back.

*Mr. Guthrie. The chair yields back, and the chair will now recognize Mr. Sarbanes for five minutes for questions.

*Mr. Sarbanes. Thank you, Mr. Chairman. Thank you, Mr. Tsai.

As you know, millions of Americans rely on Medicaid for healthcare services ranging from preventive and primary to specialty and long-term care. Of these individuals, more than 80 percent now are enrolled in Medicaid managed care plans, making it critical that these plans provide comprehensive coverage in compliance with existing law. Unfortunately, CMS does not have the tools to fully and effectively ensure this compliance.

For example, last year the IG found that Medicaid managed care plans may have inappropriately delayed or denied care for thousands of beneficiaries ranging from cancer patients to individuals with disabilities in need of long-term care services, and state oversight of this issue

was limited, likely allowing inappropriate denials to go undetected. Earlier this year the IG found that as our Nation is facing an acute mental and behavioral health crisis, some states' Medicaid managed care plans do not meet federal parity requirements.

Would you agree that this is troubling and merits a look at how we can strengthen federal oversight to make sure no patient is wrongly denied coverage for care?

*Mr. Tsai. I appreciate that question. As you noted, managed care is a significant portion of the program today across states and our firm commitment to belief is that we oversee and are working to ensure firm and strong program integrity within managed care plans which, as you noted, a core piece of that is making sure that managed care plans can deliver care in a timely way to people that are enrolled without undue burden. Our recently finalized managed care rule puts a substantial number of additional transparency and accountability measures including, as I noted, measuring appointment wait time of how long it takes to get services within managed care.

*Mr. Sarbanes. Under current law, CMS lacks effective

mechanisms to ensure compliance in many instances. And, you know, notwithstanding what you just said, because it can only defer or disallow its entire capitation payment to a state, as you know. This is effectively a nuclear option for enforcement and when that if used could have serious implications for beneficiaries' continued access to care.

Can you talk about the challenges this presents for CMS's oversight and enforcement capabilities, in particular obviously for the Medicaid managed care arena?

*Mr. Tsai. I am really glad you raised that, thank you. It is _ as part of _ as the entity overseeing Medicaid managed care, part of that, it is critical to have the right tools to be able to do so. And as you noted, current statute, unlike for the rest of the non-managed care program, I think you used the word nuclear option, but right now there is only the option if we identify an issue, a compliance issue with the managed care plan, the only option we have is to disallow say the entire payment for that month to managed care, which in the states, if it is a state that has largely managed care, that is effectively shutting off federal dollars for the Medicaid program for that entire

month. That is a very difficult option. It does not allow us, therefore, to effectively take action if we find smaller compliance issues, which we would want to remedy but we have no recourse except to do all or nothing.

*Mr. Sarbanes. Can you talk a little bit about what you try to do in spite of this gap to promote compliance in Medicaid managed care? I mean, I have introduced legislation, the Meaningful Oversight of Medicaid Managed Care Act, that would give CMS the authority that you are seeking which is to issue partial deferrals or disallowances to help hold states and managed care organizations accountable and improve patient care without threatening beneficiary access to care, so we are trying to help you here with the toolkit that you describe.

But tell me what you are trying to do in spite of this challenge you currently have as we are trying to get the cavalry there to help you out?

*Mr. Tsai. I appreciate that, thank you. And, yes, we are using every available tool to us at the moment to have strong programmatic oversight of managed care plans. As I noted, we just finalized a comprehensive rule on managed

care last week. That rule includes many strengthened provisions. For example, transparency on how certain dollars are spent within the managed care program that we did not previously have. I mentioned _

*Mr. Sarbanes. Mm-hmm.

*Mr. Tsai. _ appointment wait times a few times. How hard is it to get services with the managed care plans, and including how _ measurements of how to make sure that sufficient dollars are spent on medical care versus other types of care. Those are all pieces.

And finally I would add, our team and our colleagues at CMS and also with our colleagues at the OIG and GAO, there are a regular frequent number of direct audits on managed care plans to make sure that managed care plans are fulfilling their obligations under federal requirements.

*Mr. Sarbanes. Well, I am out of time, but hopefully we can get you some new tools.

*Mr. Tsai. Appreciate that.

*Mr. Sarbanes. Thank you, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentleman yields back. The chair recognizes Mr. Latta for five minutes for

questions.

*Mr. Latta. Well, thank you very much, Mr. Chairman. Healthcare costs have drastically risen and it is imperative we prioritize who was originally intended for Medicaid: low-income seniors, children, individuals with disabilities. Proper oversight is needed to prevent those from gaming our system to stealing resource from those who rely on them.

Mr. Tsai, CMS recently finalized a new eligibility regulation. The new regulation says that when conducting an eligibility determination, the state has to give an individual an additional _ an initial, excuse me, 30 days to respond to a request from the state verifying their eligibility. From there, the individual can be entitled up to 90 additional days before a final determination on coverage is made.

In short, someone who is ineligible for Medicaid but attempts to dispute that decision can get Medicaid coverage for up to four additional months. Just out of curiosity, do you know how much that costs states?

*Mr. Tsai. So I appreciate that question. I just _ I would say our goal is to make sure eligible people are able

to smoothly enroll into the program or renew without enormous amounts of red tape and that ineligible people are successfully transitioned or can get coverage through other sources.

*Mr. Latta. But do you have some kind of numbers as to what that would be for those that were on that for that 120 days that shouldn't have been on when it might even be costing the states?

*Mr. Tsai. So as part of _

*Mr. Latta. If you don't have that right in front of you, if you could get that for us, we would appreciate that.

*Mr. Tsai. I _ we would be very happy to follow-up with you.

*Mr. Latta. Thank you. Last year the improper payment rate was over 50 billion, following up from my friend from Texas, in Medicaid. If Medicaid kept paying for someone who was ineligible for the program for this four-month period, would that be considered an improper payment?

*Mr. Tsai. So as I have noted, we want to _ it is very important to us to make sure that states are following federal requirements on eligibility enrollment processes and

that we are minimizing that improper payment rate.

*Mr. Latta. But would that be an improper payment or how would you classify that?

*Mr. Tsai. There are a whole range of rules that we have around what the eligibility process is for states and our focus is to make sure that they follow all the required federal _

*Mr. Latta. If _ also if I could get that, those eligibility requirements, I would appreciate that to see what would be considered an improper payment.

*Mr. Tsai. We will follow up on that, thank you.

*Mr. Latta. Thank you. Recently the Biden administration finalized their mandatory staffing ratios for nursing homes. Portions of my district are extremely rural and finding staff for certain jobs can be difficult, particularly in healthcare. Independent reports are that 80 percent of nursing homes cannot comply.

And before I go into the question is this. I was on the Wood County Commission for six years. In Ohio our counties can have nursing homes, so the three commissioners in my home county, me being one, were in charge of a 120-bed

nursing home. It is difficult to find people out there today, and Wood County is not what you would consider rural.

Also, the staffing is difficult because we are very, very fortunate in our jobs, we get to go through a lot of different facilities, and not only facilities but also nursing schools, and when I have gone through the nursing schools, one of the questions I always ask to pretty much a lot of the nurses there, just about _ or the students that are about ready to graduate, what do you want to do when you graduate. And you know what they tell me? About 80 percent want to be traveling nurses. And I say why do you want to do that? And some say, well, because you get paid more. So, you know, all of the sudden you are competing in a situation like that which is human nature where people want to go.

So the other problem is is that, you know, a lot of people look at rural areas and say, well, you know, what _ we are too far from what we want to be near, and all of the sudden we don't have people there. And I _ again, having been in that situation as a commissioner, and now we had an administrator for the hosp _ for the nursing home, but I am

very concerned about that because I think it is _ we have to think about that because _ again, just out curiosity, would you know at the Center for Medicaid and CHIP Services, how many people have come from being administrators or working in nursing homes?

*Mr. Tsai. So _ well, first, I appreciate your focus and push on how we as a country and in the Medicaid program _

*Mr. Latta. Well, I _ you know, I am _ I only have a little bit of time left, but I am just _ I would like to get that information, too, because I think it is very important because if you are not in those shoes out there, it is very difficult to understand. So the question really becomes is how are _ you know, when people have to think about where they are going to have their loved ones at, and especially with our seniors who might have to relocate from a nursing home because they won't be able to have the staffing at that one because they are going to say because of the new guidelines we can only have X number of people here, and unfortunately, we are going to have to triage some of these folks and they are going to have to leave.

So the question is, is that being considered what happens to those people?

*Mr. Tsai. So I appreciate that. I mean, clearly all of us agree people need _ if someone _ if a nursing home is right for an individual, we want to make sure someone can get access to that and that they can be assured that care in that setting will be safe. And a lot of the focus on staffing and workforce, there are certainly significant staffing challenges that require a creative approach, but the evidence is clear that part of a safe level of clinical staffing, as you know from your former role, is ensuring there is enough staffing.

And the rules really do that, including some very commonsense pieces like a nursing facility, a nursing home should have a 24/7 registered nurse available in case your loved one has a cardiac arrest at 2:00 a.m. You want to make sure there is the right staffing and supports available, and that is really what the rule focuses on.

*Mr. Latta. Mr. Chairman, my time has expired and I yield back.

*Mr. Guthrie. The gentleman has yielded back, and the

chair recognizes Mr. Cardenas of California for five minutes for questions.

*Mr. Cardenas. Thank you, Chair Guthrie, and also I would like to thank Ranking Member Eshoo for holding this hearing to discuss efforts to improve access to Medicaid services and program integrity all across our great Nation. I would also like to thank Deputy Director Tsai for joining us and sharing your expertise and details of your work administering, protecting, and strengthening Medicaid for all patients.

As the Nation's single largest payor for long-term care services, Medicaid plays a critical role in meeting the day-to-day needs of millions of Americans. I am encouraged by the many bipartisan proposals discussed today that take necessary steps toward strengthening the integrity of the Medicaid program. However, I am also concerned that certain proposals included in today's hearing seem to chip away at CMS's ability to support the long-term care services system and undermine workforce protections which will take us in the wrong direction. And I believe that those workforce protections actually help the patients and the service

rendered.

In October of last year, we heard from long-term care service providers who were clear and _ excuse me, who were clear that recruiting and retaining their workforce has been a struggle. I would also like to call attention to _ once again to the fact that in my home state of California, 60 percent of direct care workforce workers was estimated to be women of color. And at the national level, foreign-born workers make up about 25 percent of the direct care workers in the home care industry and 19 percent of direct care workers in the nursing home care industry. Despite the vital work this diverse and dedicated workforce performs, they continue to face low wages and high burnout.

Mr. Tsai, your agency recently finalized rules aimed to supporting and stabilizing the direct care workforce. Can you explain how the finalized versions of the nursing home staffing rule and access rule considered the direct perspectives of long-term care stakeholders?

*Mr. Tsai. Thank you for your _ for that _ for those comments, the question, the focus on making sure we have a sufficient, a well-trained workforce, direct care workforce

to attract and retain across both home care and nursing home services. That is absolutely critical, the evidence is clear, to making sure that people not only have access to services but that is high quality and safe.

And the multiple set of rules and policies you see us having recently rolled out, not just with the 80/20 and the staffing piece that we have discussed so far, but a whole suite of things really aimed to strengthen and emphasize that, including sufficient payment, investments in the workforce to ensure that access is there for the people that need it.

*Mr. Cardenas. Thank you. And your agency also shared a commitment to advancing health equity, expanding coverage, and improving health outcomes. Can you elaborate on how these workforce provisions advance health equity, ensure access to care _ good, quality care, and improve health outcomes?

*Mr. Tsai. Absolutely. We serve _ we are the Nation's largest payor, as you noted, for home care and home health services and long-term services and supports, but from an equity standpoint, there are folks that have resources that

don't need our coverage and are able to access home care and other supports. We want to make sure that the people enrolled in the Medicaid program all across the country have equitable access and that it is culturally and linguistically competent.

And as you know, the direct care workforce, who that person is coming into your home, the relationship you have, those are critical pieces and that is why it is important to have a well-supported, well-trained workforce.

*Mr. Cardenas. And when it comes to quality care, you just mentioned that some people get their own private care or they might _ they could afford somebody to actually come to their home to take care of their aging grandmother, or what have you, but we are talking about individuals who need Medicare to make sure that their loved ones get the quality care that they deserve. Should we have a two-tiered system or should we constantly strive to make sure that our system provides the best care regardless of whether or not that family has the income to provide that private health assistance?

*Mr. Tsai. We wholeheartedly believe that people

should be able to access quality care across the board in a way that any of us would expect for ourselves or our families and that is exactly what the rules and the policies we roll out really seek to underscore.

*Mr. Cardenas. Now we are talking about the kind of care that some people need 24/7, the kind of care that may be the only caring human being that that person comes into contact with is actually their caregiver or caregivers.

*Mr. Tsai. That is indeed sometimes the case and we want to make sure that people have access to a strong set of supports, including home care, so that an individual can be as independent, say age in place in their home, and if someone desires to be in a nursing home, we also want to make sure that the care is sufficient and safe in that setting as well.

*Mr. Cardenas. Thank you. Mr. Chairman, my time has expired, I yield back.

*Mr. Guthrie. Thank you. The gentleman yields back and the chair recognizes Chair Rodgers for five minutes for questions.

*The Chair. Mr. Tsai, I would like to start off by

asking you a question that Secretary Becerra couldn't answer for us a few weeks ago. Do you know how much the Office of Actuary expects that the recent Medicaid eligibility and enrollment rule will cost Medicaid over the next decade?

*Mr. Tsai. Thank you for that question. We _ I think you were asking about both access and managed care. Across those we want to make sure that we are able to ensure access and have strong [indiscernible] managed care programs.

*The Chair. I am asking if you know how much it is going to cost.

*Mr. Tsai. The regulatory impact analyses are posted alongside every one of our rules and are publicly available for folks to take a look at.

*The Chair. So the answer is it is more then 50 billion. 50 billion in Medicaid in just the first five years. 38 billion paid by the Federal Government, 23 billion by the states. So you used to run the Medicaid program in Massachusetts. I can't help but wondering how exactly is a state going to balance their budgets when incurring those kinds of costs.

When regulation _ so my question is, when regulations

like this go through CMCS, do you consider whether states will need to cut reimbursement rates or services to offset costs that your office is imposing on them?

*Mr. Tsai. So I appreciate that. Our obligation and our focus is to make sure that people enrolled in the program have strong access to care, and program integrity, and we are able to oversee the program, ensure the right requirements are in place. The two rules that we finalized on the Medicaid side last week have a whole systematic suite of initiatives that support those things in tandem, and we work very closely with states on what the impact looks like and how to do it.

And, in fact, as a former state Medicaid director, this was very important to me. Some of the provisions that we outlined in the rules take effect over a multi-year period, precisely for the reason you mentioned.

*The Chair. So I am going to reclaim my time and just underscore. We are talking billions of dollars, mandates that I _ that you are making without any elected representatives having a say in this that is going to cost and, in fact, could actually limit access to care. That is

what we are talking about.

While I have considerable amount of concern with the recent Medicaid regulations that were finalized in the last two months, I do want to highlight an area of common interest that we share. The recent Medicaid access rule calls for increased transparency into the state of the home community-based care waiting lists. So I just wanted you to speak, if you would share with the committee what we know _ what you know about these lists, how many people are on them, what care they receive, when they get off, and what we hope to learn from the new transparency requirements.

*Mr. Tsai. I appreciate that, and we very much share that same interest. We want to make sure people have access to home care services. And as you noted in your opening statement, there are _ many states across the country have waitlists for that. Unfortunately, we, CMS, do not have a consistent data set to understand what the waitlist length is across states, are those apples to apples comparisons, and therefore, what are states doing to be able to reduce those waitlists.

The regulations we finalized require that states report

that to CMS in a consistent way that allows us to monitor and have discussions with states about that exact topic.

*The Chair. Well, the last time I heard in Washington State we are talking 15,000 people that are waiting, and I have a friend who would like to take a job in D.C., but he can't _ he won't do it because he would be put on the back _ he would have to wait years _

*Mr. Tsai. I am sorry to hear that.

*The Chair. _ in this region. Mr. Tsai, a few weeks ago our Subcommittee on Oversight and Investigations held a hearing on improper payments in the Medicaid program. So they are at an all-time high and we need to be doing more. GAO OIG highlighted a number of concerns associated with inadequate beneficiary and provider screenings where states are failing to do simple things like ensuring we aren't paying for deceased beneficiaries. GAO and OIG repeatedly urged CMS to increase its oversight of screening practices by the states. They noted mixed responses from CMS in regards to the agency's willingness to engage on these issues.

And I understand things have been challenging for

states in the Medicaid over the last few years because of continuous coverage requirements and the current unwinding process that states are going through, but can you speak to what new work CMS is doing to better audit improper payments now that the wind _ unwinding process is coming to a close?

*Mr. Tsai. I appreciate that. I _ again, I agree wholeheartedly that fiscal integrity, fiscal stewardship of the program is incredibly important and also that improper payments, any level of improper payment is unacceptable and that has been a huge focus of work for our team with states. I would note as one example of some of the new work. You noted deceased individuals with the managed care plans. We have very clear federal rules that say managed care plans cannot be paid their monthly premium for deceased individual around that. We wholeheartedly agree with the OIG and others around that point.

We just put out additional reinforcement guidance to states about exactly how to do that. And I would note, states have a common interest here. We recoup the money from states when we, or a federal auditor, or someone else audits and identifies an individual that was deceased where

there is a managed care payment, and so states have every interest to take up the reinforced guidance that we have put out.

*The Chair. My understanding is that you still allow it up for a month for the payment to still continue, so anyway, we will keep working on this. I yield back. Thank you for being here.

*Mr. Griffith. [Presiding.] I thank the gentlelady for yielding back and thank you for highlighting that excellent committee by _ that hearing by the Oversight Committee. I hear the chair did a great job. Just saying.

Now I recognize Ranking Member Pallone for his five minutes of questioning.

*Mr. Pallone. Thank you, Mr. Chairman.

Mr. Tsai, in your testimony you spoke to the benefits that the American Rescue Plan Act had on beneficiaries' ability to access home and community-based services, and that law provided states with a temporary 10 percent point increase to the federal matching rate for Medicaid home and community-based services. So my question is can you describe the types of initiatives states adopted with that

temporary increase in Medicaid funding and the investments we could expect states to make if additional funding for home and community-based services was provided in the future?

*Mr. Tsai. Thank you for that, Ranking Member, and both you and Ranking Member Eshoo referenced that 37 billion dollar American Rescue Plan investment in home and community-based services. I firmly believe that without that we would have had a large and substantial number of our HCBS providers have to shut their doors as a result of real challenges through the pandemic and ongoing.

Almost every state used that funding to strengthen the workforce, including things like retention, bonuses, increased wages, training programs, and things of that sort, really with the affirmation that without a strong workforce and a well-compensated workforce, home care, nursing home care will not be able to compete with other sectors, with hospital care, and that is critical for us being able to ensure that our enrollees can access safe, high-quality care.

*Mr. Pallone. Well, I thank you. I am concerned that

many people who need home and community-based services are unable to access them at times, you know, oftentimes waiting years to receive services.

So let me get my question second. How would the Medicaid access rule that was finalized last week help CMS to better oversee Medicaid home and community-based services and specifically how states manage waiting lists?

*Mr. Tsai. I appreciate that. I am quite _ our team is quite excited about the many provisions in the rules that we finalized because, as you noted, there is a systematic approach required to making sure that access is available in a timely way, and it is not just one solution, it is multiple, and that includes what is the rate of payment to HCBS providers and is it efficient.

We require for the first time measuring waitlists. We also require for the first time measuring how long it takes to get access to HCBS services. Those are not facts any of us have today and they are necessary and important to making sure that people could have access in a timely way.

*Mr. Pallone. Well, thanks again, and I appreciate the work that CMS has done to promote greater transparency in

this area, and that is why legislation that Chair Rodgers and I cosponsored would codify and build upon requirements for states to report on home and community-based services' waiting lists.

I want to discuss another issue, the impact that the Medicaid unwinding is having on American families. Many states' eligibility and enrollment systems and processes have long been out of compliance with federal law and, as a result, Medicaid beneficiaries are being unfairly terminated from the program and applicants are experiencing unlawful issues like long wait times before receiving the eligibility determination. So my question is when will states be required to commit to specific plans for coming into compliance with longstanding eligibility and enrollment requirements and how will CMS hold states accountable to those plans?

*Mr. Tsai. Thanks for that. And first, I have to thank you for your continued leadership and interest and perhaps persistent letters and focus on this topic. We agree, it is fundamentally important for us that everyone that is eligible be able to renew their Medicaid or

Children's Health Insurance Program coverage as easily as possible without red tape. And as you noted, what we see from the data is that state choices matter and whether or not a state adopted certain policies to reduce red tape, fundamentally impacted what the results look like.

On your question about when will states need to come into compliance, we are holding states accountable, I assure you, on following all federal requirements, both for existing rules and the recent rules for eligibility that lifted and strengthened those standards. We will be providing additional notice publicly shortly around some of the timeframes for compliance at the state level and we look forward to continued dialogue with your office on that.

*Mr. Pallone. And I appreciate it, that is really important. I really support _ or I say _ I should say I strongly support further action to ensure states commit to detailed, comprehensive plans for coming into compliance with these longstanding and critical beneficiary protections and I would like those plans made public so that we can work together to ensure states adhere to them. So with that, thank you, Mr. Tsai.

And I yield back, Mr. Chairman.

*Mr. Guthrie. [Presiding.] Thank you. The gentleman yields back. The chair will recognize Mr. Griffith for five minutes for questions.

*Mr. Griffith. Thank you very much. Directed payments are one of the largest growing portions of Medicaid spending. These payments are important for many states and I understand the need for them, but transparency is critical for the public and policy makers have to have timely access to information on what payment arrangements have been approved and the effects of these arrangements on quality and access to care for Medicaid enrollees.

And I know you touched on this in your opening, but the Centers for Medicaid & Medicare Services has already done a lot but maybe we can do more because both the Government Accountability Office, GAO, and the Medicaid and Children's Health Insurance Program Payment and Access Commission, MACPAC, have recommended bringing more transparency into state directed payments. My bill, H.R. 8113, the Transparency in State Directed Payment Act, does just that. Do you agree that this type of transparency would be

helpful, and if so, why?

*Mr. Tsai. Appreciate that. It wouldn't be a Medicaid hearing without discussion about state directed payments, so thank you for that question.

For state directed payments, we want to do two _ we have two important goals. One, we want to make sure there is adequate funding for the safety net for providers and, in fact, one of the most common pieces of outreach we have from congressional delegations is how important state directed payments are to their particular state and providers. And at the same time, as you are noting, we want to make sure we have strong fiscal stewardship of those state directed payments, we have transparency, we have oversight, and we know that they are in conformance with federal requirements.

And so we have similarly put out in the new rule more transparency requirements on state directed payments. We think it is important, even really critical for everybody to have, as you noted, excuse me, transparency into the levels of payments and how they are funded.

*Mr. Griffith. All right, I appreciate that. Are you aware of any directed payments being used by states to push

hospital reimbursements to exceed a hundred percent of costs for living care for Medicaid beneficiaries?

*Mr. Tsai. So as I noted, state directed payments are critical for reimbursement and we are making sure _ we have a lot of federal rules around what states need to do to comply with those, including various payment limits and the like. Part of the new rule that we put out, part of our oversight includes asking every one of the states those exact sorts of questions and to make sure that all the payments are in compliance with individual rules.

*Mr. Griffith. Now the chairwoman of the full committee brought up the Oversight Subcommittee hearing on overpayments and we heard at that time from GAO about the importance of state auditors to detect fraud and improper payments in Medicaid, and one of the proposals that I kind of floated at the time because it just came to me as we were listening to the witnesses was perhaps we can get more states to do audits themselves instead of waiting on you all by sharing some of the savings that they find, whether it is intentional or unintentional, it doesn't really matter, but overpayments that are made by sharing a portion of that

savings with the state. What are your thoughts on doing something like that to incentivize the states to do more state audits?

*Mr. Tsai. I think for strong program integrity you want both people from the federal standpoint, both at CMS and OIG, GAO being able to take a look and you want people at the state level that know the individual state level dynamics and programs, including state Medicaid agency and others, doing that sort of work as well.

*Mr. Griffith. Well, one of the _ one _ and I appreciate that you want to do it, the problem is the states a lot of times don't have the money for their state auditors to go off and do this, which is why the idea came up that maybe if you shared some of the savings so that if you find, you know, and I don't know what the right percentage would be, but if you find a hundred dollars, the state would get to keep 20 of those dollars. I think that that would then perhaps pay for the program and pay for the states to have auditors and have more auditors going in and checking on these things and make our whole system healthier. Do you not agree with that at least philosophically?

*Mr. Tsai. We would be happy to work through any details that is helpful. One thing I will note coming from a state is that when it comes to program integrity, including improper payments, states feel the budget pressure every day. When I was a Medicaid director and someone found a legitimate program integrity piece that I could act on, and yield savings, and administer the program in conformance with all laws and regulations, I would jump up and down with excitement.

States have a strong interest in being able to find things of that sort and so I think that is why there is both interest and real value in states being able to do a lot of program integrity work.

*Mr. Griffith. Well, I look forward to working with you on that because I do think it is important that we try to figure out a way to do that, and it is just human nature _

*Mr. Tsai. Appreciate that.

*Mr. Griffith. _ if I am gong to get a piece of the action, I might work a little bit harder. Not that the chief guy won't be excited if we find something but, you

know, if I am one of the auditors, I am thinking, yeah, I can really help my state out if I find something that is not being done right. I think that just incentivizes that.

*Mr. Tsai. We would be happy to follow up with your office on that.

*Mr. Griffith. Yeah.

*Mr. Tsai. Thank you.

*Mr. Griffith. I appreciate it, and I yield back, Mr. Chairman.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Dr. Ruiz for five minutes for questions.

*Mr. Ruiz. Thank you, Mr. Chairman. With an aging population in the United States, the importance of a strong long-term care workforce and reliable long-term care facilities like nursing homes cannot be understated. Our seniors rely on these vital services for the care they need to maintain a healthy quality of life.

However, the nurse to resident ratio at many nursing homes is abominable and unsustainable. When nurses or nurse aides are responsible for caring for too many patients at once, staff all too often experience burnout which leads to

turnover. When burnout occurs, vulnerable residents can fall through the cracks, errors can be made, treatment is delayed because a nurse or nurse aide cannot be everywhere at once.

The CMS minimum staffing standards finalized rule addresses the issue of dangerous understaffing in long-term care facilities. The rule does include temporary hardship exemptions that address concerns that some long-term care facilities face challenges in hiring and retaining staff, so there are some exemptions there. However, one of the bills before this subcommittee today, H.R. 7513, the Protecting America's Seniors' Access to Care Act, would undo this important safety measure. It would also prevent CMS from finalizing similar rules in the future. Failure to act to mitigate chronic understaffing in long-term care facilities puts patients' safety and lives at risk.

So, Mr. Tsai, how widespread is the problem of understaffing in long-term care facilities that Medicare beneficiaries rely on?

*Mr. Tsai. Thanks for that very important question, and as a physician, you are well-aware of the importance of

appropriate clinical staffing and so thanks for your attention on that. I mean, the number one concern I and my colleagues here when we talk to nursing home residents and family members is can I be assured that my loved one is going to have safe and sufficient care.

And usually that comes down to questions of, as you noted, staffing. Not only the registered nurse piece for some clinical emergencies that might happen at various hours but also having a nursing aide available to help turn an individual sufficiently to not have bed sores or there are really sad stories out there we here directly of someone needing to toilet, not having access to nursing aide for 45 minutes, and having to toilet in their bed.

That is not what any of us would accept for ourselves, our family members. And really what the rule tries to do, as you note, is to establish some minimum _

*Mr. Ruiz. I want to give it a little more doctor talk and a little more understanding of those two examples because those were two examples that came to my mind immediately. One is the fact that they can't rotate a patient. If they don't rotate a patient periodically and

timely, then they can develop bed sores. Bed sores can become infectious, they can get into their bloodstream, they become septic, they go into shock, and for an elderly person, that is very dangerous. They can _ there is a high mortality rate for that, so it is _ can save lives.

The second one is that they soil themselves and they sit there in that soil, which can go _ which can cause UTIs, which can then become kidney infections, which then becomes sepsis, and again, they can die. So we are talking about life and death here.

*Mr. Tsai. Absolutely. And I don't think we need to choose between a nursing home's economics, recognizing legitimate workforce challenges that we all need to work on creatively together and safe, dignified care. And as you noted, the rule that was finalized upholds a standard but creates time and exceptions as well.

*Mr. Ruiz. And so how would this minimum staffing standard rule impact patients' safety outcomes in long-term care facilities?

*Mr. Tsai. Well, the evidence is very clear around what some of the staffing standard should be and that you

need staffing to have not only safe but quality of care, and so that is incredibly important in making sure that we are able to deliver quality care across everybody receiving services in the program.

*Mr. Ruiz. You know, I think a _ the best way to view this nurse to patient ratio is that it is patient-centric not nurse-centric. It is patient-centric, it is for the patient, because when you have an overworked, burnt out, fatigued nurse, patients are ultimately at risk. Risk for not getting their medications on time, risks of not being appropriately attended to on time, and those risks can develop into severe illnesses that we just mentioned. So it is important that we help improve patient care, patient centric care by providing patients an adequate and safe ratio of nurses to patients.

And with that, I yield back.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Dr. Bucshon for five minutes for questions.

*Mr. Bucshon. Thank you, Mr. Chair. I appreciate the opportunity today to discuss how we can best support our state Medicaid programs. Let me just say this, federal

staffing mandates will backfire. Facilities will close. The staff just are not available. Facilities across my district have told me so. They all have job postings, they all want more people, they are just _ the employees just are not there. You cannot except _ expect salaries to increase when Medicaid is the main provider and Medicaid's reimbursement isn't increasing. It just doesn't work.

So I am going to pivot. There is an issue I would like to address that isn't covered by today's legislation. Section 203 of Title 2, the Consolidated Appropriations Act of 2020 changed the formula for calculating an individual hospital's Medicaid DSH cap. While I recognize the intent was to address the issue of Medicaid patients who are duly eligible for commercial or Medicare coverage, this policy has resulted in unintended consequences that have negatively impact hospitals in my district and across the country, many of whom treat our most vulnerable constituents.

Section 203 did include a 97th percentile exception for those hospitals that meet certain criteria. Unfortunately, this policy has created an arbitrary threshold which leaves behind many hospitals and creates year over year uncertainty

should there be changes to a hospital's payor mix. I certainly appreciate the difficult task CMS faced in identifying those hospitals that qualified for the 97th percentile exception.

Upon completion of that process just a couple of weeks ago, CMS identified only one hospital in the entire state of Indiana that qualified, Indiana University, the largest health system in the state. Surprise. It wasn't Good Samaritan Hospital in my district, a small relatively rural hospital that now faces a yearly loss of 3.8 million dollars, nor was it Eskenazi Hospital, a large safety net hospital, a la L.A. County or Cook County, in Indianapolis which faces a loss of 36 million dollars. And it wasn't Methodist Hospital in Gary, Indiana which faces a yearly loss of 27 million dollars and is currently a risk of closure. I could go on. One more, South Bend Memorial faces a yearly loss of 13.5 million.

Given that Indiana hospitals face a loss of 120 million statewide because of Section 203 implementation, I am very concerned that Methodist Hospital in Gary won't be the last one that closes in my state. It is not just Indiana. My

colleagues on the other side of the aisle from New York have hospitals that are at similar risk where nine hospitals ranging from academic medical centers in urban areas to critical access hospitals on the Canadian border are facing a combined annual loss of 290 million dollars.

So I _ the question I have is I want to confirm that there isn't anything CMS could have done to interpret Section 203 differently and allow the agency to better tailor exceptions to hospitals that truly need it. Is that the case?

*Mr. Tsai. Thanks for that, and I appreciate your focus on safety net providers and making sure there is sufficient reimbursement. I think that is absolutely critical and it is a shame that we have so many providers across the country providing care to our members at real fiscal challenges.

You are correct, our team implemented the statute which was exceedingly clear on how to calculate that 97th percentile which was done at a national level and so there was no policy discretion for CMS in this area, our staff implemented the statute.

*Mr. Bucshon. Okay, great. I mean, Eskenazi Hospital, like I said, it is like Cook County, or Grady Hospital in Atlanta, or L.A. County. Level one trauma center, serves underprivileged citizens. 36 million dollar loss based on this. It is going to be a pretty hard _

*Mr. Tsai. That is a challenge.

*Mr. Bucshon. Pretty hard to fix that, right? This isn't just big, private hospitals in suburban areas, you know, with a bunch of wealthy people going there.

*Mr. Tsai. Right.

*Mr. Bucshon. This is hot _ Gary, Indiana, you probably _ may not _ may or may not know, Gary, Indiana has been economically challenged over the years because of shifts in manufacturing and other things. Their hospital there, 27 million dollar loss. It might close. What happens to access to the type of people we are trying to create access to?

So in 2022 I coauthored a letter to congressional leadership on both sides of the aisle that called for a solution to the issue and I now renew that call and ask for you to work with me and all interested parties to find a

legislative solution that addresses this matter before the end of the year. So whatever input you or your office may have on ideas about how we can address this, I would appreciate that.

*Mr. Tsai. We would be happy to work with your office, thank you.

*Mr. Bucshon. Thank you. I yield back, Mr. Chairman.

*Mr. Guthrie. The gentleman yields back. The chair recognizes Mrs. Dingell for five minutes for questions.

*Mrs. Dingell. Thank you, Mr. Chairman and Ranking Member Eshoo, for holding this hearing. I am so thankful that the subcommittee is taking on one of the issues that I have been fighting for throughout my time in Congress, supporting the long-term care system. Systematic changes as we are considering today are vital, but we also have to consider a more robust financial investment in the HCBS.

I have talked about it before, I am not going to _ because time is tight, I am not going to do it today, but our long-term care system is broken. And I am grateful that two bipartisan bills I am leading are included as part of today's hearing. The first is H.R. 8109, Money Follows the

Person Permanency Act of 2024, and H.R. 8110, Protecting Married Seniors From The Impoverishment Act of 2024.

I would like to being with the Money Follows the Person program. This program has demonstrated it works, has strong bipartisan support, and saves taxpayers money by successfully transitioning thousands of people from institutions to a community setting where they can be with those they love. Currently, the program will expire in 2027, and my bill, instead of this constant having to renew it, would authorize it permanently and take away a lot of doubt and insecurity.

Money Follows the Person allows certain Medicaid users such as seniors and individuals with disabilities transition from a nursing home or institutional care back to their home. Since the MFP program was created over a decade ago, it has successfully helped over 88,000 individuals receive care in their own homes.

Mr. Tsai, how would authorizing this program permanently improve the quality and the efficacy for Medicaid users?

*Mr. Tsai. I appreciate that, appreciate your

attention to the Money Follows the Person program, and while I can't comment on any specific legislative proposal, I can affirm that that program is _ it works, it is _ and it has an incredible impact on helping people move from a nursing home or an institutional setting and to be set up so they can reside independently in their home. It is cost effective, it is common sense.

*Mrs. Dingell. Could you address the administrative ease a permanent reauthorization would have on the program?

*Mr. Tsai. From an administrative standpoint, whenever there is _ I would say whenever there is uncertainty about timing of a program, it leads _ coming from estate people, it impacts decision making because you don't know how long you have access to funding. And so certainly with respect to uncertainty and certainty, those are really important for how states and local stakeholders make decisions.

*Mrs. Dingell. Okay, now I would like to address Protecting Married Seniors From The Impoverishment Act of 2024. This is another program that needs a permanent reauthorization. Spousal impoverishment funding is intended to prevent individuals married to someone who requires long-

term care and services under Medicaid from spending down all of their assets to qualify for Medicaid. This program allows the spouse to retain a modest amount of their assets to cover basic living and health expenses.

In addition to this community spouse resource allowance, the program entitles the community spouse to a minimum monthly maintenance need allowance, and it is not a lot of money. Finally, it ensures that Medicaid does not count the spouse's income when determining whether the institutionalized spouse is eligible for Medicaid. Again, this program is set to expire in 2027 and my bill would create _ authorize it permanently.

Mr. Tsai, in some states, if the community spouse's income exceeds a certain threshold, they may be liable for court-ordered support for the cost of the sick spouse's care. How would permanently authorizing the exclusion of a spouse's income improve access for the beneficiaries?

*Mr. Tsai. I appreciate that question. We want to make sure that as many people as want it and need it can access home care, and part of what you are raising is right now in terms of how some of those things are dealt with

there is a bias towards institutional settings, meaning it is more difficult around those things to receive home care, and we certainly have supported and work with states in trying to find a better balance so that there is not a proclivity to have to have someone in a nursing home because of a whole range of things, including how spousal assets are dealt with.

*Mrs. Dingell. In the 30 seconds, how would permanent reauthorization allow the spousal impoverishment program to work?

*Mr. Tsai. Again, as a general comment, I think any time there is something _ when there is uncertainty, it makes it _ there is more hesitation for states and others to take things up because of not knowing how long authorization will continue for.

*Mrs. Dingell. Thank you, and I yield back, Mr. Chairman.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Dr. Dunn for five minutes for questions.

*Mr. Dunn. Thank you very much, Mr. Chairman. Thank

you, Mr. Tsai, for appearing before our committee today. I would like to begin with a question regarding the 80/20 rule which requires the HCBS providers to spend at least 80 percent of their Medicaid reimbursements on compensation. Unfortunately, that seems like a top down one size fits all mandate. I think it is misguided and will actually lead further instability in the home community-based workplace instead of its opposite effect which is intended to improve that.

My colleague from Florida, Mrs. Cammack, has introduced H.R. 8114 to block the rule, and I agree we need to rethink that approach. I have heard from individual providers in my district as well as national associations such as the National Association of Home Care who project that the regulation is unsustainable, will lead to limited services and increased costs. I also have concern about the rollout of this new requirement given CMS's track record working with states like Florida on needed flexibilities and tailor approaches to best serve our managed Medicaid programs and in a concerning pattern, frankly, of CMS setting policy via frequently asked question documents.

So, Mr. Tsai, in your statement you claim the Medicaid access rule is necessary to cap administrative overhead or profit. What do you believe are those inappropriate activities _ profits, I should say, that currently exist in Medicaid in this program that makes this rule necessary, what is that?

*Mr. Tsai. Well, I appreciate that question, that focus, and as I mentioned before, we want to make sure people have access to care, and it is high quality. And having you _ everyone here has noted the workforce challenges. Having a sufficient workforce, the ability to track and recruit that, is paramount to be able to have access.

On the 80/20 piece, the rule requires that _ I mean, Medicaid rates for home and community-based services are meant for direct care and it ensures that 80 percent of the rate goes to actual direct care workers. The administrative overhead and profit, most providers I know are deeply mission driven and committed and so this is not questioning that but it is making sure that there is good fiscal stewardship as well of scarce Medicaid resources.

*Mr. Dunn. But I would tell you that some of the resources they provide in the home are quite expensive. Ventilators come to mind and whatnot. So I think that there is expenses there that wouldn't fit in the compensation bucket, but that is _ how does CMS actually define the operating margin for an HCBS agency?

*Mr. Tsai. So again, the details of the rules are meant to ensure that a sufficient portion of the payment go to direct care workers, and the way we specify that is to really take a look at how much of the rate that a state Medicaid agency pays to the home care workers, not for ventilators, not for the other durable medical equipment, how much of that rate goes to direct care. And in the final rule, we made multiple changes based on a lot of the comments that we received, one of which being we shouldn't _ a provider should get credit for things like travel costs for a nurse across the state, PPE, training, and other things of that sort.

*Mr. Dunn. Can you give me sort of a simple average operating margin for a Medicaid HCBS agency? Do you have a number?

*Mr. Tsai. Sure. It certainly varies across entities.

*Mr. Dunn. Average.

*Mr. Tsai. All across. The _ part of fiscal stewardship is making sure that payments from _

*Mr. Dunn. Do you have a figure for that?

*Mr. Tsai. We _

*Mr. Dunn. I had a figure for my practice when I was practicing.

*Mr. Tsai. We are _ I am well-aware of individual EBITDA margins across for profit and not-for-profit home care providers. We have taken a look at those and part of what the rule also does is to have transparent reporting across the _

*Mr. Dunn. Right. So I don't think we are going to come up with a number here. Let me ask you a different question. I am also concerned with the delay in improving the expansion of Florida's CHIP program, which we call Kid Care, this is the Children's Health Insurance Program, and we are having terrible delays and this is really a terrific program. To be clear, Florida wants to put more kids in the program not less, so this is a plus for the beneficiaries,

but CMS is _ again, some frequently asked questions, style guidance preventing disenrollment of individuals related to failure of premiums. These premiums are like $20 a month and these are people who make up to 300 percent of poverty level _ federal poverty level so, I mean, I think that is reasonable. Can you address that?

*Mr. Tsai. Sure. I mean, our goal is to make sure that eligible kids _ I am sure we all want eligible kids to be covered by Medicaid and the Children's Health Insurance Program versus being uninsured, and we also appreciate that Congress provided a statutory requirement for 12 months of continuous eligibility for all kids across the country, and we are making sure that we are implementing our understanding of the statute.

*Mr. Dunn. Well, I would like you to work with Florida, if I may.

Mr. Chairman, I _ my time is expired, I yield back.

*Mr. Guthrie. Thank you. The gentleman's time is expired. I would like to _ everybody is hearing the bells and whistles. There is a vote on the floor. We are going to try to continue for at least a couple of more, but we

will have to reconvene after votes, and so thank you for your willingness to do that.

And the chair will now recognize Ms. Kelly, she is up for five minutes for questions.

*Ms. Kelly. Thank you, Chair Guthrie and Ranking Member Eshoo, for holding today's hearing. In Illinois, the Medicaid prospective payment system, PPS, for community health centers is designed to provide reimbursement that accounts for the cost of service, expansion, and delivering services to all individuals who seek care. However, there are concerns that the PPS rates in Illinois only cover just about 60 percent of the actual costs incurred by healthcare centers. And if you compare Illinois', excuse me, PPS rates for behavioral health services, our members receive maybe one-third of what their counterparts in our surrounding states receive. This indicates a significant gap between the reimbursement rates and the operational costs of providing comprehensive care.

What steps can be taken to ensure these rates are adjusted to reflect the operational costs of health centers more accurately?

*Mr. Tsai. Sure. Thank you for that health center. I think health centers are an incredibly important part of the Medicaid program, and this is not just for your state but across the board. They are a good investment, they provide primary care, they often do behavioral health and dental, they are scrappy, they are cost-effective, I think they are really good.

There is also statute, as you know, BIPA, that has clear federal statute around how states need to set the PPS rate for federally-qualified health centers, and we work with all states to make sure that they are able to comply with that. And in addition, I would say we continue to encourage and support and we have a range of policies that we put on the table, continued investment in health centers and primary care because I think it is a very _ yields a high return on investment for the program.

*Ms. Kelly. Thank you. How do you envision the future of the Medicaid community health center PPS and what changes are being considered to improve its effectiveness and sustainability?

*Mr. Tsai. So I _ again, I think it is critical that

health centers can be sustainably reimbursed and also consistent with federal statute. They play a critical role. And with every state we are I think routinely in dialogue around how they can best both utilize the PPS rate but also there are a number of states that have utilized a part of the statute called the APM, the _ an alternative payment methodology, where they pay above the PPS rate, value base with quality to ensure there is both sufficient funding for primary care in health centers and also that there are other programmatic benefits, we think those are really exciting approaches as well.

*Ms. Kelly. And are there states that you think _ I guess comparable states that you think that you would hold up as a model or is that hard to do?

*Mr. Tsai. There are a range of states that I think do a really good job including using the APM methodologies. We would be happy to follow up with your office on any specific state examples if that would be helpful.

*Ms. Kelly. Okay, you don't want to call one state? Okay.

Thank you, Chair, I will yield back.

*Mr. Guthrie. Thank you. The gentlelady yields back. The chair recognizes Dr. Joyce for five minutes for questions.

*Mr. Joyce. Thank you, Chairman Guthrie and Ranking Member Eshoo, for holding this important hearing today, and thank you, Mr. Tsai, for testifying.

The Medicaid program is essential resource for America's most vulnerable populations, including children and those with disabilities. It is encouraging to see that this committee continues legislation, much of it in a bipartisan fashion, which will only help to strengthen this critical program. Many of the proposals today will make commonsense changes to cut down on improper payments and combat fraud. Other proposals will push back on federal mandates that threaten access to home care and long-term support services for beneficiaries by imposing unattainable requirements.

As we examine these potential changes to how the Medicaid program is administered, we must consider how they will help achieve the goal of continued access to high quality care for beneficiaries through efficient use of

Medicaid funds.

Mr. Tsai, when CMS evaluates potential rules for Medicaid coverage, how do you balance expanding access to more beneficiaries versus considering access to enhance services for each beneficiary that is already covered?

*Mr. Tsai. I appreciate that. Both are important. As you know, we want to make sure from an access standpoint and a coverage standpoint eligible people can enroll and easily enroll without red tape and that the services that people enroll receive are sufficient and really help improve their health, and that is a constant ongoing dialogue that we have with every state Medicaid agency which, as you know, makes a lot of their individual choices for what to cover and how to do so in that particular state.

*Mr. Joyce. I worry that with new federal rules expected to cost billions of dollars to the Medicaid program over the next decade states will be forced to balance their costs in one of two ways, either by cutting reimbursement or cutting optional services like home care and community-based services. Both of these actions would have devastating effects on access to care, and if this happens, Medicaid

will fail to match its intended purpose for its intended population. Do you feel _ through which process does CMS ensure that new rules and increased spending will not lead to cuts to services for beneficiaries?

*Mr. Tsai. So we are highly interested in making sure we can both achieve clear federal policy goals and what our statutory objective is, which is to make sure there is coverage and access for people in the program, including quality coverage, and that we are working with our individual state Medicaid agency partners on the budget and operational reality _

*Mr. Joyce. Do you see this able to occur without cuts to home care or community-based services?

*Mr. Tsai. Every state Medicaid agency I talk to fundamentally believes that it is important to make sure there is sufficient access to home care and nursing home facilities.

*Mr. Joyce. So you talk about your collaboration with state officials. How do you officially do that through CMS and what type of contact are you having as moving forward with the state officials who are ultimately responsible for

the administration of these Medicaid funds?

*Mr. Tsai. So again, we want to make sure across the program there is coverage, there is access, we are able to strengthen these programs, and we _ it _ I mean, daily we are working with state Medicaid agencies who are running and operationalizing their own programs at the state level.

*Mr. Joyce. I think that daily collaboration, I think that is important. Additionally, though, I am concerned, especially in rural areas like I represent in Southwestern and South Central Pennsylvania, that they are also facing shortages of healthcare professionals and para professionals. Nursing homes, unfortunately, might not be able to meet the new staffing mandates.

Mr. Tsai, how does CMS collaborate with state Medicaid programs when creating such staffing mandates? Is there a reality of health professional and para professional shortages that is taken into account as you issue these mandates?

*Mr. Tsai. Well, as you are referencing, states are unique, they have different demographic compositions, and so we wanted to make sure that we can both affirm ability for

people across the country to have access to safe nursing home care through minimum safe staffing standards, but also to count for exactly some of the across the country variation that you mentioned. So the final rule does incorporate, for example, a longer timeframe for nursing homes to come into _ five years.

*Mr. Joyce. But to your point, there are different demographics from state to state, and particularly some states have significant rural areas, like mine in Pennsylvania. Does your collaboration allow for that to occur and to be recognized when you put out these mandates?

*Mr. Tsai. I can assure you our state Medicaid directors and counterparts are constantly raising things of this sort and that is very much part of the daily dialogue that we have with our state partners.

*Mr. Joyce. Mr. Chairman, my time has expired. Thank you, and I yield.

*Mr. Guthrie. Thank you. The gentleman time has expired. We are watching the vote. We will at least get Ms. Kuster in. We hopefully can do two more, but Ms. Kuster, you are recognized for five minutes.

*Ms. Kuster. Thank you _

*Mr. Guthrie. You are recognized for five minutes for questions.

*Ms. Kuster. Thank you, Chairman Guthrie, and to Ranking Member Eshoo for holding this important hearing, and I want to thank the witness. You are about to get a little bit of a break when we go to vote.

As we have heard today, Medicaid covers the most vulnerable populations in need of healthcare services, but unfortunately, this does not include individuals who are involved in our criminal justice system. The Medicaid inmate exclusion that most of my own colleagues don't know about because it happened over 50 years ago before any of us were here when Medicaid was created, bars coverage of all healthcare services for incarcerated individuals, including mental health and substance use disorder services. This has been extremely expensive for our society. If you multiply out 50 states for 50 years and take away the various services that people might need in terms of mental health, trauma, treatment, dealing with addiction and substance use disorder, that is why we have these incredibly high

recidivism rates.

Without Medicaid coverage, states and localities struggle with the cost of providing these services, and frankly, the services are inadequate. Studies show that for every dollar we spend to treat substance abuse in our prisons and jails, we can save up to seven dollars down the road, so it is a one dollar to seven dollar savings. That is an incredible return on investment.

We should be doing more to maximize effective cost-saving treatment, and that is why I introduced the Rehabilitation and Recovery During Incarceration Act. This bill, which has bipartisan support, would reform the Medicaid inmate exclusion policy so that incarcerated individuals who are otherwise eligible for Medicaid would be able to access mental health and substance use treatment and recovery services during incarceration. Failing to provide medical coverage to incarcerated people leads to worse health outcomes and increases the risk of serious illness and injury, and in fact, continued drug use in our communities.

Mr. Tsai, how does providing healthcare to incarcerated

individuals help our communities stay safe and healthy?

*Mr. Tsai. First, thank you for raising that, and I have to thank Congress for _ and your leadership on this and Congress for emphasizing some of the Section 1115 demonstrations we have done with states to make sure there is pre-release services for folks involved with the carceral system. I think this is really, really important. As you note, there is a strong ROI, and I think that is not just from the cost standpoint but also from an outcome standpoint.

We have also seen broad bipartisan support. The states that have come forward wanting to do this I think ranged the continuum because there is a lot of shared recognition and understanding that there is some very commonsense principles here. When someone is being released back into the community, have them _ having them set up with the right medication, medication assisted treatment, case management, having a mental health provider able to _ that they can see on a consistent basis. Things of that sort are really critical and we are excited to continuing to partner with states and this body on how best to continue supporting

those efforts.

*Ms. Kuster. Perfect segue, thank you. In New Hampshire over 50 percent of incarcerated individuals have an opioid use disorder. On one of my recent trips to our women's prison, 100 percent of the inmates in our women's prison have either sexual abuse or neglect in their childhood or some type of trauma that they have experienced. Failure to comply with treatment and substance use were among the top three reasons for parole revocations in 2017 and higher rates of recidivism. That is why it is so important, as you pointed out, that our New Hampshire Section 1115 waiver request gets approved.

The state submitted its application in 2022, but it is still pending without a decision. Waivers like ours will support successful community reentry, as you have outlined, will improve community safety, and will save federal dollars in the long run. Mr. Tsai, what steps is the Centers for Medicaid & Medicare Services taking to expedite the review of these pending waiver requests?

*Mr. Tsai. Thanks for that. We _ the flip side of having so much interest in this is that there is a lot _

there are a lot of these 1115 demonstrations to process and, as you know, there is a whole outline path for that. We have _ excuse me, a fly there. We have put out both some consistent guidance about how states can implement these programs in a more consistent way that actually helps to speed up the approval.

So we just met I think our team last week with a whole range of states with active 1115 demonstration proposals before us to talk about I think for the first time a more streamlined way to deal with multiple states who all have very similar requests. At the same time, we hope that will help us be able to process and administer those as quickly as possible.

*Mr. Guthrie. We are kind of running low on _

*Ms. Kuster. Yeah, sorry, my time is up.

*Mr. Guthrie. Do you yield back?

*Ms. Kuster. I _

*Mr. Guthrie. We are going to try to get just a _

*Ms. Kuster. Thank you, Mr. Chairman, I yield back.

*Mr. Guthrie. _ as quickly as _ Dr. Meeks, you are recognized for five minutes until we have to adjourn.

*Mrs. Miller-Meeks. Thank you, Mr. Chairman, and thank you, Mr. Tsai, for testifying before the subcommittee today.

Mr. Tsai, you are probably aware that the recent federal regulations are expected to add over 100 billion in new federal spending to Medicaid over the next 10 years. Because this will also have fiscal implications for states, especially states like Iowa with large Medicaid populations, it is important that Congress and the CMS work together to ensure the original purpose of Medicaid remains available to those who need it.

My bill, H.R. 8111, the Medicaid Program Improvement Act, co-led by Congressman Cartwright, would create a process for state Medicaid programs and managed care organizations to obtain address information of program beneficiaries to ensure they are not enrolled in multiple states' Medicaid programs. This good governance legislation would maintain program integrity and help control unnecessary costs to states and the Federal Government without restricting access to those who legitimately qualify for Medicaid. Congress and the administration have learned a lot about outreach to beneficiaries from the

redetermination process.

What important lessons should Congress consider to support state outreach to beneficiaries, and do you think ensuring people are not enrolled in multiple state programs is good for program integrity? Similarly, how is Congress supposed to interpret your agency statement via FAQ in October of 2022 where you directly tell states not to pursue or prosecute even those convicted of fraud?

*Mr. Tsai. Thanks for all this. So I think first, we want to make sure eligible people, as you noted, can be enrolled in the program, and that is who we are serving through the program. And I can't underscore enough how much we agree wholeheartedly, program integrity, good program _ good government that both reduces red tape, doesn't put undue burden, and also ensures that eligible people are receiving and being paid for services, that is _ I think we very much agree on.

And so Medicaid _ the deceased enrollee question came up before. Your _ you raised a good piece around enrollees in different states. We wholeheartedly agree, those are very important _ excuse me, important program integrity

initiatives and we support and are working with states on those.

*Mrs. Miller-Meeks. So states could pursue or prosecute those convicted of fraud?

*Mr. Tsai. On the fraud question, I just want to be clear, the guidance we put out, two important things. One is that when there is suspicion of fraud and things of that sort, any of us, federal and state level for the Medicaid program, we are not law enforcement agencies. States and we are required to refer those cases to law enforcement.

The guidance is around making sure that from a state Medicaid administrative process there is due process for individuals, but nothing around that changes any of the obligations and the work of law enforcement authorities.

*Mrs. Miller-Meeks. Okay. And when you were the Medicaid director _

*Mr. Guthrie. I think we can probably let you continue. If you want to come back and do your final two minutes or if you want to yield back, that is fine, but I think we are getting close on vote time, we are going to have to _

*Mrs. Miller-Meeks. Okay, then I will yield back.

*Mr. Guthrie. Yield back. The gentlelady yields back. The subcommittee will now recess for votes on the House floor. We will reconvene 10 minutes after the last vote is called, and the subcommittee is in recess.

[Recess.]

*Mr. Bucshon. [Presiding.] The subcommittee will come to order. I now recognize Ms. Schrier for five minutes.

*Ms. Schrier. Thank you, Mr. Chairman, and thank you, Director Tsai, for being here today with us.

As a pediatrician, I know how important Medicaid is for children, particularly children with disabilities. Almost half of the children in the United States are insured through Medicaid, and so the best way to take care of our kids is to strengthen the program. That is why I introduced the Kids Access to Primary Care Act which would require any Medicaid primary care services to be reimbursed at least at the same rate as Medicare. Doing so would be fairer reimbursement and would increase the number of available physicians, reduce waiting periods, and increase healthcare coverage for families on Medicaid.

Mr. Chairman and Director Tsai, I look forward to working with you on this bill. As everyone as said before me, Medicaid is a critical program for our most vulnerable, so making sure that Medicaid reimbursement rates are fair or at least fairer is important to maintaining access to care for patients.

Now shifting gears to the bills before us today. As a physician, I am particularly interested in oversight over the Medicaid managed care organizations, the MCOs. In Washington State, I generally hear positive things about our MCOs because the Washington State Healthcare Authority, which oversees them, is responsive and proactive when it comes to concerns. However, I want to make sure that all states have the necessary oversight tools to respond to concerns with MCOs that may arise from providers or patients. Currently states have sort of an all or nothing approach for MCOs that violate conditions of the Medicaid program, and this one size fits all approach is in place despite a pretty wide range of violation severity.

So, Director Tsai, in your professional experience, would having additional perhaps more proportional options to

address violations committed by a managed care organization be helpful or appropriate?

*Mr. Tsai. Thanks for your comment around adequate reimbursement to Medicaid providers. That is critical, it is consistent with a lot of what we have tried to put forward in rules as well, so thanks for your continued attention to that. In Medicaid managed care, managed care is _ 70 to 80 percent of our enrollees now get their care through managed care. There are incredible things health plans can do and we want to make sure, as you noted, we have strong oversight and accountability for plans.

We _ the President's budget included at one point a similar piece which is, as you noted, having more tools in our toolkit to be able to hold health plans, managed care plans accountable for compliance issues that we don't otherwise have today.

*Ms. Schrier. And, of course, compliance issues could be anything from documentation to really malpractice, and so we might want to think about having a more proportional response.

I want to shift gears a little bit again to touch on

the pediatric home and community-based services. Access for pediatric home and community-based services is a lifeline for families with children that have significant care needs. However, this important Medicaid program has been hindered by pediatric caregiver pay that is actually below the pay for adult services and yet which requires a greater degree of training. Ensuring adequate training and levels of caregiver pay would be critical to safeguarding this really important healthcare access for our youngest patients.

And so again, Director, how will Medicaid's recent rulemaking help to ensure adequate caregiver pay and training to level that playing field for access specifically to pediatric home and community-based services?

*Mr. Tsai. Well, thank you for that. As someone on my team likes to say, kids are not just little adults, and so there are really unique care needs that kids have, and we want to make sure both for home and community-based services, also pediatric care, mental health services, they are sufficient to access.

And so there is a few things. One is in our recent rules to really support access, we are requiring that states

report to us the rates that they pay across the board and for a range of services that would help identify some of these things that would be a very important piece. And second, one of the most _ the areas I hear most about from parents with medically complex kids is how difficult it is to get access to say 24/7 nursing required for a medically complex maybe vent-dependent kid to be able to be supported at home. And so we both are requiring states to actually measure for the first time how long it takes to wait to get services.

And also specific for kids, the percent of hours that a kid needs. Say if you need 10 or 12 hours of nursing, how many is the parent actually able to fill. That gives a really important measure of whether there is sufficient access.

*Ms. Schrier. Thank you. I am out of time. I look forward to working on coverage of dental care, too, for kids, and I yield back.

*Mr. Tsai. Thank you.

*Mr. Bucshon. The gentlelady yields back. I now recognize Mr. Bilirakis for five minutes.

*Mr. Bilirakis. Thank you, Mr. Chairman, I appreciate it very much. Again, thanks for holding the hearing, the legislative hearing, to examine Medicaid and ensure program integrity and targeted help for individuals who are often the most in need: children, low-income seniors, and those with disability.

Republicans are also pushing back on significant overreach from this administration and its attempts to federalize the Medicaid program into a one size fits all approach that will harm patient's access to care, in my opinion. We should reject policies that further this overreach and instead empower states and providers. That is why I am in support of Representative Cammack's H.R. 8114 legislation that prevents CMS from finalizing its 80/20 rule that would be catastrophic for Americans that rely on long-term services, especially now, and supports an increase of shortage of workers we already have. So we have got to be careful, the staffing issue is a real problem, particularly in the State of Florida.

Among our other proposals are commonsense bipartisan solutions such as Representative Miller-Meeks' H.R. 8111

that ensures streamlined updates of Medicaid beneficiaries' address information, and Chair Rodgers' H.R. 8106 which allows states to provide home and community-based service options for those that don't meet an institutional level of care. Vital, vital. Quality of care, quality of life is so very important for our seniors.

As well as my bill, H.R. 8084, the Leveraging Integrity and Verification of Eligibility for Beneficiaries Act. This bipartisan bill I lead with Representative Craig will address concerns that many states repeatedly have made improper capitation payments to managed care organizations after enrollees had died. So this is a real issue, folks. This is a no-brainer policy, in my opinion, and yet it is a serious issue, very serious issue since we know there is a lot of fraud that can and does occur.

Mr. Tsai, I wanted to thank you for your recent state Medicaid director letter sent last week that addresses these concerns with deceased beneficiaries remaining enrolled in the Medicaid program. As you know, this was also a subject of the oversight hearing in this committee a few weeks ago as well. In the letter, you noted that the identification

that a beneficiary is deceased should be considered as a, and I will quote, "potential change in circumstance,'' and that states must conduct a redetermination of eligibility. About how long would that redetermination process take for a state to confirm that someone is in fact deceased?

*Mr. Tsai. Well, thanks for that question and thanks for your focus on that topic and program integrity. I want to just start by saying we agree very much, not only is program integrity and fiscal stewardship important, Medicaid should not be paying capitation premium payments to _ Medicaid managed care plans should not be paid with Medicaid dollars. We have clear rules that say we recoup funding.

And so you reference the letter we put out last week. I would note with respect to the provisions you are noting, one important thing that I would know we all agree with is as states and managed care plans are doing data matches to help identify if someone is deceased, number one, we just want to make sure those are correct. Obviously, sometimes a data match happens and you think someone is deceased and the worst thing would be to send a letter to say your husband is deceased and disenrolled from the Medicaid program when it

was due to a data error. And so we work with states to make sure they can do that but do that as quickly and efficiently as possible.

*Mr. Bilirakis. Okay. So the death master list is considered to be highly accurate by the Office of Inspector General, and they believe that the likelihood of false positives where someone who is alive is reported in the database is near zero. So do you think it is prudent that states should be required to pay for at least one, if not multiple, per member per month payments to Medicaid managed care organizations when they know that someone is already dead? So they were _ they are _ yeah, it is _ if you could answer that question, I would appreciate that.

*Mr. Tsai. Sure. And as I noted, we agree that it _ not only is fiscal integrity important, we _ as I said, Medicaid capitation payment should not be paid out for that, and states have a strong incentive to do this as quickly as possible because they know if we audit, if we identify, or OIG or GAO audit, we go recoup that funding from the states and so they are on the hook, and so there is a strong incentive from states to utilize a range of files.

Sometimes the data match is not just the issue with the death master file itself, it is with matching between the data set that the state has to that and making sure that that is accurate.

And again, no one wants to get a letter in the mail that says somebody has deceased when they have not actually, and so there are pieces there, but we ask states to do that as quickly and efficiently as possible.

*Mr. Bilirakis. Very good, thank you.

I yield back, Mr. Chairman.

*Mr. Bucshon. The gentleman yields back. I recognize Ms. Barragan for five minutes.

*Ms. Barragan. Thank you, Mr. Chairman. Thank you, Director Tsai, for your work and for being here today. I want to echo that Medicaid serves as a vital safety net that provides essential healthcare coverage to millions of low-income Americans, including about 12 million Californians where my district is.

We have seen over 20 million people have been disenrolled from Medicaid after the continuous coverage requirements expired a year ago and many of those were

disenrolled for procedural reasons. And it is important I think that states have flexibility and resources to help eligible people renew their Medicaid coverage during the process. One bill in today's hearing, H.R. 8111, would put into statute and expand, one, flexibility provided by regulation which requires the managed care organizations to report updated address information to states.

Can you share a little bit about why it is important to keep flexibility such as this one to limit how many people lose Medicaid?

*Mr. Tsai. Thanks for that question and focusing on _ we very much agree with. We want to make sure eligible people, kids, adults, others in the program, can successfully renew their coverage with as little red tape as possible. That is good government. And we have focused on doing that with states including, as you are referencing, during this whole Medicaid unwinding process where states have had to do redeterminations, we have provided important and significant policy flexibilities. Many are very common sense to help be able to renew someone without undue burden and a lot of red tape.

And as you are noting, included in those policy pieces are various options to get more updated contact information, including using health plans to help support that because clearly if you are sending a letter out to renew someone, you want to make sure that letter is getting to the right address, the right person at the right address.

*Ms. Barragan. Well, thank you. I want to also talk a little bit about the HCBA program, the home and community-based services. First, I was ecstatic and very pleased to see the President's budget proposal include 150 billion dollars over 10 years for Medicaid home and community-based services. This is the program that allows Americans and people with disabilities to remain in their homes and supports family caregivers.

I am a primary caregiver myself. Didn't even learn about the program until half my time into Congress. I think I was in about three years. And it is so critically important that we give people that option and availability to stay in their homes, and so I was really happy about that.

Can you talk a little bit about how this investment for

the home and community-based services program will help support family caregivers?

*Mr. Tsai. Of course. And thanks for _ well, thanks for your caregiving, and thanks for also noting this is _ it is very important that people have access to home care, home and community-based services so that people can either age in place or remain in their home independently, or as independently as possible, if they so desire, and having strong access, having caregivers is really important, and that is true very much on a lot of the rules and policies we have put forward to make sure the direct care workforce is able to be retained and sufficiently compensated.

On family caregivers, excuse me, I think that is very important piece as well. We have worked with a range of states who have come to us and approve _ we have approved various ways to help support and give family caregivers respite in appropriate situations. We have also helped for medically-complex kids, there are a lot of parents that have been able to help provide critical support during a workforce crisis, and we have worked with states with the right supports to be able to affirm and support that as

well.

*Ms. Barragan. Well, thank you. The _ I mean, there is a huge other benefit if _ for example, my mother has Alzheimer's. She needs to stay in that familiar home and setting.

*Mr. Tsai. Mm-hmm.

*Ms. Barragan. Which I believe could extend her life and extend her experience and her memory. So thank you for that.

Now my mom was on the waiting list for several months to get into the HCBA waiver program, and that is one reason I think the proposal _ the budget _ the President's budget proposal is good. In California alone, there are 4,720 people on the waiting list just to be able to access this critical program. Now the final Medicaid access rule requires states to report how they establish and maintain home and community-based services waitlists for waiver programs and assess wait times. Could you share how these requirements can help improve access to the program?

*Mr. Tsai. Absolutely. We want to make sure that access is available for any Medicaid enrollee that needs it,

precisely for the reasons you mentioned and some of the benefits for your mother for being _ someone being able to stay in their home. And, unfortunately, across the country there are waitlists for access to home and community-based services. However, we at CMS have not had consistent data to oversee, to monitor, to work with states around that, so the new regulations actually require states to report what those waitlists look like and we will work with them to make sure those are as apples to apples as possible, and that really starts to tackle that important issue you raised.

*Ms. Barragan. Great, thank you. I yield back.

*Mr. Bucshon. The gentlelady yields back. I recognize Mr. Carter for five minutes.

*Mr. Carter. Thank you, Mr. Tsai, for being here, appreciate it very much. You know, I am from the State of Georgia and our population is booming, particularly our elderly population as a lot of retirees are coming to our state and certainly that is important. Professionally I am a pharmacist. In fact, more specifically I was consultant pharmacist at nursing homes. I reviewed patient's charts, made recommendations for senior citizens, and I have

probably _ I suspect _ I don't know, but I suspect I have spent as much time in nursing homes as just about any other member of Congress, if not every other member of Congress, and I have seen it firsthand and I have seen the struggles of nursing homes firsthand, and that is why I am so concerned about the nursing home minimum staffing standard rule.

And you know, when it comes down to it, and I have often said this, we all, whether it be a Republican, a Democrat, or an Independent, we all want the same thing. We want accessible, affordable, quality healthcare. Everyone wants that. And I am worried about the accessibility of this, I am worried about the _ what impact that this rule is going to have on accessibility for senior citizens to the nursing home setting. It has been estimated in Georgia that it is going to result in 10,000 senior citizens not being able to be in a nursing home. And I am very concerned, as I say.

Let me ask you a yes or no question. Do you believe that a rule that decreases accessibility and increases healthcare costs is in the patient's best interest?

*Mr. Tsai. Thanks for that question.

*Mr. Carter. It is simple, yes or no. I am _ do you believe a rule that decreases accessibility and increases healthcare costs is in the patient's best interest?

*Mr. Tsai. I believe that we as federal regulators need to make sure there is safe access for everyone residing in a nursing home.

*Mr. Carter. Okay, okay, I can see you are not going to answer that. So let me ask you, what is CMS's response to an independent analysis that several nursing homes in Georgia will be forced to either reduce capacity or close due to the nurse staffing rule?

*Mr. Tsai. I think _ again, everyone that lives in a nursing home, or if you are a family member with a loved one in a nursing home, has the right to know that that nursing home is able to provide safe care, and the rule really reaffirms that. I also acknowledge _ we acknowledge, I know a lot of individual nursing home operators, they are good people that want to serve the residents, and there are workforce challenges, and we heard many comments, had many discussions with the industry and others, and that is why

the rule really gives a balanced, staggered approach.

*Mr. Carter. But if it is going to result _ as this independent study has said, if it is going to result that several nursing homes in Georgia close and that they will be _ that some will be forced to reduce capacity, where are the seniors going to go, where are they going to go if they can't go to the nursing home?

*Mr. Tsai. So the final rules makes some important adjustments to account for comments we made really to help preserve access to safe care, including extending the timelines, having exceptions, and I don't believe we need _ that we should choose or have a binary choice between a nursing home's economics and safe care in those nursing home for patients.

*Mr. Carter. Aren't nursing homes _ unless it has changed since I have been in a nursing home _ and listen, I have spent countless hours in nursing homes, and _ I mean, countless hours in nursing homes, probably 40 to 50 hours a week at one point in my career, and I know about the challenges in nursing homes. I know them firsthand, I have seen them, I have experienced them.

But let me ask you, what kind of data _ do you know what continuum of care is where, you know, you have a senior citizen who goes into a hospital, and then they are going into the nursing home for rehabilitation, and then they hopefully get to go back home? Well, what kind of data did CMS look into to suggest that the nurse staffing rule wouldn't impact the continuum of care for seniors?

*Mr. Tsai. Well, I would say two things. First, as a _ the evidence is clear, and as a clinician you know that staffing is critical for safety and quality, and there are clear clinical standards around what safe care looks like, but there is also a timeframe for implementation.

*Mr. Carter. I am not arguing that. That is a given, just _ but at the same time, nursing homes go through inspections, nursing homes go through inspections quite often and they have to meet certain guidelines, and they have to meet certain standards in order to get relicensed. What is wrong the rule as it is now and what they have been doing?

*Mr. Tsai. I think there are real challenges in the status quo around quality of care, and there _ the rules

really focus on access to safe, quality care for everyone that needs to and wants to reside in a nursing home.

*Mr. Carter. I understand. Let me ask you, and with all due respect, and I do mean it respectfully, when is the last time you were in a nursing home? Listen, I have been in nursing homes late at night, I have been in there on weekends, I have seen it firsthand. When is the last time you were in a nursing home?

*Mr. Tsai. I have spent significant time in nursing homes with staffing, with nurses, with patients, with families. The number one _

*Mr. Carter. Significant time being?

*Mr. Tsai. Yes, especially during COVID. On the ground in facilities figuring out how to staff.

*Mr. Carter. Well, you must have gotten a free pass because during COVID the nursing homes _ the family members weren't able to go in, they had to go to the windows to see the patients.

*Mr. Tsai. The number one thing I heard from family members and residents of nursing homes was how do I make sure my nursing home is able to staff safely, and that is

really what the rule focuses on.

*Mr. Carter. Well, I can't help but disagree that this is going to result in nursing homes reducing capacity and closing, and I don't think that is good. I _ we agree that they should have proper staffing, but I would submit to you that that is why we have licensing and that is why they have reviews, and that is what they have to pass. Thank you again for being here.

*Mr. Tsai. Thank you.

*Mr. Carter. And I yield back.

*Mr. Bucshon. The gentleman yields back. I recognize Ms. Craig, five minutes.

*Ms. Craig. Thank you, Mr. Chairman. I am proud to see that my bipartisan bill, the Live Beneficiaries Act, is included in today's hearing. This bill would prevent Medicaid capitation payments from being issued on behalf of deceased enrollees to Medicare managed care organizations. I want to thank Representative Bilirakis for his partnership on this commonsense piece of legislation. I wish we didn't have to put in these types of commonsense legislation because it seems so silly.

According to a recent HHS Office of Inspector General report, an audit of just 14 states found that more than 249 million in improper Medicaid capitation payments were made to MCOs on behalf of deceased enrollees between 2009 and 2019. Of that, OIG found that over 3.5 million in improper payments were made on behalf of deceased enrollees to MCOs in my home state of Minnesota. That same report noted that CMS is working with states to collect the federal share of these unallowable payments.

Mr. Tsai, can you tell me a little bit about the initiatives that are currently underway at CMS, such as the reclamation of unallowable payments aimed at reducing wasteful spending and making sure that Medicaid beneficiaries are getting the most out of the program?

*Mr. Tsai. Well, I appreciate that question, that focus, especially since we had much discussion about the need for important home and community-based service investments. Finding efficiencies through good program integrity and fiscal stewardship is very important, very important to us. On the deceased beneficiary piece _ and oh, actually you reference improper payments overall, and we

have worked substantially with states to bring those down. I have noted in the past the vast majority of those are not fraud, they are documentation pieces, but nonetheless, any level of improper payment is unacceptable.

For deceased beneficiaries that you referenced, it is an important piece. There are multiple initiatives we have underway. One of those is continuing to reinforce, and as you noted the audit report notice, we recoup funding when we identify or an auditor or a _ any auditor identifies that payments of the sort have been made, and so states have a very strong incentive to be able to catch these upfront as early as possible, and we have reinforced how states can use data and also contracts with their managed care plans to help be able to address this sooner upfront versus having to recoup things on the back end.

*Ms. Craig. I appreciate that so much, Mr. Tsai. You know, when I came to Congress, I promised I would work across the aisle and look for ways to reform the way government works. This bill in particular makes important reforms to the government's oversight of those tax dollars. By tackling this waste, we can make room to fund other

important priorities like the home and community-based services so _ that many Medicaid beneficiaries rely on.

I want to know how we can continue to work together to find the resources and authorities you need to combat more of that waste, fraud, and abuse.

*Mr. Tsai. Well, I appreciate that, and I just affirm very much how important that is. We are using every tool in our toolkit to make sure that there is strong program integrity and we are holding states and health plans accountable. The President's budget has included in the past, also I believe something that has been referenced here, the ability for us to be able to have more tools for oversight of managed care plans, or as today we _ it is an all or nothing thing for financial penalties with states and managed care to be able to differentiate that level of accountability to whatever the compliance issue is would be a very important tool and that has been reflected in the President's budget as well.

*Ms. Craig. Well, thank you so much for being here to answer our questions.

In closing, I just want to make something very clear.

I believe that my colleagues and I have a duty of fiscal responsibility, but unlike a lot of folks here in Washington, I refuse to balance the budget on the backs of our most vulnerable populations by slashing critical healthcare programs. Our bill is about improving the integrity of Medicaid and ensuring that Congress remains a good steward of taxpayers' hard-earned dollars.

And with that, Mr. Chairman, I yield back.

*Mr. Bucshon. The gentlelady yields back. I now recognize Mr. Crenshaw, five minutes.

*Mr. Crenshaw. Thank you, Mr. Chairman. Thank you, Mr. Tsai, for being here.

You know, frame this discussion, there is obviously generally a philosophical debate on how states should administer Medicaid. There is a line of thinking that Medicaid should simply be expanded so that there are more people enrolled in it, and in states like mine, there is a more targeted approach and I think an approach that focuses on access and focuses on making sure that the actual infrastructure of healthcare is better funded so that people who need it actually have a place to go, not just a piece of

paper that says they have a place to go. That is an honest disagreement. I think we will debate that forever.

The problem that we have today and what I want to bring up to you is that honest disagreement is there and that would be fine, but now we are in a situation where you are actually targeting states like mine as a result of that disagreement. So as first reported by National Review, records show that CMS targeted Florida, Texas, and Missouri with attempted audits based on a new interpretation of Medicaid financing rules. That interpretation is summarized pretty well in a bulletin that you wrote. It is from February of last year regarding these hold harmless arrangements.

Now that interpretation of financing rules _ by the way, those rules have _ that 1115 waiver has been approved over and over and over again. But this new interpretation would cost states like Texas billions of dollars and it can't help but wonder why, and it seems like it is an attempt to force them to go into Medicaid expansion. And I am going to introduce that document for the record, that particular bulletin.

So, Mr. Tsai, can you explain why did you feel the need to release that new bulletin and _ on hold harmless arrangements and come up with this new interpretation of what is okay and what is not okay?

*Mr. Tsai. I appreciate that question. I think at the core of this we support two very important things simultaneously. One is making sure that states, including Texas, is able to provide sufficient reimbursement funds for critical safety net providers, and the financing arrangements you are referencing really are funding state-directed payments, which this committee has talked about quite a bit, to support safety net and other providers, and in Texas, that is incredibly important, full stop.

We also have an obligation to make sure we are administering the program consistent with federal law. And on the bulletin you are referencing with the "hold harmless,'' that is not new interpretation from the CMS standpoint. That is our understanding of the statute in 1903 and that is how our team has been focused on that. I would note _

*Mr. Crenshaw. Yeah, but it would represent a change

in CMS policy because it is _ again, this framework has been approved by every other _ every other time and now it is not or now you are saying it might not.

*Mr. Tsai. No, the informational bulletin represents longstanding CMS policy. The arrangements in Texas are relatively new, the LPPF funding that is of more recent days. But I would note we last week, alongside our managed care rules, put out another bulletin that noted that as we have discussed with a range of states, the three you have referenced and others, it is clear that we stand by our interpretation of the statute, but it is clear that states need some time and data to transition, and we are giving states more time on that.

*Mr. Crenshaw. Okay, but which states and why only are these states being _ these three states being audited because CMS has approved "healthcare related tax arrangements involving the redistribution of Medicaid payments among providers subject to the tax,'' and we _ you know, we have this in writing, in emails that were FOIA'd that CMS is aware that other states have very similar hospital tax arrangements, California being one, but they

are not being audited. So why just them?

*Mr. Tsai. It is far more than these three. These three came about because there were specific pieces of documents that were sent to and provided to CMS and our staff has to respond in accordance with their statutory obligations to things sent to us. But the informational bulletin we released last week actually references that we _ it appears that there are a range of states beyond those that you referenced, as you noted, that have these arrangements, and so we have been very clear what the direction is and that we are giving all states time to be able to transition really in support of ensuring there is sufficient payments in your state and other states for safety _

*Mr. Crenshaw. Transition to what exactly?

*Mr. Tsai. To make sure that the financing arrangements are complying with our view of federal statute as outlined by Congress.

*Mr. Crenshaw. And what would that _ well, we don't have _ we have six seconds, but I would like a follow-up answer on what exactly that would entail.

*Mr. Tsai. We would be happy to follow up on that, thank you.

*Mr. Crenshaw. I yield back.

*Mrs. Harshbarger. [Presiding.] Mr. Balderson, it is your turn. Is there a Democrat? No, there is _ who is it?

*Ms. Eshoo. No, she is waiving on.

*Mrs. Harshbarger. Oh, she is waiving on? Okay.

*Voice. Yes, yes, yes.

*Ms. Eshoo. Yeah.

*Voice. No, it is Mr. Balderson.

*Mrs. Harshbarger. Go ahead.

*Mr. Balderson. Thank you, Madam Chair. Thank you for being here, Mr. Tsai, I appreciate that.

Before I get started on my question _ that is loud _ I would like to express my concerns with H.R. 8115. This bill would allow the Federal Government to overreach into what has always been the states' responsibility. States and CMS already have plenty of tools to ensure managed care organizations are playing by the rules. I would like to enter into the record a statement from Medicaid Health Plans of America opposing this legislation and listing out the

oversight mechanisms that already exist.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Balderson. Moving on, I want to thank Representative Dingell for her _ leading her bill to Make the Money Follows the Person, or MFP, program permanent. MFP allows nursing home residents to transition to home and community-based services, or HCBS, care. Excuse me. One of the most important things we can do to ensure Medicaid beneficiaries have the flexibility to decide what setting for long-term care is best for them, whether that is a nursing home or in their own home.

My father stayed in his own home. So this program, which is called Home Choice in Ohio, has allowed 16,000 Ohioans over nearly 20 years to move from a long-term care facility back into their home. The area Agency on Aging shared a recent story of a woman in my hometown of Zanesville, Ohio who suffered a car accident. She was homeless when she fractured her leg and MFP funds helped her to move from a facility to a secure apartment when she is recovered.

Mr. Tsai, can you briefly speak to how MFP works and why it saves Medicaid money?

*Mr. Tsai. I am so glad you raised that and thanks for

sharing both the story for your father and that individual because that is what this is all about.

*Mr. Balderson. Mm-hmm.

*Mr. Tsai. We want to make sure, as you noted, that people have access to home care, home and community-based services if that is where they choose to want to reside, and that is absolutely critical. And the Money Follows the Person program is I think a very strong, proven, and commonsense way of doing that.

To your question of how does it work, as you have referenced, for an individual in institutional say nursing home setting who actually would like to reside at home, right now all the dollars are kind of tied up around the nursing home care for that individual. They might have _ not have the supports they need. The Money Follows the Person approach really says let's take the funding and the approach for having someone in a nursing home and let's actually use that creatively to make sure we can set them up with the right supports, whether that be home modifications with a ramp or the right home care supports and other things so that they are actually able to transition into their home

or their community.

*Mr. Balderson. Okay, thank you. Well, I agree that MFP is very effective. I am worried that new rules finalized under your leadership will minimize the value of this program. The combination of minimal _ minimum staffing rule and the access rule will force nursing homes to reduce bed counts to meet the required staff ratios or even worse close them.

At the same time, home care agencies will reduce their availability of care to meet the new 80/20 pass through requirements. I recently spoke again with a home health provider in Ohio and Indiana who is already facing staffing shortage. They currently serve 315 Ohioans. In just six weeks between October and September of 2023, they turned away over 4,600 patients. The CEO even stopped taking a salary in hopes of keeping her company alive. These new requirements will only make things worse.

Mr. Tsai, how is a program like Money Follows the Person supposed to work if we reduce the availability of nursing home care and HCBS care?

*Mr. Tsai. Well, thank you for that, and please pass

my thanks to that CEO for what they are doing to serve our enrollees.

*Mr. Balderson. Mm-hmm.

*Mr. Tsai. Let me just take the home care topic for a minute. And, as you noted, there are great home care providers working day to day to make sure care can be provided for folks in the home. We all want to make sure there is access, and there is quality of access, and that there is sufficient workforce and staffing for that, and that a sufficient portion, 80 percent of Medicaid rates for direct care, really should go to direct care workers.

But as you noted, we have had many discussions with providers and the industry and we received a lot of comments during the rulemaking period, the rule we finalized is different from the proposed rule in multiple ways. One, for _ and I _ we allow states to have a fair amount of local discretion around some of this, but it allows for exemptions _ exceptions for small providers, others for which the 80/20 might be particularly difficult.

Two, it extends the timing out for six years so that 80/20 provision would not go into place until 2030. And

third, which I think maybe that is _ the CEO of your home care _

*Mr. Balderson. Mm-hmm.

*Mr. Tsai. _ would resonate with, any time I talk to the industry, they say it is not, yes, I want to pay my workers more, it is not just about that, it is also about whether my state agency pays a sufficient rate. And so we have put in multiple things in the rule to really up the ante for what states need to do to make sure there are sufficient rates being paid to the agencies as well.

*Mr. Balderson. Okay, thank you very much for your time.

*Mr. Tsai. Thank you.

*Mr. Balderson. Madam Chair, I yield back.

*Mrs. Harshbarger. Thank you, Mr. Balderson. And I now recognize myself for five minutes.

Thank you for being here, Mr. Tsai. You noted earlier that you have data that supports the 80/20 wage pass through mandate, and the proposed and final rule appears to be absent of this information and analysis. In fact, CMS noted that the number of providers that was used to measure the

impact of this rule is based on unpublished provider relief fund data.

Can you please be specific on what data was used and the outcome of the impact analysis specific to the percentage of Medicare beneficiaries that will have increased access to home and community-based services?

*Mr. Tsai. Sure, I would be happy to. Thanks for that question.

*Mrs. Harshbarger. Mm-hmm.

*Mr. Tsai. And as we just discussed, our goal here is to make sure there is a sufficient, strong workforce to ensure that there is access. For how we arrived at the 80 percent, I would say a few things. Some of this is in what we published in the final rule as well. There are clear data points that we used to get to the 80 percent across a number of states.

I would also note, and I have to thank this body, Congress, for some of the HCBS funding that the ranking member noted before around _ from the American Rescue Plan. Almost every state that took up that funding put money into the workforce and many of the states on a _ you know, across

the spectrum, put in requirements that guaranteed a certain portion of that funding would go to the direct care workforce. We looked at what states identified to us that they were already doing, thought that was a good idea, and incorporated that into the rule.

And perhaps the final thing I would say is the rule also in addition to pushing out the implementation timeframe, requires there is data reporting in every state so that every provider might know what their baseline point is to start with.

*Mrs. Harshbarger. Okay. Can you tell me how many direct care workers will have wage increases under your wage mandate requirement?

*Mr. Tsai. Well, we want to make sure all direct care workers across the country are adequately and sufficiently paid so that they can provide appropriate care.

*Mrs. Harshbarger. So we don't have a number, though, or you don't have a proposed educated guess on the number?

*Mr. Tsai. Well, a lot of this would also depend on again what we noted, which is states are also obligated to make sure they are able to pay sufficient rates, and so home

_ what we have heard from the industry a fair point is, like I said, it is not just about the 80/20, it is about what _

*Mrs. Harshbarger. Yeah.

*Mr. Tsai. _ my actual rate is. That is a fair point. We included provisions in the rule to really put extra attention to the actual rates that they receive from the state agency as well.

*Mrs. Harshbarger. It is like you have had many questions on this because this is a huge topic back home when we go to talk to these providers.

Let me ask you briefly about H.R. 8089, the Medicare and Medicaid Fraud Prevention Act. The bill would implement a GAO recommendation to require states to check with the Social Security Administration death master file before automatically re-enrolling Medicaid providers. This would also allow states to deactivate the national provider identification numbers, or NPIs, of deceased physicians and providers and prevent any fraudster from using that deceased provider's NPI to defraud Medicaid or Medicare.

Does CMS generally support this proposal and how would it help strengthen Medicaid program integrity?

*Mr. Tsai. Thanks for that. While I can't comment on any specific legislative proposal, I will say we wholeheartedly agree for the integrity of the program payments should be efficient, they should be going out to eligible people for _

*Mrs. Harshbarger. Mm-hmm.

*Mr. Tsai. _ eligible services and we want to make sure states and health plans as well are doing everything in their power, using data sources as well.

*Mrs. Harshbarger. Because this is the provider's NPI that they use if that provider has passed away. And, I mean, it has happened at my pharmacy before where _ or you can have _ build a claim, and then the provider passed away, and then you didn't get paid for that claim. So, yeah, we need to make sure all that is fair and square here.

Let me make sure I have got enough time. Earlier this month the HHS Office of Inspector General released a report titled, "The Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollee's Access to Care,'' and the State of Tennessee was involved. And overall the report found there were few behavioral health providers in the

selected counties who actively served Medicare and Medicaid enrollees. These providers represented about one-third of the total behavioral health force in the counties, and despite unprecedented demand for behavioral health services, treatment rates in Medicaid and Medicare remained relatively low.

I don't know if you and your team have had a chance to review that report, but the OIG makes a number of recommendations for CMS, including taking steps to encourage more behavioral health providers to serve Medicare and Medicaid beneficiaries, explore options to expand Medicare and Medicaid coverage to additional behavioral health providers, and increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities. Do you agree with those general recommendations, sir?

*Mr. Tsai. Thanks. I know time is _

*Mrs. Harshbarger. Yeah.

*Mr. Tsai. Thank you for _ mental health, substance use disorder treatment _

*Mrs. Harshbarger. Yeah.

*Mr. Tsai. _ incredibly important. Oftentimes access takes too long for _

*Mrs. Harshbarger. Yeah.

*Mr. Tsai. _ Medicaid and other enrollees.

*Mrs. Harshbarger. Mm-hmm.

*Mr. Tsai. We support a whole range of efforts to try to strengthen that. The regulations we finalized last week also puts substantial new requirements in place on that front. We would be happy to work with your office on that.

*Mrs. Harshbarger. Yeah, great. I have a lot of ideas. Thank you, sir.

*Mr. Tsai. Terrific, thank you.

*Mrs. Harshbarger. I yield back.

And I recognize Ms. Schakowsky from Illinois.

*Ms. Schakowsky. Thank you so much. I want to _ first of all, let me thank you so much for allowing me to waive on to this committee for something so important and I think devastating.

I want to discuss the Medicaid recovery _ the estate recovery program. I think it needs to be ended. Medicaid is the only public benefit program that forces the families

of a dead person who benefitted from home or community-based care to pay from their own pocket and usually from their homes to cover the cost of that care. Families grieving because of the death of their loved one are suddenly hit with a bill that can amount to thousands of dollars. Medicaid is for low-income people and often their families are often low-income as well.

The Associated Press has done a big story about it, the New York Times has done a big story. I want to put those two articles with your permission in the record. Without objection, if I could put those into the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Ms. Schakowsky. So since 2021 in the State of Illinois alone, 17,000 families have lost their homes. One of my constituents who has _ who was taking care of her mother in the mother's home was told that she is owed $77,000 now that her mother has died. This program is so cruel.

And so what I am asking for is that the _ that this program _ and let me ask you the question. I don't understand. This is the only program. And the other thing to note is that the recovery that the states get because they follow the law, whether they like it or not, and some states don't want to do this, go after people's homes and their assets, the return on that has been about one _ less than one percent.

It is not working. They aren't getting the money back. And yet families _ I have met with people who are absolutely without money because they have been asked and surprised that they were asked to pay for this recovery program.

And I want to ask you, what are we going to do about this? This has been all over the biggest newspapers now what a scandal it is that they go after the family of dead

people.

*Mr. Tsai. I appreciate you raising that and I appreciate you highlighting stories of individuals and the impact it has. Certainly when I hear and chat with folks you hear very powerful, moving stories of the sort you mentioned. I would note perhaps for this committee, we are tasked with administering the program with states who run their own programs consistent with federal law, the federal law on the books. Federal law requires that in Medicaid there is estate recovery and so the reason it exists, the reason why we continue to approve states around that and work with states on that is because we are doing so as directed by federal law.

*Ms. Schakowsky. But the people often don't know. States are supposed to inform people, maybe they send them a letter. They don't know that when their poor person dies, and I mean poor sick but also poor because they are on Medicaid, they are low income, that they are going to have to come up with thousands of dollars. This is the only program, the only helping program that we have in the United States of America that requires this. It is absolutely

shocking.

And am I over? No. And I _ it just seems to me that this has to be looked at, that the states are supposed to implement it. As I said, many don't even want to do that and want to spend the money going after the money to get reimbursed. How is it that someone on Medicaid, that their family has to come up with the dough when they are dead?

*Mr. Tsai. Well, again I really _ this _ I appreciate you raising this and highlighting the impact on individual people and families. We would be happy to work with your office on this topic. It is very important. As I have noted, we follow the statute that is on the books from the federal standpoint, but we would gladly work with your office on this.

*Ms. Schakowsky. We need to take a look at it. Thank you very much.

And with that, I yield back.

*Mr. Guthrie. [Presiding.] The gentlelady yields back. The chair will now recognize the gentleman from Texas, Mr. Pfluger, for five minutes for questions.

*Mr. Pfluger. Thank you, Mr. Chair. And, Secretary,

thanks _ or Mr. Tsai, thanks for being here. I am getting to my first question in your role as Assistant Secretary for Mass Health and Medicaid Director.

I believe you submitted a comment letter to CMS's 2019 proposed Medicaid Fiscal Accountability Regulation, MFAR, rule which had similar implications for the state financing of Medicaid programs. And in your comment letter you asked CMS to withdraw its rule stating its imposition of new state obligations, administrative burdens, and federal overreach. I kind of want to know how you justify your current role in employing similar policies that you previously condemned as exceeding CMS's statute authority.

*Mr. Tsai. I appreciate that. On the financing and the related topics, as I have noted, we want to make sure there is sufficient funding and reimbursement for states and state-directed payments, which are really important in your state and the State of Texas, and that the financing arrangements are in compliance with federal statute and our understanding of what Congress has required us to do, and that is really how we administer each of those _ the financing arrangements that come before CMS.

*Mr. Pfluger. So in that role and in this role, do you _ are there things that have been conflicts of interest that you saw differently from the state level that now you see from the federal level?

*Mr. Tsai. No, I don't think so. On this particular topic, again, we want to make sure there is access and support and everyone is following the law, which we can all agree to. And in that particular comment, I think we were _ I was referencing some very specific pieces, not around this hold harmless or the financing arrangements but around other elements of that particular rule, and that is distinct from the issues that play here currently.

*Mr. Pfluger. It just seemed that comments like that maybe highlighted over regulatory, burdensome, excessive, or unwarranted policy. Do you think that is true? I mean, is that an accurate characterization of what that comment at that point in time represented versus now some of the policies that you are implementing?

*Mr. Tsai. I think it is really important, which I think we have demonstrated as this administration, that we are _ and I would say this, I know we have gotten a lot of

questions around state directed payments, and the growth, and what are you doing for program integrity. I think it is important for us to hold two things together at the same time. Making sure there is strong fiscal integrity and where scrutinizing all payment arrangements to make sure they are complying with federal law, and that is a lot of what is underlying some of that, and that we are supporting adequate funding and reimbursement for the safety net.

And in the State of Texas, for example, even as we were having some of these discussions, we continued to approve payments. And I would note, we recently released national guidance to note, hey, we think this is an issue in multiple areas, but we think time is required. We are here to work with states, with providers. We don't want to disrupt the safety net and we want to basically _ we want to also hold true to our fiduciary responsibilities across the program. So holding those two intention is sometimes quite complex, but it is really important and we look forward to working with you all on that.

*Mr. Pfluger. I know this has been discussed. I think my colleague, Mr. Crenshaw, also from Texas highlighted

this. Let me get back into it because I am last on the panel. It may be duplicative, but how does CMS define hold harmless agreements within the context of Medicaid financing and what specific criteria are used to identify the impermissible arrangements?

*Mr. Tsai. I appreciate that. I would note our position around that is very explicitly outlined in multiple areas, including the informational bulletin that is publicly posted that Representative Crenshaw noted. And we are trying to make sure we both support reimbursement _ adequate reimbursement for safety net providers, which we all agree are critical, and we want to make sure that we are administering the program in line with our understanding of federal statute. And Congress has outlined specific statutory requirements in this area.

*Mr. Pfluger. Lastly, can you clarify the rationale behind the _ requiring providers to attest they are not engaged in any hold harmless agreements in the Medicaid MCO rule that was finalized last week?

*Mr. Tsai. Sure. Again, I _ in line with this balance, that particular provision of the rule, we do not do

any interpretation, we just say is a provider willing to attest that they are able to follow the plain text of the statute. There is no CMS interpretation around that. We can all agree the plain text of the statute is important.

But I would also note that in response to public comments in recognition around how important this is to states like Texas and others, we _ in the final rule, we delayed the timing until 2028 and we put out an informational bulletin that noted that we wanted to work with states, with providers, and others with time to resolve these issues because at the end of the day, as you are noting, these payment sources are critical to safety net providers in your state and many others and this administration is all about making sure there is sufficient reimbursement and funding available for Medicaid providers.

*Mr. Pfluger. Thank you.

*Mr. Tsai. Thank you.

*Mr. Pfluger. Mr. Chairman, my time is expired. Yield back.

*Mr. Guthrie. Thank you. The gentleman yields back. That appears to be all members appearing to ask questions.

Thank you. You have been here for a long day, including the break for votes. Really appreciate your willingness to be here and appreciate your time and the information that we received today.

I will ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

*Ms. Eshoo. It is fine with the minority, Mr. Chairman. If you would just give me 60 seconds or less to close out today.

*Mr. Guthrie. Sure.

*Ms. Eshoo. I would like to _

*Mr. Guthrie. Well, without objection, it will be an order to accept the list.

*Ms. Eshoo. Without objection.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Guthrie. Okay, now you are recognized for _

*Ms. Eshoo. Thank you.

*Mr. Guthrie. _ 60 seconds.

*Ms. Eshoo. Thank you.

*Mr. Guthrie. We won't start the clock, but 60 seconds.

*Ms. Eshoo. Thank you. I think it is very important to note after listening, and I thank the Assistant Secretary for being here to answer all of the questions on both sides of the aisle. We really don't have standards in nursing homes today. The 80/20 is new. 80/20 is new, and there is a reason for it. I have an opposite view, as you know, in terms of staffing and the pay. I think it is going to improve, it is going to improve for patients, number one, but it is also going to I think improve the business model.

70 percent of nursing homes today in our country are corporately owned. They wouldn't be in business unless they were making money. I mean, that is their model. That is their model in our country. It is the 30 percent of others that we need to be careful in terms of the construct, and I think the 80/20 three years, five years, especially _ five

years in Rural America is really very important. So I continue to support what is going to make it better for people.

I have to tell you, and I have leaned over said this to you, Mr. Chairman, our former colleague who lost her life, Eddie Bernice Johnson. Eddie Bernice Johnson was the first RN, registered nurse, to be elected to the Congress. She was a first-rate professional. Look at how she died. In a nursing home healing from surgery.

Her wound became infected because there weren't enough people staffing the place. She kept calling out for help, they couldn't come, they didn't have enough people, and they had to rush her to the hospital, operate on her all over again to cut out the infection. We can do better than that in this country. And so I thank you _

*Mr. Guthrie. Thank you.

*Ms. Eshoo. _ for giving me the time, Mr. Chairman. And it has been a long hearing _

*Mr. Guthrie. Thank you. It has been.

*Ms. Eshoo. _ but a worthwhile one.

*Mr. Guthrie. Yeah, I think so as well.

*Ms. Eshoo. Mm-hmm, mm-hmm.

*Mr. Guthrie. So thank you for your words.

So I will remind members that they have 10 business days to submit questions for the record, and I ask the witness to respond to the questions promptly. Members should submit their questions by the close of business on May 14th.

Without objection, hearing none _

*Ms. Eshoo. Without objection.

*Mr. Guthrie. _ the subcommittee is adjourned.

[Whereupon, at 1:57 p.m., the subcommittee was adjourned.]