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ONE HUNDRED EIGHTEENTH CONGRESS

Congress of the United States
House of Representatives
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June 7, 2024

Mr. Daniel Tsai
Deputy Administrator and Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Tsai:

Thank you for appearing before the Subcommittee on Health on Tuesday, April 30, 2024, to testify at the hearing entitled "Legislative Proposals to Increase Medicaid Access and Improve Program Integrity."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Friday, June 21, 2024. Your responses should be mailed to Emma Schultheis, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to Emma.Schultheis@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Brett Guthrie
Chair
Subcommittee on Health

cc: Anna Eshoo, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Cathy McMorris Rodgers

Centers for Medicare and Medicaid Services (CMS) officials have repeatedly stated that the proposed Transitional Coverage for Emerging Technologies (TCET) program represents more than a doubling of the number of national coverage reviews that CMS conducts each year. (See, e.g., comments from Dr. Steve Farmer during a public TCET webinar on August 1, 2023[1] — "I note that these additional reviews more than double the National Topic Review volume that CAG conducts each year.") However, an analysis of annual reports to Congress from CMS on national coverage determinations (NCDs) shows that while CMS has only implemented five NCDs on average each year since 2011, the agency completed on average more than 15 NCDs annually from 2003 through 2010. Other coverage activities, such as the number of Medicare Coverage Advisory Committees (MedCAC) held each year, show a similar decline over time.[3]

- Resources:
  - [1] Centers for Medicare and Medicaid Services, *Transitional Coverage for Emerging Technologies*, August 1, 2023. https://www.cms.gov/files/document/transcripttransitionalcoverageforemergningtechnologies08012023.pdf
  - [2] Centers for Medicare and Medicaid Services, *Reports*. https://www.cms.gov/medicare/coverage/determination-process/reports
  - [3]

Fiscal Year	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Months to Proposed Decision Made	390*		248*	5.7	6	6	6	5	6.5	<6
Days from Proposed to Final Decision				85	86	78	77	88	87	89
Days from Final NCD to Implementation				81	114	126	127	118	72	81
Initiated										
Implemented	5	15	16	23	26	20	9	12	11	5
MedCAC Meetings Per Year	3	3	5	5	3	4	5	5	3	4

*Days from request to decision

Fiscal Year	2013	2014	2015	2016	2017	2018	2019	2020	2021
Months to Proposed Decision Made	5.7	6.2	4.9	6.4	5.7	5.7	2.85	6.63	7.1
Days from Proposed to Final Decision	86	85.6	79.8	84	83.5	84	96.5	112.3	125
Days from Final NCD to Implementation	132	159.6	244.8	301.3	225	344	396	346	363
Initiated									4
Implemented	6	5	5	4	4	3	2	4	3
MedCAC Meetings Per Year	2	1	2	2	2	2	0	1	1

1. Please explain the reduction in CMS national coverage determinations and related coverage activities since 2010, including a comparison of the number and responsibilities of CMS staff assigned to the NCD process during the period from 2003 to 2011 compared to current staffing and other changes in resources allocated to the NCD process.

The Honorable Robert Latta

1. CMS recently finalized a new eligibility regulation. The new regulations say that when conducting an eligibility determination, a state has to give an individual an initial 30 days to respond to a request from the state verifying their eligibility. From there the individual can be entitled to up to ninety additional days before a final determination on coverage is made. In short, someone who's ineligible for Medicaid but attempts to dispute that decision can get Medicaid coverage for up to 4 additional months. How much does something like this cost a state?

2. Just last year, the improper payment rate was over $50 billion 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?

3. 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 health care. Independent reports show that 80 percent of nursing homes cannot comply. What do you plan to do with all the seniors who will now have to relocate, I imagine further away from family and loved ones, due to this unworkable staffing mandate?

    a. How many Administration staff, who wrote and are implementing this mandate, have ever worked in a nursing facility?

The Honorable Gus Bilirakis

1. We have significant health challenges in this country: The skyrocketing costs of hospital bills, the scourge of fentanyl poisoning, and even you have called the maternal mortality situation in this country a crisis. Despite these priorities Americans are struggling with on a daily basis, you have approved 1332 waivers in two states that would allow taxpayer resources to be diverted to the coverage of illegal immigrants. On top of that, HHS has spent time and resources turning the healthcare.gov website into a voter registration drive. Why does HHS think it is more valuable to use taxpayer dollars to subsidize coverage for illegal immigrants instead of using that money to improve maternal care and help taxpaying Americans?

The Honorable Richard Hudson

1. Mr. Daniel Tsai, as you have probably seen, California has announced they will be covering sex changes for illegal immigrants, using taxpayer dollars to fund these surgeries. Despite the fact that current law prohibits federal funds from being used to provide Medicaid benefits to illegal immigrants, states have taken advantage of existing loopholes to expand these benefits using federal funds. I have introduced legislation to close the loopholes and prevent states from using federal funds to provide Medicaid coverage to illegal immigrants. More importantly, Medicaid's statute already prohibits

the use of federal funds to furnish Medicaid care to illegal immigrants. I am concerned that Medicaid is not prioritizing the populations it was intended to protect, and taxpayer dollars are not being used in the most proper way. Not to mention the federal regulations are expected to add over $100 billion in new federal spending to Medicaid over the next decade. Can you give a number on how much of taxpayer dollars have been directed towards health care for non-citizens?

a. Can you give the amount of and list the states that are taking advantage of these loopholes?

b. Is HHS doing anything to ensure these dollars are not comingling?

The Honorable Earl "Buddy" Carter

1. Proprietary Laboratory Analyses (PLA) codes are legitimate HIPAA compliant Current Procedural Terminology (CPT) codes that describe proprietary clinical laboratory analyses that can be provided either by a single (sole-source) laboratory or licensed or marketed to multiple providing laboratories (e.g., cleared or approved by the U.S. Food and Drug Administration). The specificity of PLA codes provides a greater level of transparency for the type of testing being performed, which enhances program integrity. It is my understanding that any entity transmitting health information in electronic form pursuant to HIPPA must process claims that include PLA codes, but a number of States still refuse to do so, resulting in disruption to care for patients due to the inability of providers to be reimbursed. Will you commit to issuing written communication to State Medicaid programs outlining their responsibility to process claims that include PLA codes?

2. Mr. Tsai - The Biden Administration has announced they are looking at the impacts of consolidation on health care. Providers of these services are already noting that consolidation will be an inevitable outcome of the 80/20 rule. What is the Administration's plan to ensure that this rule does not make sure this does not result in provider closure and consolidation? The small provider exemption is highly burdensome to states and still requires a plan for exempt providers to comply which undermines its effectiveness.

The Honorable Dan Crenshaw

1. Essential hospitals rely on patchwork public support, including Medicaid disproportionate share hospital (DSH) payments, which Congress created to stabilize these financially fragile hospitals. Do you feel these payments play a critical role in helping to ensure these health systems can continue providing quality health care?

a. Will you pledge today to work with me to eliminate the remaining DSH cuts?

The Honorable Troy Balderson

1. Both the nursing home staffing rule and the part of the access rule that is under scrutiny contain reporting requirements for providers to tell their states what percentage of payment they spend on the direct care workforce. How does CMS plan to support states in creating these reporting templates?

    a. How will CMS ensure any consistency in what is reported?

    b. How will CMS compare data across states if there isn't consistency in how it is defined and reported?

2. How is CMS going to know and distinguish if the non-workforce costs are, in fact, essential to running a business – such as making needed repairs on a nursing home or ensuring staff in people's homes have appropriate technology to do their jobs?

3. In the case of the HCBS Access rule 80/20 threshold, why is CMS mandating a threshold before gathering this data?

4. What data did CMS use to calculate an 80 percent threshold? The rule cites high level examples of ARPA projects but provides no actual data used. Please share all relevant data sources.

5. The ARPA projects referenced were never formally evaluated – does CMS have any plans to evaluate the effectiveness of the ARPA interventions?

6. Did CMS consider other ways in which the effects of this rule would not be unduly born on small providers? The small provider exemption is highly burdensome to states and still requires a plan for exempt providers to comply which undermines its effectiveness.

The Honorable Mariannette Miller-Meeks

1. Mr. Tsai, when you were the Medicaid director of Massachusetts, I am sure you had a lot of people seeking care from out-of-state. Boston Children's is one of the premier children's hospitals, and I know kids from all over the country fly there to get care. I have a bill with Representative Trahan, the Accelerating Kids Access to Care Act, which would reduce burdens associated with providers enrolling in other state Medicaid programs to ensure they can more easily be reimbursed for the out-of-state child's care, increasing the ability to get care in a timelier manner. Can you speak to the burdens that you saw during your time in Massachusetts and whether it was difficult for doctors to deliver care to kids from other states?

2. What steps does CMS plan to take to address the critical workforce shortage in direct care in order to protect access for older adults in skilled nursing and home-and community-based services, especially once the staffing minimums and compensation requirements take effect? The final rule estimates the total cost to LTC facilities over 10

years to be $43 billion while CMS is only committing $75 million to help increase the LTC workforce. Several bills being discussed here today would begin to address this issue - does the agency have additional proposals?

The Honorable Kim Schrier

1. Would you agree that Medicaid funding generated by school-based clinicians, in the course of delivering Medicaid-covered services to students with special needs, should be returned to special education departments in those public schools, rather than being diverted by states for other purposes?

2. CMS has claimed a lack of authority to dictate how Medicaid funds generated by special education services are distributed once they are paid to the state. Given the recent Medicaid Managed Care Rule, where CMS has set standards regarding how state funds must be used with respect to Medical Loss Ratio (MLR) requirements and other new parameters, why has CMS made the decision not to regulate on the matter of school-based services returning to the special education departments or even schools that generated them, when CMS has imposed other requirements on Medicaid payments to states?

3. What specific authority does CMS believe is necessary in order to ensure that funding generated by school-based billing is returned to special education services?

The Honorable Jan Schakowsky

1. Mr. Tsai, the Medicaid estate recovery program is a unique program that has harmed many families. Medicaid is the only public benefit program that forces the families of dead recipients to give up their assets, usually homes, to pay for the costs of long-term care. Since 2021, the state of Illinois pursued over 17,000 estate recoveries cases. One of my constituents, who helped care for her mother on Medicaid in her mother's home, was billed $77,000 right after her mother's death. She is now on the verge of losing her mother's home.

    a. Does CMS recognize the harm that Medicaid estate recovery has on families?

    b. What steps is CMS taking to remedy this?

2. All states are required to provide a notice to Medicaid applicants explaining the estate recovery policy. However, AARP found that awareness of estate recovery is low because notices lacked necessary information – including which long-term care services are subject to estate recovery and the use of liens.

    a. What specific steps is CMS taking to ensure that states notify applicants about the Medicaid estate recovery program in a clear, concise manner?