Questions for the Record
for Deputy Administrator and Director Daniel Tsai
House Committee on Energy and Commerce, Subcommittee on Health
Hearing on April 30, 2024
"Legislative Proposals to Increase Medicaid Access and Improve Program Integrity"

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, 20231 — "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 (Medac) held each year, show a similar decline over time.3

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.

Answer:

I would defer to my colleagues in the Center for Clinical Standards and Quality on questions related to the Medicare coverage determination process. CMS does not have statutory authority to conduct NCDs within Medicaid.

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?

Answer (1-2):

Since the passage of the ACA, states have been required to apply streamlined application and renewal processes to applicants and beneficiaries whose financial eligibility is based on modified adjusted gross income (MAGI). These procedures have been optional for individuals excepted from use of the MAGI-based methodologies at § 435.603(j) ("non-MAGI" individuals). In March 2024, CMS updated policies[1] to require that states adopt many of the streamlined application and renewal procedures currently required for MAGI applicants and beneficiaries for non-MAGI individuals as well.

For MAGI individuals, states are required to provide a minimum of 30 calendar days from the date the agency sends the renewal form to return the signed renewal form along with any required information. They are also required to provide, for MAGI individuals, a 90-day reconsideration period for individuals who return their renewal form after the end of their eligibility period and following termination for failure to return the form. CMS finalized policies that will require states to apply these requirements to non-MAGI individuals, as well as MAGI individuals. CMS did not propose or finalize any changes to the amount of time required for MAGI beneficiaries to return requested information at renewal or to the 90-day reconsideration period for MAGI beneficiaries. The 90-day reconsideration period applies to individuals who were terminated for not returning requested information. It is important to note that individuals who return their renewal form during the 90-day reconsideration period do not automatically receive four months of coverage. Rather, State Medicaid Agencies must treat the renewal form as an application and reconsider the eligibility of the individual; in general, a Medicaid beneficiary who would have been eligible for coverage during the 3 months prior to application qualifies for a 3-month retroactive coverage of Medicaid-covered services provided within that period. In addition, the 90-day reconsideration period is different from the appeal and fair hearing process, which is an administrative process that lets people challenge certain Medicaid decisions made by their state, including if they think their Medicaid eligibility determination was wrong or not acted upon promptly.

In finalizing these policies, our goal was to provide an equitable experience for all Medicaid beneficiaries and applicants, regardless of the financial methodologies used to determine their eligibility (MAGI and non-MAGI). We believe these changes promote equity across all populations served by Medicaid and will promote continuity of coverage, decrease churn, and

[1] Streamlining Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (CMS-2421-F2) final rule, available at: https://www.federalregister.gov/documents/2024/04/02/2024-06566/medicaid-program-streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health

simplify the renewal process for non-MAGI beneficiaries in a manner that is in the best interest of beneficiaries. This alignment will be particularly beneficial to individuals in households in which some individuals are eligible based on MAGI and others are eligible on a non-MAGI basis, as non-MAGI household members may otherwise be subject to more burdensome administrative requirements. We also believe alignment will reduce administrative burden for States.

We do not believe that requiring States to provide non-MAGI beneficiaries who have been terminated for procedural reasons with 90 calendar days for the reconsideration period to return their renewal form and any additional documentation needed will have any impact on improper payments. CMS's mission for program integrity is to prevent, detect, and combat fraud, waste, and abuse in the Medicare, Medicaid, CHIP, and the Federally-facilitated Marketplace programs. CMS works diligently to prevent fraudulent claims from being paid and to verify that it is paying the right entity the right amount for services covered under our programs. This work includes providers, states, and other stakeholders to support proper enrollment, accurate billing practices, and focuses on protecting patients while also minimizing unnecessary burden. During FY 2022, CMS's comprehensive program integrity efforts resulted in estimated Medicaid and CHIP federal share savings of $2.6 billion.[2]

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?

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

Answer:

Staffing in LTC facilities is a persistent concern, especially among low-performing facilities that are at most risk for providing unsafe care. Numerous studies have shown that staffing levels are closely correlated with the quality of care that LTC facility residents receive. CMS believes that national minimum nurse staffing standards in LTC facilities are necessary at this time to protect resident health and safety and ensure residents' needs are met. At the same time, CMS acknowledges the unique challenges that rural LTC facilities face, especially related to staffing, and recognizes the need to strike an appropriate balance that considers the current challenges some LTC facilities are experiencing.

[2] FY 2022 Medicare & Medicaid Program Integrity Annual Report to Congress: https://www.cms.gov/files/document/fy2022-medicare-and-medicaid-report-congress.pdf

The final rule provides a staggered implementation timeframe based on geographic location as well as possible exemptions for qualifying facilities for some parts of these requirements based on workforce unavailability and other factors. CMS will closely monitor and evaluate the provisions of this final rule, including but not limited to, the minimum staffing standards, the 24/7 RN requirement, the exemption process, and the definition of "rural," as they are implemented over the next several years to determine whether any updates or changes are necessary in the future.

While we fully expect that LTC facilities will be able to meet our final minimum staffing standards, we recognize that in some instances, external circumstances may temporarily prevent a facility from achieving compliance despite the facility's demonstrated best efforts. Moreover, we know that some LTC facilities may still be experiencing challenges in hiring and retaining certain nursing staff because of local workforce unavailability. Therefore, in addition to the existing statutory waiver of requirement to provide licensed nurses on a 24-hour basis, CMS finalized our proposal for hardship exemptions, with some modifications, to apply in limited circumstances, to the HPRD and 24/7 onsite RN requirements.

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?

Answer:

CMS implements its programs consistent with the law.

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?

Answer:

CMS implements its programs consistent with the law. To oversee how federal dollars are spent, CMS uses several tools to monitor states' efforts to accurately verify beneficiary eligibility, including audits of beneficiary eligibility determinations; Payment Error Rate Measurement (PERM) Corrective Action Plans; and the Medicaid Eligibility Quality Control Program.

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?

Answer:

Proprietary Laboratory Analyses (PLA) codes, which are established by the American Medical Association, describe proprietary clinical laboratory analyses. CMS does not have the authority to mandate which codes are used by State Medicaid Agencies. While a HIPAA covered entity must use the applicable medical data code sets adopted at 45 CFR 162.1002, CMS does not

mandate which specific codes from within the adopted code set they are required to accept. CMS allows states to use discretion to determine the codes that best work for their systems.

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.

Answer:

CMS does not believe that implementing the proposed minimum performance level would have the unintended consequence of causing program cuts or provider closures. The agency believes that the current environment—in which providers and beneficiaries routinely struggle to find qualified direct care workers, and direct care workers leave the HCBS workforce for better-paying jobs—poses a significant threat to access and community integration because there are an insufficient number of direct care workers to meet beneficiaries' needs. In addition, the direct care worker shortage threatens beneficiary access to services and community integration as such shortage may lead to provider closures if providers are unable to find enough workers to deliver services. This shortage also threatens service quality through the loss of well-trained and experienced direct care workers, if left unaddressed. Further, we believe that the modifications we have finalized to this requirement will help to mitigate these concerns.

The purpose of this final rule is not to set a particular wage for direct care workers, but to ensure that Medicaid payments are being allocated in ways that promote efficiency, economy, and quality of care. The HCBS payment adequacy requirements in the Ensuring Access to Medicaid Services final rule (42 C.F.R. 441.302(k)) generally require States to assure that payment rates are adequate to ensure a sufficient direct care workforce to meet the needs of beneficiaries and provide access to services in the amount, duration, and scope specified in Medicaid beneficiaries' person-centered service plans. Specifically, § 441.302(k) provides that, beginning July 9, 2030, each State must ensure that each provider spends 80 percent of total payments the provider receives for furnishing certain HCBS (homemaker, home health aide, or personal care services) on total compensation for direct care workers who furnish those services, subject to certain exceptions. While this requirement is colloquially referred to as the "80/20 rule," we finalized several nuances and exceptions that provide flexibility for States as they work toward complying this finalized HCBS payment adequacy policy.

We agree that some small providers may experience additional challenges in meeting a payment adequacy requirement, as any fixed costs must be covered by a smaller pool of revenues than for larger providers, and small providers have fewer opportunities for administrative efficiencies than larger providers do. We share your desire that the minimum performance level not have a disparate impact on small providers, new providers that may still be developing their processes, providers that may, for various reasons, have additional administrative tasks (such as an increased need for interpreter or translation services), or providers that face disparately high costs, such as providers that may have to pay for temporary lodging for direct care workers delivering services to clients in extremely rural areas.

We also agree that some providers may experience hardships with meeting a payment adequacy requirement because, for instance, they are new to serving Medicaid beneficiaries and thus have not had time to develop administrative efficiencies. Additionally, we agree that special attention needs to be paid where a provider may be at risk of closure and could cause beneficiaries to lose access to HCBS in a particular area. States are best positioned to identify the nature of the hardships and which providers are experiencing these hardships.

As a result, the final rule allows States to establish a separate small provider minimum performance level as well as a hardship exemption.

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?

Answer:

As is the agency's custom, CMS is always willing and able to provide technical assistance on any proposed legislation.

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.

Answer (1-4):

In the case of certain home and community-based services (HCBS), CMS believes that ensuring adherence to a Federal standard of the percentage of Medicaid payments going to direct care workers is a concrete step in recruitment and retention efforts to stabilize this workforce by enhancing salary competitiveness in the labor market. In the absence of such requirements, we may be unable to support and stabilize the direct care workforce because we would not be able to ensure that the payments are used primarily and substantially to pay for care and services provided by direct care workers. The HCBS payment adequacy requirements in the Ensuring Access to Medicaid Services final rule (42 C.F.R. 441.302(k)) generally require States to assure that payment rates are adequate to ensure a sufficient direct care workforce to meet the needs of beneficiaries and provide access to services in the amount, duration, and scope specified in Medicaid beneficiaries' person-centered service plans. Specifically, § 441.302(k) provides that, beginning July 9, 2030, each State must ensure that each provider spends 80 percent of total payments the provider receives for furnishing certain HCBS (homemaker, home health aide, and personal care services) on total compensation for direct care workers who furnish those services, subject to certain exceptions. We also separately finalized reporting requirements at 42 C.F.R. § 441.311(e), providing that, beginning July 9, 2028, States must report to CMS annually on the

percentage of total payments (not including excluded costs) for furnishing certain HCBS (homemaker, home health aide, personal care, and habilitation services) that is spent on compensation for direct care workers, at a time and in the form and manner specified by CMS. (89 Fed. Reg. at 40,867-68).

While some States have already voluntarily established such minimums for payments, we believe a Federal standard would support ongoing access to, and quality and efficiency of, HCBS. Our proposal was based on feedback from States that have implemented similar requirements for payments for certain HCBS under section 9817 of the American Rescue Plan Act of 2021 (ARPA) or other State-led initiatives. For example, Minnesota has established a minimum threshold of 72.5 percent, while North Carolina required that 80 percent of its rate increases for certain HCBS be spent on direct care worker wages.

The HCBS payment adequacy reporting requirement for homemaker, home health aide, personal care services, and habilitation services we finalized at § 441.311(e) may also generate standardized data that is more amenable to national comparisons and may yield important data that will support transparency around the portion of Medicaid payments being shared with direct care workers; such transparency in and of itself may well encourage States and providers to look critically at their rates and how they are allocated. Further, we believe that gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in understanding the ways we can enact policies that support the direct care workforce and thereby help advance access to high quality care for Medicaid beneficiaries. We intend to release subregulatory guidance to assist States with implementation of this requirement, and we plan to also provide technical assistance and best practices to help States identify ways to use existing infrastructure or tools to gather and report. Further, we intend to provide States with technical specifications for the new reporting requirements in this final rule, which will aid in consistent data reporting. In addition, we will be making the reporting template available for public comment through the Paperwork Reduction Act notice and comment process. Through that process, the public will have the opportunity to review and provide feedback on the elements of the required State reports, including the methodology of the calculations, as well as the timing and format of the report to us.

Likewise, for the Medicaid institutional payment transparency reporting provision finalized at § 442.43, we will be making the reporting methodology and reporting template for the transparency and reporting requirements available for public comment through the Paperwork Reduction Act (PRA) notice and comment process. This will give the public the opportunity to provide specific feedback and help us align the methodology and reporting process with existing State practices to the greatest extent possible. However, we acknowledge that because State processes, timelines, and definitions vary, it may not initially be possible to align all details of

the reporting process with existing practices in multiple States. We therefore plan to provide technical assistance, as needed, to facilitate further alignment with States' current reporting practices, to the greatest extent possible.

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

Answer:

Section 9817 of the American Rescue Plan Act of 2021 (ARPA) provided states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for HCBS — an estimated $36.8 billion in planned spending. As a result of the ARP increase in the federal matching rate on activities, states originally were expected to use during a three-year period (from April 1, 2021, through March 31, 2024) the state funds that equal the amount attributable to the ARPA's increased FMAP, on activities to enhance, expand, or strengthen HCBS in Medicaid. In June 2022, CMS extended this deadline to March 31, 2025. The extended timeframe will help to facilitate high-quality, cost-effective, person-centered services for people with Medicaid.

Among the requirements participating states are expected to comply with is that participating states must submit semi-annual HCBS spending plans and narratives to CMS on the activities the state has implemented and/or intends to implement. Between now and the March 2025 deadline, CMS will continue to monitor states' progress and compliance to ensure funding is used to strengthen HCBS under their Medicaid program.

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.

Answer:

The purpose of this final rule is not to set a particular wage for direct care workers, but to ensure that Medicaid payments are being allocated in ways that promote efficiency, economy, and quality of care consistent with the statute. The HCBS payment adequacy requirements in the Ensuring Access to Medicaid Services final rule (42 C.F.R. 441.302(k)) generally require States to assure that payment rates are adequate to ensure a sufficient direct care workforce to meet the needs of beneficiaries and provide access to services in the amount, duration, and scope specified in Medicaid beneficiaries' person-centered service plans. Specifically, § 441.302(k) provides

that, beginning July 9, 2030, each State must ensure that each provider spends 80 percent of total payments the provider receives for furnishing certain HCBS (homemaker, home health aide, and personal care services) on total compensation for direct care workers who furnish those services, subject to certain exceptions.

We also agree that some small providers may experience additional challenges in meeting a payment adequacy requirement, as any fixed costs must be covered by a smaller pool of revenues than for larger providers, and small providers have fewer opportunities for administrative efficiencies than larger providers do. We share your desire that the minimum performance level not have a disparate impact on small providers, new providers that may still be developing their processes, providers that may, for various reasons, have additional administrative tasks (such as an increased need for interpreter or translation services), or providers that face disparately high costs, such as providers that may have to pay for temporary lodging for direct care workers delivering services to clients in extremely rural areas.

We also agree that some providers may experience hardships with meeting a payment adequacy requirement because, for instance, they are new to serving Medicaid beneficiaries and thus have not had time to develop administrative efficiencies. Additionally, we agree that special attention needs to be paid where a provider may be at risk of closure and could cause beneficiaries to lose access to HCBS in a particular area. States are best positioned to identify the nature of the hardships and which providers are experiencing these hardships.

As a result, the final rule allows States to establish a separate small provider minimum performance level as well as a hardship exemption.

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?

Answer:

CMS is committed to strengthening children's access to critical Medicaid and CHIP services, especially for those with special health care needs. CMS is always happy to provide technical

assistance on proposed legislation that improves access to care. And as you may know, Section 1945A of the Social Security Act provides an opportunity for states to cover care coordination, care management, patient and family support, and similar services that are expected to support a family-centered system of care for children with medically complex conditions, and that could help to improve health outcomes for these children. Often, children with medically complex conditions require specialized diagnostic or treatment services that may not always be readily available from providers within their state of permanent residence. By implementing the section 1945A health home option, states can cover coordination of care for children with medically complex conditions, including coordination of the full range of pediatric specialty and subspecialty medical services and coordination of care and services from out-of-state providers. In August 2022, CMS issued a letter to State Medicaid Directors on this Medicaid health home benefit for children with medically complex conditions. The letter to State Medicaid Directors is available on Medicaid.gov here: https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

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?

Answer:

Staffing in LTC facilities is a persistent concern, especially among low-performing facilities that are at most risk for providing unsafe care. Numerous studies have shown that staffing levels are closely correlated with the quality of care that LTC facility residents receive. CMS believes that national minimum nurse staffing standards in LTC facilities are necessary at this time to protect resident health and safety and ensure residents' needs are met. At the same time, CMS acknowledges the unique challenges that rural LTC facilities face, especially related to staffing, and recognizes the need to strike an appropriate balance that considers the current challenges some LTC facilities are experiencing.

The final rule provides a staggered implementation timeframe based on geographic location as well as possible exemptions for qualifying facilities for some parts of these requirements based on workforce unavailability and other factors. CMS will closely monitor and evaluate the provisions of this final rule, including but not limited to, the minimum staffing standards, the 24/7 RN requirement, the exemption process, and the definition of rural, as they are implemented over the next several years to determine whether any updates or changes are necessary in the future.

While we fully expect that LTC facilities will be able to meet our final minimum staffing standards, we recognize that in some instances, external circumstances may temporarily prevent a facility from achieving compliance despite the facility's demonstrated best efforts. Moreover, we know that some LTC facilities may still be experiencing challenges in hiring and retaining certain nursing staff because of local workforce unavailability. Therefore, in addition to the existing statutory waiver of requirement to provide licensed nurses on a 24-hour basis, CMS finalized our proposal for hardship exemptions, with some modifications, to apply in limited circumstances, to the HPRD and 24/7 onsite RN requirements.

CMS' finalized requirements are complemented by actions to strengthen the health workforce and respond to recruitment and retention challenges exacerbated by the COVID-19 pandemic, especially in rural and underserved communities. Through the Biden-Harris Administration's recently launched Health Workforce Initiative, HHS is strengthening the health workforce by connecting skilled health care providers to communities in need through grants, loan repayment, and scholarship programs and helping to build the pipeline of health workers in the most underserved communities.

As you noted, CMS has also announced that they will be investing over $75 million to launch a national nursing home staffing campaign to increase the number of nurses in nursing homes, thereby enhancing residents' health and safety. CMS will also be making it easier for individuals to become nurse aides by streamlining the process for enrolling in training programs and finding placement in a nursing home. We also will continue to advocate for nursing home operators to increase pay and improve job quality for nursing staff, which can help reduce high rates of turnover in LTC facilities and draw additional staff to the field.

Further, CMS finalized a requirement for state Medicaid programs to report on compensation for direct care workers and support staff in nursing facilities and intermediate care facilities for individuals with intellectual disabilities. Information on the portion of Medicaid payments that are spent on compensation can help inform efforts to grow and expand this critical workforce. This rule could also make it easier to help recruit and retain workers by improving their working conditions by making sure there is a minimum level of staff to provide the support that workers need.

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?

Answer (1-3):

School-based services (SBS) play an important role in the health of children and adolescents. Although schools are primarily providers of education-related activities, the school setting offers a unique opportunity to enroll children in Medicaid and facilitate access to coverage as well as provide health services directly to any Medicaid-enrolled children. Schools provide a venue to enhance early identification of health needs and connect students to a broad range of health care services, including behavioral health resources.

The Medicaid program is a partnership between the state and Federal governments. CMS provides Federal Financial Participation to states by matching qualifying state program expenditures at a specified percentage through a quarterly grant award process. CMS also oversees state programs to ensure that they are consistent with federal requirements. Within federal statutory and regulatory requirements, states operate the Medicaid program and make decisions about program administration, eligibility, and covered services. States are also responsible for establishing methodologies to pay providers for furnishing health care services to Medicaid beneficiaries. The methods and policies that states use to determine how their Medicaid programs operate are described within a written Medicaid State plan, which is approved by CMS. In addition, states provide guidance to providers through program manuals and billing instructions that are generally available on state Medicaid agency websites.

In May 2023, CMS released the "*Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*" to help expand access to Medicaid health care services in schools, including behavioral health services, and to help reduce administrative burden for states and schools. The guide offers new flexibilities and consolidates existing guidance, making it easier for all schools, no matter their size or the resources available to them, to receive payment for delivering Medicaid-covered services. This guide can be found here: https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf.

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?

Answer (1-2):

Federal statute requires states to recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States have the option to recover payments for all other Medicaid services provided to these individuals, except Medicare cost-sharing paid on behalf of Medicare Savings Program beneficiaries.

Under certain conditions, money remaining in a trust after a Medicaid enrollee has passed away may be used to reimburse Medicaid. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. States are also required to establish procedures for waiving estate recovery when recovery would cause an undue hardship.

States may impose liens for Medicaid benefits incorrectly paid pursuant to a court judgment. States may also impose liens on real property during the lifetime of a Medicaid enrollee who is

permanently institutionalized, except when one of the following individuals resides in the home: the spouse, child under age 21, blind or disabled child of any age, or sibling who has an equity interest in the home. The states must remove the lien when the Medicaid enrollee is discharged from the facility and returns home. CMS supports states that want to make that process less burdensome for family members, and we would be happy to provide technical assistance on legislation related to this issue.

The State Medicaid Manual, published by CMS, provides informational and procedural material needed by states to administer the Medicaid program. It states in 3810.G.1 that the state should provide notice to individuals at the time of application for Medicaid that explains the state's estate recovery program. Federal regulations at 42 CFR 435.905(a) require that the Medicaid agency furnish information to all applicants (and others upon request) on their rights and responsibilities; it does not require information to specifically be part of the application. The CMS Handbook on Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid provides additional information on estate recovery requirements.