September 12, 2025

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1832–P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS–1832–P)

Submitted electronically: https://www.regulations.gov/commenton/CMS-2025-0304-1544

Dear Administrator Oz:

I write to you on behalf of the National Association of Social Workers (NASW). NASW is the largest membership organization of professional social workers in the world, with chapters covering all 50 states and the DC metropolitan area, Guam, Puerto Rico, and the U.S. Virgin Islands. The association promotes, develops, and protects the practice of social work and professional social workers. Social workers are the largest provider of mental, behavioral, and social care services in the nation and serve a crucial role in connecting individuals and families to health care services.

NASW appreciates the opportunity to submit comments on CMS–1832–P, *Notice of Proposed Rule Making (NPRM) on the revisions of Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program*. As an association, we have long advocated for an equitable health care system that helps Medicare beneficiaries by enhancing health care quality, decreasing out-of-pocket costs, and improving health care outcomes.

NASW's comments address the following subjects:

- Determination of Practice Expense (PE) Relative Value Units (RVUs) Allocation of PE to Services, Facility and Nonfacility Costs

- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act
  - Proposal to Modify the Medicare Telehealth Services List and Review Process
  - Requests to Add Services to the Medicare Telehealth Services List for CY 2026: Multiple-Family Group Psychotherapy and Group Behavioral Counseling for Obesity
  - Proposal to Delete Social Determinants of Health Risk Assessment from the Telehealth Services List
  - Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations
  - Direct Supervision via Use of Two-Way Audio/Visual Communications Technology
  - Telehealth Originating Site Facility Fee Payment Amount Update

- Valuation of Specific Codes
  - Integrating Behavioral Health into Advanced Primary Care Management (ACPM)
  - RFI Related to APCM and Prevention

- Policies to Improve Care for Chronic Illness & Behavioral Health Needs
  - Updates to Payment for Digital Mental Health Treatment (DMHT)
  - Comment Solicitation on Payment Policy for Software as a Service
  - Prevention and Management of Chronic Disease—Request for Information
  - Community Health Integration and Principal Illness Navigation for Behavioral Health
  - Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health

- Provisions on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Other Covered Services

- Determination of Malpractice (MP) RVUs

- Geographic Practice Cost Indices (GPCIs)

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
  - Integrating Behavioral Health into APCM
  - Payment for Communication Technology–Based Services (CTBS) and Remote Evaluation Services—HCPCS Code G0071
  - Aligning with the Physician Fee Schedule (PFS) for Care Coordination Services

- Ambulatory Specialty Model (ASM)
  - Proposed ASM Performance Assessment Approach, Data Submission Requirements, and ASM Performance Category Requirements and Scoring—Use of High-Risk Medications in Older Adults (MIPS Q238) Screening for Depression and Follow-Up Plan (MIPS Q134) Functional Status Change for Patients with Low Back Impairments (MIPS Q220) and Falls—Plan of Care
  - Improvement Activities
  - Proposed Data
  - ASM Beneficiary Initiatives

- Medicare Shared Savings Program
  - Proposal to Allow Modifications to the SNF Affiliate List for SNF Affiliate CHOWs During a Performance Year
  - Revisions to the Definition of Primary Care Services Used in Shared Savings Program Beneficiary Assignment
  - Removal of Health Equity Adjustment Applied to an ACO's Quality Score and Revision of Social Determinants of Health Terminology

- Updates to the Quality Payment Program
  - Measure Proposals
  - Integrating Oral Health in Primary Care

NASW's comments follow.

Determination of Practice Expense (PE) Relative Value Units (RVUs)

Allocation of PE to Services, Facility and Nonfacility Costs
NASW appreciates CMS's attention to refining the allocation of PE RVUs. We urge CMS to continue prioritizing equitable reimbursement efforts all across service settings.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

Proposal to Modify the Medicare Telehealth Services List and Review Process
NASW supports CMS's proposal to streamline the Medicare Telehealth Services List review by eliminating Steps 4 (mapping to an existing permanent service)

and 5 (requiring evidence of analogous clinical benefit) from the current five-step process. The proposed three-step approach can be beneficial in reducing administrative burden and avoiding unnecessary delays in care.

Requests to Add Services to the Medicare Telehealth Services List for CY 2026 [Multiple-Family Group Psychotherapy and Group Behavioral Counseling for Obesity]
NASW supports adding CPT 90849 and HCPCS G0473 to the Medicare Telehealth Services List to expand access to care. These proposals help to promote equity and continuity in behavioral health treatment.

Proposal to Delete Social Determinants of Health (SDOH) Risk Assessment from the Telehealth Services List Telehealth
NASW disagrees strongly with CMS's proposed deletion of the SDOH Risk Assessment code from the telehealth services list, as proposed in Section II.D.1.c(10). As research has demonstrated, "Medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population" (Magnan, 2017). Thus, the primary contributors to health outcomes are environmental factors, socioeconomic factors, and health-related behaviors.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations
NASW respectfully disagrees with CMS's proposal to remove frequency limitations for subsequent nursing facility visits as reflected in CPT codes 99307 through 99310. These codes reflect subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and varying degrees of medical decision making either by a physician or by a qualified nonphysician practitioner (NPP), such as a nurse practitioner or a physician assistant. As we have expressed in our responses to this proposal within preceding NPRMs, nursing facility residents have acute and complex health conditions that necessitate careful monitoring and treatment. We offer the following information to elucidate how implementation of CMS's proposal could decrease the quality of care provided to nursing residents and, consequently, the safety of residents.

Assessment is the foundation of all health care, regardless of the health care practitioner's specialty or the resident's condition. Moreover, assessment is an iterative process; each decision to continue or change a resident's treatment is rooted in a practitioner's updated assessment. Such assessment requires that health care practitioners observe the resident in person rather than relying solely on a brief telehealth interaction and communication with nursing facility staff. An in-person assessment provides a more complete picture of the resident's behavioral, cognitive, emotional, mental, physical, and social condition. This is especially important because a resident's condition can change quickly.

Furthermore, assessment, care planning, and treatment decisions involve mutual communication and collaboration between the practitioner and the resident. When practitioners outside the facility setting do not meet in person with residents on a routine basis, they are neither able to conduct the thorough assessments necessary to guide care nor to engage residents (and, if appropriate, resident representatives) in care planning and treatment decisions. Several factors contribute to this reality:

- Meaningful participation in telehealth visits requires a level of digital literacy that many residents lack. Although a facility staff member may assist the resident in using the technology, the staff member may be too busy to spend the amount of time the resident needs. Moreover, the staff member's inclusion in the visit decreases the confidentiality of the relationship between the external health care practitioner and the resident, thereby compromising the resident's privacy.

- Many residents live with significant vision loss, hearing loss, or both. Such sensory loss can make meaningful participation in telehealth visits extremely difficult for residents.

    - Vision loss: Nearly 6 million people in the United States live with vision loss (based on the best visual function obtainable with proper glasses or contact lenses), and another 1.1 million people are blind (Centers for Disease Control and Prevention [CDC], 2024, Table 1). More women experience permanent vision loss or blindness than do men; across genders, people who are Black and non–Hispanic/Latino experience disproportionately high rates of vision loss in relation to other racial and ethnic groups (CDC, 2024, Figure 2). Likewise, the prevalence of vision loss tends to increase with age: Approximately 1 percent of people 55 through 59 years old experience vision loss, and only 0.12 percent are blind; these figures double for people 60 through 64 years old and continue to increase exponentially, with 20 percent of people 85 years and older experiencing vision loss and more than 5 percent living with blindness (CDC, 2024, Figure 1). Moreover, the risk of vision loss and blindness can be even greater for nursing home residents than for their peers who live in other settings: Recent studies have found prevalence rates of moderate to severe vision loss and blindness of approximately 47 percent and 16 percent, respectively, among nursing home residents in Delaware (Andersson et al., 2020); similarly, a North Carolina study found prevalence rates of 43 percent and 23 percent, respectively, for vision loss home and blindness among nursing home residents (Monaco et al., 2023).

      Without visual cues, nursing home residents may not comprehend communication from health care practitioners thoroughly. Similarly, without being able to see practitioners clearly in an audiovisual platform, residents with vision loss may struggle to remain engaged.

- Hearing loss: A recent nationally representative study found that about two-thirds of Medicare beneficiaries 71 years or older lived with clinically significant hearing loss, and this figure increased by more than 30 percent for beneficiaries 90 years or older; yet, less than 30 percent of beneficiaries with such hearing loss used hearing aids (Reed et al., 2023). Within this same beneficiary cohort, a related study found, nearly 80 percent of those living with probable or possible dementia experienced clinically significant hearing loss, a figure that increased to almost 95 percent in participants 85 years or older—and only about 22 percent of these beneficiaries living with both dementia and hearing loss used hearing aids (Nieman et al., 2024). In this second study, using weighted population estimates, researchers determined that women living with probable or possible dementia were about 25 percent more likely to experience clinically significant hearing loss; similarly, among both women and men, people living with dementia who identified as Black or Hispanic were about 55 or 70 percent more likely, respectively, to experience hearing loss than were people who identified as white (Nieman et al., 2024, Table 2). (Given the high prevalence of nursing home residents who live with dementia—which we address in our next point—hearing loss may be even more common among nursing home residents.)

  The impact of hearing loss on a nursing home resident's ability to participate meaningfully in a telehealth visit cannot be overestimated. Even if the resident seems to respond appropriately to a health care practitioner's questions and statements, the resident may not perceive accurately the practitioner's intent. Such misperception often results in minimization of a resident's concerns or agreement with the practitioner's statements, either because the resident does not want to ask the practitioner to repeat themselves or because the resident grows tired.

- Many nursing home residents live with neurological conditions or symptoms that render virtual communication difficult or even impossible. These residents often need extra time and, sometimes, accommodations to comprehend health care practitioners and to express themselves. They also tend to rely heavily on visual and auditory cues from practitioners. In turn, practitioners may be able to understand residents better in person than they can during telehealth visits.

  - Dementia: According to the most recent data compiled by the Alzheimer's Association, 46 percent of nursing home residents live with Alzheimer's disease or another form of dementia, with a 36-percent prevalence among residents staying less than 100 days and a 58-percent prevalence among residents staying 100 days or more (National Center for Health Statistics, 2024, as cited in Alzheimer's Association, 2025, pp. 87–88). Similarly, the Alzheimer's Association's 2025 data compilation shows that Medicare beneficiaries living with Alzheimer's or other dementias are five times more likely than beneficiaries without dementia to experience a skilled nursing facility (SNF) stay (p. 80) and 95 percent more likely to live in a nursing

home at some point during the course of the illness than are beneficiaries without dementia (p. 88).

- Aphasia: Aphasia, which affects more than 2 million people in the United States (National Aphasia Association [NAA], n.d.-b), affects a person's ability to express or comprehend spoken, signed, or written language (National Institute on Deafness and Other Communication Disorders [NIDCD], 2025). Stroke is the primary cause of aphasia, affecting about one-third of survivors (NIDCD, 2025). Other common causes of aphasia include brain infection (such as encephalitis or meningitis), brain tumor, and traumatic brain injury (NAA, n.d.-c). Alzheimer's disease and other forms of dementia—such as frontotemporal dementia, Lewy Body dementia, and vascular dementia—can also cause aphasia (NIDCD, 2025). Some people with dementia experience aphasia as the first symptom; such primary progressive aphasia worsens over time and may result in complete loss of language (NAA, n.d.-a; NIDCD, 2025). Some people with aphasia also experience apraxia of speech, "a neurological disorder that affects the brain pathways involved in planning the sequence of movements involved in producing speech" (NIDCD, 2017, para. 1).

- Voice production: Various conditions that can affect vocal production include dysarthria, "a group of speech disorders caused by disturbances in the strength or coordination of the muscles of the speech mechanism as a result of damage to the brain or nerves" (NIDCD, n.d., para. 1; please refer, also, to American Stroke Association [ASA], 2024, & NIDCD, 2025). It can affect pronunciation, the loudness of the voice and the ability to speak at a normal rate with normal intonation. Other conditions that can affect the voice include Alzheimer's disease (Columbia University School of Nursing [Columbia], 2023; Parlak et al., 2023), dementia with Lewy bodies (Lewy Body Dementia Association [LBDA], 2020), Parkinson's disease (Parkinson's Foundation, n.d.), and stroke (ASA, 2024). Symptoms of these various conditions may include vocal fatigue, tremor, or weakness; decreased vocal clarity; and changes in intonation, pace, pronunciation, and volume (ASA, 2024; Columbia, 2023; LBDA resume Lewy Body Dementia Association, 2020; NIDCD, n.d.; Parkinson's Foundation, n.d.; and Parlak et al., 2023).

The preceding factors often limit the ability of nursing home residents to advocate for themselves within the health care system, and some residents lack representatives (care partners) who can support them in such advocacy. Even when such care partners exist, they may be coping with some of the same challenges as the residents whom they support. For these reasons, in-person visits promote maximal inclusion of both residents and (when desired or needed by each resident) care partners. An in-person visit can enable health care practitioners to communicate most effectively with residents and care partners. If a care partner cannot be present physically during an in-person visit, the practitioner can be physically present with the resident and offer to incorporate

the care partner using communications technology. On the other hand, if a telehealth visit is the only option, the practitioner may not be able to communicate meaningfully with either the resident or the care partner.

In the absence of routine in-person, facility-based visits by physicians and NPPs, the quality of care provided to residents would suffer, and resident safety could be affected. For example, lack of thorough assessment information could increase preventable emergency department (ED) use and hospitalizations, thereby increasing the resident's risk of infection and cognitive decline. (Such ED and hospital utilization also increases health care costs for beneficiaries and the Medicare program alike.)

In conclusion, NASW strongly discourages CMS from removing frequency limitations on Medicare telehealth subsequent care services in nursing facility settings. (Our comments do not extend to hospital settings—either inpatient or observation—or to critical care consultation services.) In offering this input, we note that the current regulation enables any given physician or qualified NPP to conduct a nursing facility via telehealth up to once every 14 days (after the practitioner's initial in-person visit), and that this allotment extends to each treating practitioner involved in a resident's care. We believe that this regulation provides a feasible balance for practitioners while promoting high-quality care and resident safety. We appreciate CMS's consideration of our feedback on this important question.

Other Non–Face-to-Face Services Involving Communications Technology Under the PFS Direct Supervision via Use of Two-Way Audio/Visual Communications Technology
NASW supports CMS's proposal to permanently adopt a definition of direct supervision that includes real-time audio and video communication. This change enhances flexibility for clinical supervision while maintaining patient safety and oversight.

Telehealth Originating Site Facility Fee Payment Amount Update
NASW supports CMS's proposed increase in the telehealth originating site facility fee (HCPCS Q3014) to $31.85. This proposal supports broader access to care by ensuring originating sites are adequately reimbursed.

Valuation of Specific Codes

Integrating Behavioral Health (BHI) into Advanced Primary Care Management (APCM)
NASW supports adopting add-on codes for APCM to facilitate billing of complementary behavioral health services and requests clear implementation guidance to mitigate issues and avoid service disruption.

RFI Related to APCM and Prevention
NASW supports CMS's exploration of how APCM billing could better support prevention focused care. Clinical social workers (CSWs) play an important role in delivering preventive services like screenings, counseling, and health education while addressing SDOH across in person and telehealth modalities. We encourage CMS to consider models that recognize and reimburse these contributions within APCM to promote whole person, team-based care. Integrating social workers into primary care teams using standardized, evidence based workflows, patient and family engagement, and coordination with community based supports addresses mental health and social needs, reduces clinician burden, and helps organizations reach quality goals (Center for Health and Social Care Integration, n.d.). APCM could include a brief risk and needs assessment that screens for depression, substance use, and SDOH; an individualized treatment plan with goals and referrals; outreach; and streamlined documentation elements that support claims transparency without double payment, such as service dates, services furnished, and attribution to the billing practitioner, along with tracking of timely follow up after positive screens and patient reported outcomes.

NASW encourages CMS to address Medicare same-day billing limitations for multiple providers in the same group and specialty for a single episode of care. These restrictions can impede coordinated preventive services and may lead to added visits and delays; APCM flexibilities that enable coordinated same day encounters without duplicative payment would better support whole-person, team-based care.

Policies to Improve Care for Chronic Illness & Behavioral Health Needs

Updates to Payment for Digital Mental Health Treatment (DMHT)
NASW supports CMS's efforts to expand access to mental health services, including the proposed coverage of DMHT devices under § 882.5803 for treatment of attention deficit hyperactivity disorder. Although digital therapeutics can enhance care, NASW emphasizes that it should complement not replace clinical judgment. Trained providers are needed to ensure these tools are used ethically, responsibly, and in ways that support safe, equitable, patient-centered care (American Psychological Association, 2024; Wellness and Oversight for Psychological Resources Act, Ill. Pub. Act 104–0054, 2025). As coverage grows, NASW also encourages CMS to conduct ongoing evaluation of clinical effectiveness, adoption, and strong safeguards to protect patient health information.

Additionally, NASW urges CMS to require Section 508/WCAG 2.2 AA compliance (screen-reader/keyboard access, high contrast, captions, plain-language and multilingual interfaces); fund digital-divide supports (reimbursed onboarding/literacy/caregiver training, low-bandwidth/offline/SMS options, device-loan programs); allow in-person equivalents when tech is a barrier;

mandate accessible consent/privacy notices; and guardrails against aggressive marketing to beneficiaries (U.S. General Services Administration, 2018).

Comment Solicitation on Payment Policy for Software as a Service (SaaS)
NASW encourages CMS to establish a consistent and transparent payment framework for SaaS and artificial intelligence (AI) tools. The Outpatient Prospective Payment System (OPPS) claims data may already reflect pricing for similar services used in hospital outpatient settings. Leveraging OPPS geometric mean costs can help CMS set a fair and consistent national payment rate, particularly in cases where there is insufficient cost or utilization data from provider offices.

NASW supports CMS's initiative to explore national pricing and total RVUs for services to maintain relativity within the PFS. We believe this helps to ensure that clinical social work services are accurately valued in relation to other provider types. As CMS considers new methodologies, we urge the agency to incorporate data that reflects the complexity, time intensity, and clinical impact of behavioral health services provided by CSWs. Establishing fair and consistent pricing will help maintain access to these services, particularly in underserved communities, and promote equity across service settings.

Prevention and Management of Chronic Disease—Request for Information
NASW offers multiple recommendations in response to CMS's questions regarding prevention and management, including self-management, of chronic conditions. We note that these recommendations not only address the prevention, root causes, and management of chronic conditions, but also address the loneliness and social isolation experienced by many Medicare beneficiaries. Moreover, we affirm that the services we describe are provided by CSWs in community-based organizations CBOs—such as Area Agencies on Aging (AAAs) and other local aging and disability organizations—as well as in traditional health care settings.

EXPANSION OF COVERAGE FOR ALL SERVICES WITHIN CSWS' SCOPE OF PRACTICE
As noted previously within these comments, the primary contributors to health outcomes are environmental factors, socioeconomic factors, and health-related behaviors. Social workers are uniquely trained and positioned to identify and address these factors. Drawing on their ecological framework and strengths-based perspective, social workers collaborate with beneficiaries, families, and other health and human service professionals to understand each beneficiary's priorities and to develop, implement, and modify a care plan that enhances the beneficiary's health and well-being.

When social workers participate in health care teams, they save resources for overburdened care systems and make health care as effective and efficient as possible. Social workers intervene on a beneficiary's behalf in the following ways:

- coordinating care plans across medical specialties such as primary care, mental health, substance use, and various specialists
- bridging communication between health care and human service systems
- teaching strategies to support lifestyle adjustments and medication adherence
- maximizing beneficiary autonomy while mitigating risk and supporting families
- facilitating support groups to aid in understanding and managing a chronic condition
- convening family meetings to facilitate communication about a beneficiary's condition and care options
- providing counseling and therapy for co-occurring stress, grief, and depression

Notwithstanding these critical functions, beneficiary access to social workers is often limited because of Medicare reimbursement restrictions. For example, CSWs can bill Medicare only for the diagnosis and treatment of mental illness, even though their scope of practice is much broader. NASW appreciates that CMS has authorized CSWs to bill Medicare Part B not only for Health and Behavior Assessment and Intervention (HBAI) services, but also for Caregiver Training Services (CTS), Community Health Integration (CHI), and Principal Illness Navigation (PIN) services when CTS, CHI, or PIN is part of a care plan for a beneficiary's mental health or substance use condition. We recommend that CMS build on this progress by enabling CSWs to bill Part B for advance care planning services and care coordination.

This recommendation is particularly pertinent to CMS's question regarding existing or new codes, payment, or models that could support practitioner provision of successful interventions through partnerships between health care entities, AAAs, community care hubs, and other local aging and disability organizations. With expertise in navigating complex systems, social workers are leaders in the aging services network. CSWs provide a comprehensive approach to addressing the multifaceted concerns facing older adults and families by assisting with local service connections, linking people to resource hubs, and providing overall care coordination. Given that CSWs cannot bill directly for these care coordination contributions, clinics and other CBOs must allocate financing specifically to have a physician or other supervisory billing staff on payroll. If CSWs could access Medicare reimbursement for the full scope of services they are already authorized to perform under their state licensure, they could be the direct navigators and coordinators of interventions between community-based programs and health care entities—as they are trained to be.

Consequently, NASW urges CMS to exercise its regulatory authority and authorize Medicare Part B reimbursement for all relevant services within CSWs' state scopes of practice. Such authorization—which would mirror the mechanism by which psychologists and other health professionals bill under Medicare—would increase the likelihood that beneficiaries who live with or are at risk for chronic conditions receive appropriate, whole-person interventions.

Coverage of Medically Tailored Meals

NASW supports CMS's proposal to add Medicare billing for medically tailored meals. Proper nutrition can help prevent exacerbation of chronic conditions and prevent unnecessary hospitalization and emergency department use. Medicare reimbursement for medically tailored meals would support beneficiary self-management of chronic conditions in the following circumstances:

- discharge from a hospital
- recent diagnosis of a chronic condition
- diagnosis of multiple chronic conditions
- exacerbation of a chronic condition
- recent transition to palliative care

NASW recognizes that most CBOs do not directly employ a provider who could serve for supervised billing. These organizations do, however, often collaborate with health providers in other capacities. Thus, NASW recommends that CMS allow meal delivery under general supervision of a physician, NP, PA, or other billing provider. Furthermore, we urge CMS to include CSWs in the group of billing providers. This inclusion makes sense, given that CSWs are likely to have pre-existing clinical and social integrations with CBOs.

Motivational Interviewing and Coaching for Health and Well-Being

CSWs use motivational interviewing as one of their treatment modalities when providing mental health services. NASW does not support separate coding for motivational interviewing which is currently coded using the psychiatric code set and payment structure. Providing separate coding and payment would change the coding structure and create a pathway for other treatment modalities to seek separate coding and payment.

Given that the focus of coaching is on health and well-being, it seems fitting that coding and payment would be similar to that of the HBAI codes. NASW recommends that coaching be added to the HBAI code set.

Expansion of Mental Health Services Available to Beneficiaries in SNFs

NASW urges CMS to increase Medicare beneficiaries' access to mental health services in SNFs by excluding CSW services from SNF consolidated billing and allowing independent billing under Part B. Medicare beneficiaries in SNFs frequently experience complex mental health needs that require timely and specialized care. However, current Medicare policy prohibits independent CSWs from billing Medicare Part B for services rendered to beneficiaries receiving SNF services under Part A.

NASW respectfully reminds CMS that psychiatrists, psychologists, and (as of 2024) MFTs and MHCs are excluded from the SNF Prospective Payment System (PPS) and are permitted to bill Medicare independently. This authorization has not been extended to CSWs, even though these professionals have been recognized Medicare providers since 1989 (CMS, n.d-b.). As a result, CSWs are uniquely limited in their ability to bill independently for services provided to

beneficiaries in SNFs. This policy inconsistency places CSWs at a structural disadvantage and perpetuates inequity within the Medicare reimbursement framework.

More importantly, this CSW reimbursement restriction undermines CMS's own strategic goals of expanding behavioral health access and improving care equity, especially for underserved populations in long-term care settings. For example, it disrupts continuity of care for any beneficiary receiving outpatient mental health services from an independent CSW when the beneficiary enters a SNF. This disruption creates or exacerbates confusion, loneliness, social isolation, and feelings of desertion at a time when the beneficiary requires continuous supportive and mental health services. Moreover, the reimbursement restriction limits the available pool of providers to address new or worsening mental health conditions that often arise during SNF stays (Bedney, 2024). When unaddressed, these conditions may impede treatment for or even exacerbate medical conditions. To address this problem, NASW urges CMS to recommend excluding CSW services from SNF consolidated billing and to permit independent Part B billing for mental health services provided by CSWs to Medicare beneficiaries residing in SNFs.

Expansion of Mental Health Providers Who Participate in Medicare

Finally, NASW encourages CMS to increase reimbursement rates for CSWs. As CMS is aware, CSWs are reimbursed at only 75 percent of the Medicare PFS, a rate lower than the 100 percent paid to psychiatrists and psychologists and the 85 percent received by other NPPs, such as audiologists, occupational therapists, speech–language pathologists, and physical therapists (Bedney, 2024). This longstanding disparity contributes to provider shortages and restricts access to care for Medicare beneficiaries. As Mental Health America notes, low reimbursement rates discourage mental health professionals from participating in insurance networks, reducing service availability for individuals in need (Mental Health America, 2023). In addition, recent research shows that even Medicaid reimburses psychiatric services at approximately 81 percent of Medicare rates, with significant variation across states—further illustrating how payment structures can impact access (Zhu et al., 2023).

CHI and PIN for Behavioral Health

NASW appreciates CMS's clarification that CSWs can bill Medicare Part B directly for CHI and PIN services when those services are part of a treatment plan for a mental health condition. We encourage CMS to include CSWs as billing providers for auxiliary health care providers who provide CHI and PIN services in the context of mental health treatment. Moreover, CSWs have the expertise necessary to provide CHI and PIN services as incident to providers to physicians and other billing NPPs in the context of treatment for medical conditions.

The association agrees with CMS's recommendation of allowing CPT codes 90791 and the HBAI codes for the initial visit of CHI services related to mental health.

Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health

NASW agrees that consistent terms should be used when providing services related to SDOH. We recommend "social drivers," which would be a better representation of what the services are instead of "upstream drivers."

NASW strongly recommends retention of code G0136, Administration of a Standardized Evidence-based Social Determinants of Health Risk Assessment. Identification of SDOH is key in establishing treatment plans. Similarly, we urge CMS to retain SDOH risk assessment within the annual wellness visit.

Provisions on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Other Covered Services

NASW appreciates and affirms CMS's ongoing work to clarify and implement "inextricably linked" oral health coverage in Medicare. The agency's actions are essential to beneficiaries whose (nondental) medical treatment could be complicated, compromised, delayed, and even denied because of unresolved dental conditions. We urge CMS to continue its efforts to elaborate on, operationalize, and educate medical and dental practitioners about the payment rules so that Medicare beneficiaries may access the covered dental care that they require. We respectfully encourage CMS to consider the following suggestions, informed by our work with the Center for Medicare Advocacy and the Medicare Oral Health Coalition, to advance implementation of the existing payment rule:

- Adopt the 837D dental claim form, enable dental providers to submit this form electronically, and provide modifiers that simplify the process of seeking reimbursement of "inextricably linked" dental services.

- Stipulate and enforce three requirements for Medicare Administrative Contractors (MACs): (1) Provide current, comprehensible dental pricing schedules on its website in a location that is easy to find. (2) Verify and update website information about Medicare's dental payment policy. (3) Assign designated trained staff to answer inquiries from practitioners about dental coverage, billing, and enrollment, as well as to help troubleshoot problems.

- Enable dental practitioners to revoke their Medicare opt-out status and enroll in Medicare immediately, rather than awaiting the expiration of the two-year opt-out period (when their opt-out status automatically renews if they take no action).

- Evaluate the extent to which Medicare Advantage Organizations (MAOs) that offer MA plans are ensuring that those plans carry out their statutory obligation (under 42 C.F.R. § 411.15(i)) to provide coverage for "inextricably linked" dental services by furnishing, arranging, or making payment for those services. This

action involves the following steps: (1) CMS needs to provide guidance to MAOs to facilitate proper implementation of this coverage by MA plans. (2) MAOs need to require contracted plans to give accurate information to enrollees about the benefit and how to access "inextricably linked" dental care through an appropriate oral health provider. (3) MAOs need to ensure that contracted plans process those dental claims correctly. (4) MAOs need to educate in-network medical providers about how to refer enrollees for "inextricably linked" dental services and about how to obtain prior authorization (if necessary) and submit claims for inextricably linked dental services.

- Implement one of two actions to enable Medicare beneficiaries enrolled in MA plans or Dual Special Needs Plans to receive all of the covered care they need from the in-network dental provider of their choice: (1) CMS could enable in-network dental providers to submit claims for reimbursement by the MA plan when they furnish "inextricably linked" care to enrollees, even if those dental providers have formally opted out of Medicare. (2) CMS could reinstate its prior policy of requiring in-network dental providers to enroll in Medicare, just as other in-network providers are required to do.

- Publish additional guidance concerning payment for dental services to address dental or oral complications following treatment of head and neck cancer (HNC). Because severe dental and oral complications of HNC treatment can result in devastating health problems for different people at different points in time, NASW respectfully suggests that any criteria not limit access to payment to a defined window of time.

Submissions Received Through Public Submission Process

NASW thanks CMS for reviewing the seven public recommendations submitted for CY 2026 and for emphasizing its commitment to consider recommendations through the annual nominations process. Nonetheless, we are disappointed by the agency's decision not to identify additional examples of clinical scenarios in which payment for dental services is appropriate. Leading health care advocates presented strong evidence demonstrating how diabetes-associated retinopathy and diabetes-associated nephropathy are complicated by chronic oral infections, such as periodontitis. We urge CMS to reconsider this nomination. We also encourage CMS to reconsider prior recommendations supporting payment for dental care that is vital to the effective management and treatment of conditions such as autoimmune conditions, hemophilia chromatoses, oral graft host disease, sickle cell disorder, and poorly controlled diabetes.

NASW's comments on Section IV of this NPRM address how quality measurement can promote access to oral health care.

Determination of Malpractice (MP) RVUs

NASW supports CMS's proposal to update the methodology for calculating MP RVUs using current and comprehensive data sources. We appreciate that CSWs

were included with complete data and assigned a direct risk index that reflects low malpractice risk. We believe these calculations are fair and accurate given the services CSWs provide.

Geographic Practice Cost Indices (GPCIs)
NASW appreciates CMS's efforts to refine the GPCIs and PE methodology. As CSWs are paid under the PFS, we find that these changes that better reflect the costs of providing care in diverse settings. We urge CMS to ensure that any updates to cost share weights and indirect PE allocations do not inadvertently disadvantage behavioral health providers, particularly those serving underserved or rural communities.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers

Integrating Behavioral Health into APCM
NASW supports adopting add-on codes for ACPM to facilitate billing for BHI and CoCM in RHCs and FQHCs, which can strengthen integrated behavioral health in primary care. We recommend that, when unbundling G0512 and requiring reporting of individual CoCM codes, CMS provide clear guidance, align documentation with existing processes, and offer technical assistance to help RHCs and FQHCs implement the change, mitigate issues, and avoid service disruption.

Payment for Communication Technology
NASW supports making G2250 separately billable in RHCs and FQHCs to improve reimbursement for asynchronous services and expand timely access to care. For the unbundling of G0071 and reporting of individual CTBS codes, we recommend CMS provide clear guidance, align new requirements with current processes, as well as offer technical assistance to reduce administrative burden and disruption of services.

Aligning with the PFS for Care Coordination Services
NASW supports CMS’s proposal to adopt care management services under the PFS as care coordination services for separate payment to RHCs and FQHCs. Paying new care coordination HCPCS codes separately from the RHC AIR or FQHC PPS at the national non-facility PFS rate will promote consistent valuation and encourage delivery of BHI, chronic condition management, and patient navigation. We recommend CMS provide clear implementation guidance, align documentation with existing codes to reduce burden.

Ambulatory Specialty Model (ASM)

Proposed ASM Performance Assessment Approach, Data Submission Requirements, and ASM Performance Category Requirements and Scoring

NASW supports CMS's proposal to include the following measures in the low back pain quality measurement set:

- Use of High-Risk Medications in Older Adults (MIPS Q238)
- Preventive Care and Screening—Screening for Depression and Follow-Up Plan
- Functional Status Change for Patients with Low Back Impairments (MIPS Q220)

NASW offers feedback on one other quality measure, Falls—Plan of Care. We believe this measure could be a meaningful addition to the low back pain measure set. As CMS stated in the NPRM, people with low back pain are at high risk for falls, and assessment of fall risk could mitigate that risk. Should CMS determine over time that these data were not useful, the agency could discontinue to requirement. Were CMS not to include this measure for CY 2026, we encourage the agency to continue to solicit information for consideration for CY 2027.

Improvement Activities

NASW supports CMS's proposal to implement the following improvement activities within ASM:

- Improvement Activity 1 (IA-1): Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs Screening
- Improvement Activity 2 (IA-2): Establishing Communication and Collaboration Expectations with Primary Care Using Collaborative Care Arrangements

Proposed Data Sharing

NASW encourages CMS to incorporate strong beneficiary protections in relation to sharing of personal health information (PHI). To that end, NASW encourages CMS to align the ASM data-sharing requirements with the stronger data-sharing policy used in other voluntary Innovation Center models. Moreover, ASM participants need to provide information—including beneficiaries' right to request restrictions on data sharing—to beneficiaries in consumer-friendly language. The language should be available in multiple languages (using professional translations, which we urge CMS to develop). Additionally, ASM participants should provide this information to beneficiaries orally or using American Sign Language during an in-person visit.

ASM Beneficiary Initiatives

Although NASW does not offer comment on the advisability of beneficiary incentives to participate in ASM, we encourage CMS to proceed with caution so as to prevent coercion of beneficiaries. As CMS is aware, informed consent is essential to participation in ASM and all other health care services. We are concerned that financial incentives could influence beneficiaries' decision making and compromise self-determination.

Medicare Shared Savings Program

Proposal to Allow Modifications to the SNF Affiliate List for SNF Affiliate CHOWs During a Performance Year

NASW is concerned about CMS's proposal to enable a SNF affiliate that experiences a change of ownership (CHOW) resulting in a change to the Medicare-enrolled taxpayer identification number (TIN) to remain affiliated with an accountable care organization (ACO) without waiting until the subsequent performance year. We recognize the value of the SNF three-day rule waiver, which waives the three-day prior inpatient hospitalization rule for a beneficiary enrolled in an ACO when the beneficiary transitions to an eligible SNF affiliate without a three-day inpatient hospitalization. Yet, we assert that CMS's current requirement for ACOs to await the change request cycle each performance year to update their SNF affiliate list serves an important protective role for Medicare beneficiaries. Nursing home ownership and operations can impact the quality of care drastically, particularly given complex ownership and operations structures, including the growing involvement of private equity and real estate investment trusts in the nursing home industry—a reality made clear by the U.S. Government Accountability Office (GAO, 2023), the National Academies of Sciences, Engineering, and Medicine (2022), the Center for Medicare Advocacy (Edelman, 2021, 2024; Harrington & Edelman, 2023), the National Consumer Voice for Long-Term Care, commonly known as the Consumer Voice (Brooks, 2024; Consumer Voice, 2023), the Private Equity Stakeholder Project (O'Grady, 2021), NASW (Bedney, 2023), and numerous media reports (such as Kauffman, 2024).

Consequently, CMS's current requirement that ACOs wait until the next change request cycle to report a CHOW that results in a change in the Medicare-enrolled TIN for an approved SNF affiliate is both modest and necessary. Elimination of this requirement would undo, to some extent, the limited but significant progress made by CMS's final rule addressing nursing home ownership and disclosable parties (2023). NASW urges CMS to withdraw this proposal.

Removal of Health Equity Adjustment Applied to an ACO's Quality Score and Revision of SDOH Terminology

NASW respectfully opposes CMS's proposal to remove the health equity adjustment applied to an ACO's quality score. As noted previously, we strongly urge CMS to use the term "social drivers" rather than the proposed "upstream drivers."

Updates to the Quality Payment Program (QPP)

Transforming MIPS: MVP Strategy

NASW supports CMS's proposal to allow groups to self-attest to their specialty composition during MVP registration, as this promotes flexibility and reduces administrative burdens while enabling practices to more accurately represent

their care delivery structure. However, we encourage CMS to implement safeguards against misclassification to uphold the integrity of the reporting process. Continued engagement with stakeholders will be essential in refining this approach and addressing any unintended consequences.

Moreover, NASW supports CMS's proposal to enable small multispecialty practices (15 or fewer clinicians) to report as a group without forming subgroups. We believe it could help to reduce administrative burden for small behavioral health practices and supports collaborative, team-based reporting without added complexity.

Performance Threshold

NASW supports CMS's proposal to maintain the performance threshold at 75 points through the CY 2028 performance period/2030 payment year. Maintaining the 75-point threshold allows for a stable performance target that provides predictability for MIPS eligible clinicians such as CSWs, enabling consistent planning for quality reporting without the risk of sudden changes in scoring expectations. NASW encourages CMS to consider removing penalties associated with quality reporting as we believe it could be helpful way to increase provider QPP participation.

MIPS Performance Categories

QUALITY PERFORMANCE CATEGORY

NASW strongly opposes CMS's proposal to update quality measure inventory by removing "health equity" from the definition of a high-priority measure. We are concerned that it would diminish the emphasis on reducing health disparities and could minimize incentives to address equity in care delivery. This proposal is also not in alignment with CMS's foundational pillar of advancing health equity, which emphasizes the importance of integrating equity into all aspects of quality measurement and care improvement (CMS, n.d.-a).

MEASURE PROPOSED FOR ADDITION TO THE CSW SPECIALTY SET FOR THE CY 2026 PERFORMANCE PERIOD/2028 MIPS PAYMENT YEAR AND FUTURE YEARS

Quality #495—Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood

NASW supports adding Quality #495 to the Clinical Social Work Specialty Set. This measure reflects how well patients believe they are listened to and understood in palliative care settings. These aspects of care are part of effective communication and relationship-building, which social workers practice daily. Including this measure will help ensure the patient's perspective is a consistent focus and will highlight the role of social workers in improving patient experience.

Measures Proposed for Removal from the CSW Specialty Set

Quality #487—Screening for Social Drivers of Health. NASW strongly opposes CMS's proposal to remove Quality #487. Screening for social drivers of health is necessary to address nonmedical factors that influence health outcomes, including those associated with mental health and substance use. Without such screening, there is a risk of reduced identification of needs and weaker connections to community-based supports. For example, a large cross-sectional study conducted across primary care and emergency department settings found that patients who screened positive for social needs—such as housing instability, food insecurity, and transportation barriers had significantly higher odds of experiencing depression and other mental health conditions. Specifically, individuals with depression were more than twice as likely to report unmet social needs, indicating a strong connection between these needs and mental health outcomes (Vilendrer et al., 2023).

Social workers routinely assess needs such as housing stability, food access, and safety. The removal of this measure may result in less consistent identification of these needs, which can limit early intervention and coordination with community services. If CMS decides to remove this measure, we encourage identifying alternative ways to capture this information that minimize or avoid additional administrative burden for clinicians, such as incorporating elements into existing workflows, leveraging electronic health record data fields, or using already collected information from other reporting programs.

Quality #498—Connection to Community Service Provider. NASW does not support removing Quality #498. The measure addresses whether patients with identified needs are connected to community resources. Social workers regularly facilitate these connections, and without tracking them, there is less accountability for ensuring needs are addressed. If CMS decides to remove this measure, we recommend exploring ways to monitor these linkages that do not create additional administrative tasks, such as repurposing data already documented in care coordination records, using existing claims or referral tracking systems, or drawing from measures in other programs that already require related information.

Improvement Activities Inventory

NASW opposes CMS's proposal to replace the "Achieving Health Equity" subcategory with "Advancing Health and Wellness." While the association supports updating the Improvement Activities (IAs) inventory, we believe removing a dedicated health equity category could minimize focus on equitable person-centered care. Absorbing such activities into a broader wellness category could dilute their impact and reduce incentives for equity-centered practice; therefore, NASW urges CMS to maintain a distinct Achieving Health Equity subcategory.

Promoting Interoperability Performance Category
NASW supports CMS's proposal to update the Security Risk Analysis and SAFER Guide measures to better reflect current practices in health IT and data protection. These updates can help maintain participation and safeguard patient information.

NASW supports CMS's proposal to add a new optional bonus measure for reporting using the Trusted Exchange Framework and Common Agreement. However, we recommends that CMS provide funding and technical assistance to small practices to encourage participation.

NASW supports CMS's proposal to adopt a policy allowing certain measures to be suppressed when scoring would be unfair. This policy would prevent clinicians from being penalized due to factors outside their control. It could also bolster provider participation in the QPP program.

Suppress Electronic Case Reporting Measure for CY 2025 Performance Period
NASW supports the proposed suppression of the Electronic Case Reporting measure for the CY 2025 performance period due to the CDC's temporary pause in onboarding new healthcare organizations and public health agencies. This proposal would help to prevent undue burden on providers who may otherwise struggle to meet this requirement.

We respectfully urge CMS to reconsider its decision to remove automatic reweighting of the Promoting Interoperability category for CSWs. Many CSWs operate in small or solo practices with limited financial and technical resources, making access to certified EHR technology difficult (Office of the Assistant Secretary for Planning and Evaluation, 2022). Interoperability requirements are often misaligned with behavioral health workflows, which rely heavily on narrative documentation and individualized care plans (Medicaid and CHIP Payment and Access Commission, 2021). Additionally, privacy regulations such as 42 CFR Part 2 impose stricter confidentiality standards for substance use treatment, complicating data exchange and limiting compatibility with broader health IT systems (Confidentiality of Substance Use Disorder Patient Records, 2024; Social Security Act § 290dd-2). NASW appreciates CMS's commitment to equitable implementation of health IT measures and encourages continued support for behavioral health providers in future rulemaking.

Proposed Revisions to Measures and Activities

PROPOSAL TO REVISE IA_EPA_X—ENHANCE ENGAGEMENT OF MEDICAID AND OTHER UNDERSERVED POPULATIONS
NASW supports CMS's proposed revisions to broaden examples of engagement strategies, clarify that activities can be tailored to local population needs, and add language encouraging collaboration with CBOs. We especially affirm the recognition that strategies can be adapted to local contexts. NASW recommends

that CMS continue to allow engagement activities to be documented using existing records and workflows, minimizing additional reporting burden.

Proposal to Remove Five Improvement Activities for CY 2026

NASW opposes CMS's proposal to remove the following improvement activities for CY 2026:

- IA_AHE_1—Enhance Engagement of Medicaid and Other Underserved Populations
- IA_AHE_3—Promote Use of Patient-Reported Outcome Tools
- IA_AHE_5—MIPS-Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research
- IA_AHE_9—Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols
- IA_AHE_12—Practice Improvements that Engage Community Resources to Address Drivers of Health

These activities each represent important aspects of behavioral health care. Removing these activities could reduce the ability to measure interventions that address equity, SDOH, and whole-person care.

#Q134—Preventive Care & Screening: Screening for Depression and Follow-Up Plan

NASW supports CMS's proposed clarifications of denominator exclusions, updates of references to standardized screening tools, and alignments of follow-up documentation requirements with current clinical guidelines, provided CMS continues to accommodate validated screening tools widely used in behavioral health settings and allow for flexibility in documenting follow-up plans. We encourage CMS to structure the revisions in a way that fits seamlessly into existing behavioral health workflows to avoid creating additional administrative burden.

#Q502—Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder

NASW supports CMS's proposal to update measure specifications to clarify eligible patient populations, refine the definition of "maintenance of functioning" and to broaden acceptable functional assessment tools provided CMS continues to allow the use of functional assessments that are common in behavioral health care and reflect real-world improvements or maintenance of patient functioning. Any updated definitions should remain inclusive of diverse behavioral health populations.

Refining the description to specify that tools must be validated for the patient population served, can be administered in person or remotely, and should be integrated into treatment planning

NASW supports these refinements, which provide clarity while preserving flexibility in how Patient-Reported Outcome (PRO) tools are administered. NASW

recommends that CMS continue to recognize a wide range of validated behavioral health PRO instruments and collection methods, including tools such as the PHQ-9 for depression and the GAD-7 for anxiety.

Integrating Oral Health in Primary Care

NASW applauds and strongly supports CMS's proposal to adopt a new improvement activity, Integrating Oral Health Care in Primary Care, within the inventory of activities that MIPS-eligible clinicians can use to improve care delivery. In many communities—particularly in urban and rural areas, both of which tend to be underserved—primary care practitioners play the key role in caring for beneficiaries with chronic and serious illnesses. This trend underscores the need to integrate dental assessment, education, and referrals into primary care delivery.

NASW perceives tremendous value in incentivizing primary care practitioners to engage in the following activities: conducting an oral health risk assessment and intraoral screening of beneficiaries served; educate beneficiaries about the importance of oral health, including the relationship between oral health and systemic conditions; and providing dental referrals to beneficiaries who have oral health needs and to those who are not connected with dental practitioner. Adoption of this improvement activity can have far-reaching impact in treating and managing not only oral–dental conditions, but also other prevalent chronic conditions. We thank CMS for recognizing the value of medical–dental integration and for taking this important step to encourage the inclusion of oral health in whole-person care.

Requests for Information

Core Elements in an MVP

NASW encourages CMS to consider core elements that reflect the services provided in behavioral health, including measures tied to patient functioning, engagement, and equity. We believe that selecting measures that already align with common behavioral health practices would make reporting easier for CSWs and increase the relevance of MVP participation without creating new administrative steps.

Well-Being & Nutrition Measures

NASW supports the addition of measures related to emotional well-being, social connection, purpose, and other broader wellness concepts. These areas reflect outcomes that CSWs regularly address. If CMS develops these measures using tools and processes that are already familiar in behavioral health settings, it will encourage meaningful participation and keep additional workload low while still capturing important aspects of care.

Procedural Codes for MVP Assignment

NASW urges CMS to proceed cautiously with procedural code-based assignment and to involve behavioral health stakeholders in its design. Codes used for CSW

services should be accurately mapped to MVPs that reflect the profession's scope. Furthermore, any assignment process should use existing claims and EHR data, so it integrates naturally with current reporting systems and avoids extra administrative work.

Transition Toward Digital Quality Measurement

NASW encourages CMS to make the transition to FHIR-based eCQM reporting in a way that builds on existing behavioral health documentation processes and EHR platforms. Providing optional templates, phased timelines, and technical support would help CSWs adopt digital quality reporting without disrupting patient care or overburdening small practices.

Performance-Based Public Health and Clinical Data Exchange

NASW recommends that any shift from attestation-based public health and clinical data exchange reporting to performance-based reporting be designed so that it works with current behavioral health workflows and technology. Leveraging existing data exchange capabilities in EHRs and community health systems could make participation straightforward for CSWs while still improving the usefulness and completeness of public health reporting.

Data Quality

In regard to CMS's request for input on the current state of data collection, exchange, and quality, NASW encourages CMS to explore ways to capture behavioral health and SDOH information that are standardized and easy to integrate into behavioral health workflows. We recommend that CMS build on existing documentation practices, aligning with established SDOH data frameworks, and making use of current EHR functionality can help CSWs contribute meaningful information without adding administrative burden, while giving CMS a more complete picture of how behavioral health services support overall health outcomes.

All Proposed Measures and Activities in Mental Health and Substance Use Disorders MVP

NASW appreciates the opportunity to provide feedback and supports CMS's ongoing efforts to improve behavioral health care delivery through meaningful, person-centered measurement strategies. We commend CMS for incorporating measures that reflect the complexity of mental health and substance use conditions, and we encourage CMS to structure revisions in a way that aligns with existing behavioral health workflows to minimize administrative burden and support practical implementation across varied care environments.

Thank you for your consideration of NASW's comments on this NPRM. Please do not hesitate to contact me at bbedney.nasw@socialworkers.org if you have questions.

Sincerely,

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[References follow on the next page.]

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