

September 13, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

Electronic Submission: <https://www.regulations.gov/>

Re: CMS – 1751-P Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

Dear Administrator Brooks-LaSure:

I am writing to you on behalf of 110,000 members of the National Association of Social Workers (NASW). Founded in 1955, NASW is the largest professional social work organization in the United States. NASW promotes, develops, and protects the practice of social work and professional social workers and advocates for the clients we serve. Clinical social workers (CSWs) are the largest non-physician professional group that provides mental health services to Medicare beneficiaries. NASW appreciates the opportunity to submit comments on CMS-1751-P, Notice of Proposed Rule Making on the revisions of Medicare payment policies on the Physician Fee Schedule for the calendar year (CY) 2022.

Below are our comments on the following sections of the proposed rule:

- Telehealth
- Rural Health Clinics and Federally Qualified Health Centers
- Quality Payment Program

- Reimbursement Cut
- Opioid Treatment Program
- Chronic Pain Management
- Accountable Care Organizations
- Closing the Health Equity Gap in CMS Quality Programs
- Collection of Health Equity Data
- Health Equity Measures
- COVID-19 Vaccines
- Medications Covered by Medicare Part B
- Colorectal Cancer Screening
- Pulmonary, Cardiac, and Intensive Cardiac Rehabilitation

Telehealth

NASW greatly appreciates the CMS' continued leadership during the COVID-19 pandemic and supports the agency's proposal to extend several of the telehealth flexibilities which were implemented early in the pandemic. These flexibilities have been transformational in addressing the mental and behavioral health needs of millions of beneficiaries. We support the removal of geographic restrictions and are pleased that CMS has proposed to allow beneficiaries' homes as an originating site for telehealth services for the purpose of diagnosis, evaluation, and treatment of mental health disorders. We also welcome the proposed continuation of audio-only devices as a telehealth modality. That said, we do have a number of revisions we hope will be reflected in the final rule:

- *In-Person Requirement:* NASW urges CMS not to impose an in-person requirement for telehealth for mental health telehealth services, either before or after the first telehealth visit. Such a requirement will impede access to services for individuals currently receiving treatment and discourage others from seeking treatment. The frequency of any in-person sessions should be determined by clinicians, together with their clients, as has been the case during the PHE. If CMS is forced to institute such a requirement, we would support an in-person visit being required at intervals of no more than once every 12 months.
- *Audio-Only Documentation:* We urge CMS to refrain from requiring additional documentation for coverage of audio-only services. The documentation in the medical record already provides sufficient information needed to justify medical necessity for the service. Additionally, under the proposed rule providers will already self-certify that they have two-way audio-visual telecommunications devices, but the patient requires or has chosen to receive the service via audio-only. No other documentation should be required.
- *Include Behavioral Health Services in Audio-Only:* We urge CMS to allow the use of audio-only devices for substance use disorders (SUD) and behavioral health services. Given the high prevalence of co-occurring mental health and substance use disorders, this approach

will advance CMS's goal of providing the "right care at the right time" to improve patient and population health outcomes.

- *Psychotherapy with Crisis and Higher-Level Codes:* We urge CMS to allow high-level services such as crisis psychotherapy to be furnished through audio-only telehealth. By definition, a mental health crisis is urgent, and help is required as soon as possible. There should be nothing that delays or discourages immediate contact with a provider and audio-only telephones are the easiest telecommunications devices for many beneficiaries to use.
- *Payment Parity:* A key payment issue not directly addressed in the proposed rule is whether the agency will continue to pay for telehealth services at the same rate as in-person visits once the PHE ends. For mental and behavioral health providers, whose patients rely heavily on telehealth services, it would be a costly reduction if payment for these services returns to pre-pandemic reimbursement levels. We urge CMS to continue to ensure payment parity for telehealth services.

Rural Health Clinics and Federally Qualified Health Centers

NASW welcomes CMS' proposal to expand the definition of RHCs or FQHCs mental health visits to include encounters furnished through interactive, real-time telecommunication technology for mental health disorders, and to allow them to furnish mental health visits using audio-only interactions to beneficiaries when two-way, audio/video communication is not available.

Quality Payment Program (QPP)

NASW is pleased that CMS has proposed to revise the current eligible clinician definition to include clinical social workers in the QPP. The association also appreciates efforts made to simplify the Merit-Based Incentive Payment System (MIPS) by developing the MIPS Value Pathways program (MVP). We support CSWs having the opportunity to provide meaningful data to promote improved treatment outcomes for beneficiaries and encourages CMS to consider MVP topics applicable to CSW practice.

Reimbursement Cut

NASW opposes CMS' proposal to reduce the conversion factor by 3.75 percent, which will result in payment cuts for CSWs. The projected 3.89 percent loss for 2022 as a result of this change in conversion factor follows a 3.3 percent budget neutrality-related reduction in 2021. Together, this is a 7+ percent reduction in payment from 2020 to 2022. The proposed cut is particularly harmful to CSWs. CSWs are the largest group of mental health service providers in the nation and among the few mental health professions that provide psychotherapy services for Medicare beneficiaries. Despite possessing extensive education and training and billing the exact same codes, CSWs are reimbursed at only 75 percent of the PFS. This has not changed since CSWs were first added to Medicare in 1989, despite the growing need for our services. Further reduction of already low payments will jeopardize beneficiary access to essential mental health services.

Chronic Pain Management

NASW appreciates CMS' recognition of the need for greater attention to the public health issue of chronic pain and the health and social risks posed by untreated and/ or inappropriately treated chronic pain. Further steps are needed to increase Medicare beneficiary access to behavioral and therapeutic management of chronic pain. Social workers can serve in key roles in the delivery of clinical and supportive services to patients who experience chronic pain. Making social workers independently reimbursable for the provision and delivery of pain management-related services (e.g., clinical assessments, consultation, therapeutic care etc.) will expand much needed supportive care to Medicare beneficiaries.

Opioid Treatment Programs

NASW agrees with the proposal to require Opioid Treatment Program (OTP) to use a service-level modifier for audio-only services for counseling and therapy. The association also concurs with the requirement to document in the medical record the rationale for using audio-only services.

Accountable Care Organizations

NASW appreciates efforts to improve quality of care for all beneficiaries participating in Affordable Care Organizations (ACOs), and efforts to encourage ACOs to report on quality measures for all patients. ACOs can help reduce health inequities by addressing social risk factors that affect the patient populations they serve. Standardization of data collection, including documentation of health-related social needs, is an important step. ACOs should prioritize data integration with community organizations with which they partner. External, community-based organizations often have longstanding relationships with patients that can enhance care coordination and accurate data collection.

Historically, cost reduction has been the key consideration in evaluating ACO success. However, cost reduction efforts do not necessarily yield evidence of greater health equity. The ACO model could be further adapted to include quality measures that better align with health equity by creating mechanisms to factor in the social acuity of attributed patient populations given the established relationship between social risk factors and increased morbidity and mortality. There is a need to incentivize outreach to and engagement with patients with marked social and medical acuity. Social workers are skilled in conducting outreach to socially vulnerable patient populations, conducting preventive social needs screenings, coordinating linkages to services, and addressing co-occurring behavioral health and social care needs. ACOs should consider employing or contracting directly with providers such as social workers who specialize in addressing the social determinants of health linking beneficiaries to appropriate resources. This type of inclusion of social workers within the ACO framework would serve to further encourage health care providers serving vulnerable populations to participate in this model of care.

Closing the Health Equity Gap in CMS Quality Programs

NASW agrees that capture of patient-level data is critical in providing effective patient care. We endorse the strategy of improving demographic data collection. While stratification by race and ethnicity is important in any effort related to evaluating health disparities, improving the capture of demographic data will offer a more inclusive and intersectional analysis of factors that

contribute to disparate health outcomes (e.g., dual eligibility, disability status, spoken language, socio-economic status, gender etc.). All of the aforementioned elements can offer a more robust analysis of population-level health disparities. Research has shown that rates of patient-provider discussion about social demographic circumstances were found to be associated with significant risk of adverse outcomes¹. Improved capture of patient-level contextual data can enable proactive identification of barriers to care and opportunities for enhanced care coordination efforts.

Collection of Health Equity Data

NASW is pleased CMS is working to advance health equity. As mentioned previously the association supports efforts to improve data collection to better measure and analyze health disparities across program policies that also includes telehealth. There are a number of practice-related barriers to effectively assessing for and appropriately documenting relevant patient demographic data. At a fundamental level, there is a need for comprehensive academic and practice-based training for interprofessional workforces on the importance and relevancy of these efforts and how they can positively contribute to the overall quality of care. Provider solicitation of sexual orientation and gender identity-related information, for example, is exceedingly complex. The healthcare workforce at large could benefit from basic and routinized training on LGBTQIA+ communities and the principles of affirming care.

Practice-based stigma and population stereotypes are significant barriers to adhering to standards of care. Healthcare systems could benefit from resources and technical assistance to appropriately modernize their electronic health record (EHR) and related registry systems to capture this salient information in order to promote optimal care. There is a need for the creation and promotion of EHR-related standards to organize and respond to non-medical data. Social workers have a comprehensive understanding and training to help with factors that contribute to health disparities. Thus, NASW encourages CMS to consider CSWs as it works to improve health equity for its beneficiaries in the delivery of essential education for the healthcare workforce at large.

Health Equity Measures

NASW recommends that health equity measures be broadly applicable to various specialties and subspecialties. Given that interprofessional care and collaboration are standard in healthcare systems, it is essential that health equity standards be applicable to all provider types. The following factors should be considered when developing health equity measures: improvement of access and health delivery; the production of quality and timely data on social risk factors and disparities; performance measures that are aligned with progress made toward health equity;

¹ National Academies of Sciences, E. and M., Health and Medicine Division, Board on Health Care Services, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating Social Care Into the Delivery of Health Care : Moving Upstream to Improve the Nation's Health. National Academies Press.

and payment models that incentivize the reduction of health disparities². At both the individual patient and community level, this work requires more deliberate alignment across sectors through formal business arrangements, data sharing, payment policy and financial arrangements, and, where necessary, enabling legislation and regulation³. Lastly, the association recommends that a health equity measure be included at the foundational layer of all MVPs to ensure that there is a sustained focused on identifying and responding to population-based health disparities and to incentivize health systems to reform their systems of care.

COVID-19 Vaccines

NASW supports continued Medicare reimbursement for vaccination administered in beneficiaries' homes. We specifically support CMS' definition of "home" and the types of clinical and nonclinical circumstances that make it difficult for a beneficiary to receive a COVID-19 vaccine outside the home.

Medications Covered by Medicare Part B

NASW supports CMS' proposal to require pharmaceutical manufacturers without a Medicare drug rebate agreement to report average sales price (ASP) data for drugs and biologics payable under Medicare Part B, just as manufacturers with Medicaid drug rebate agreements currently do. Similarly, NASW supports the proposal to amend § 414.806 to reflect the new provisions specifying civil monetary penalties for manufacturers without Medicaid drug rebate agreements.

NASW supports CMS' proposal to modify the definition of "drug" at § 414.802 to include any item, service, supply or product that is payable under Part B as a drug or biological.

Colorectal Cancer Screenings

NASW supports CMS' proposal to add a paragraph at § 410.37 indicating that screening flexible sigmoidoscopy or screening colonoscopy tests that require a related procedure (including removal of tissue or other matter) furnished in connection with, as a result of, and in the same clinical encounter as the screening test, be considered a colorectal cancer screening test.

NASW also supports CMS' proposal to implement, at § 410.152(l)(5), phased-in Medicare reimbursement increases (and associated decreases in beneficiary cost sharing) for colorectal cancer screening tests between CY 2022 and CY 2030. Given that Medicare already covers colorectal cancer screening tests in full, NASW encourages CMS to clarify that the specified reimbursement phase-in applies specifically to colorectal cancer screening that involves removal

² NQF Issues Quality Roadmap for Reducing Healthcare Disparities:

https://www.qualityforum.org/NQFs_Roadmap_to_Health_Equity.aspx

³ National Academies of Sciences, E. and M., Health and Medicine Division, Board on Health Care Services, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating Social Care Into the Delivery of Health Care : Moving Upstream to Improve the Nation's Health. National Academies Press.

of tissue or other matter furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Pulmonary, Cardiac and Intensive Cardiac Rehabilitation

NASW supports CMS's proposed revisions to definitions for pulmonary rehabilitation (PR) at § 410.47(a) and for cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) at § 410.49(a). Similarly, NASW supports proposals to revise PR components and settings to align with those of CR and ICR. NASW strongly supports CMS's proposal to add long COVID as a qualifying condition for Medicare-reimbursed PR.

Thank you for considering NASW's comments. I look forward to the final rule and other opportunities to make comments on regulations. If you have questions, please do not hesitate to contact me at amangum.nasw@socialworkers.org.

Sincerely,

A handwritten signature in cursive script that reads "Anna Mangum".

Anna Mangum, MSW, MPH
Deputy Director, Programs