September 11, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2027 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-1848-P; Docket ID CMS-2026-2377)

Submitted electronically: https://www.regulations.gov/docket/CMS-2026-2377

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 nation, 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 constitute the largest provider group of mental health, behavioral health, and social care services in the nation. As such, our profession plays critical roles in connecting individuals and families to a broad array of health care services.

NASW appreciates the opportunity to submit comments on CMS-1848-P, *Notice of Proposed Rule Making (NPRM) on the revisions of Medicare and Medicaid Programs; CY 2027 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*. 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 within the physician fee schedule (PFS) NPRM for CY 2027 (hereafter, "CY27"):

- Determination of Practice Expense Relative Value Units

- Payment for Medicare Telehealth Services
  - Changes to the Medicare Telehealth Services List: CMS Proposal to Add New Codes to the List
  - Telehealth Flexibilities and Modifiers
  - Telehealth Originating Site Facility Fee Payment Amount Proposed Update

- Valuation of Specific Codes
  - Remote Monitoring
  - Smoking and Tobacco Use Cessation; Screening, Brief Intervention, and Referral to Treatment
  - Psychiatric Collaborative Care Management
  - Shared Medical Appointment
  - Health Coaching

- Request for Information (RFI): Redesigning Primary Care to Make America Healthy Again
  - Care Management Code "Family"
  - Payment Implications of Technology Enablement of Primary Care
  - Technology and Artificial Intelligence Augmentation in Primary Care via the Medicare Annual Wellness Visit

- Supporting Beneficiaries Planning for Future Medical Decisions
  - Advance Care Planning Services
  - RFI: Community-Based Palliative Care
  - RFI: Intensive Lifestyle Interventions to Slow Progression of Alzheimer's Disease

- Current Procedural Terminology (CPT) RFI

- Rural Health Clinics and Federally Qualified Health Centers
  - Payment for Certain Preventive Services
  - Services Furnished Using Telecommunication Technology

- Proposed Changes to the Ambulatory Specialty Model: Voluntary Data Submission for the Development of Patient-Reported Outcome-Based Performance Measures

- Limiting Medicare Coverage of Certain Individuals
  - Amending the Eligibility Criteria for Part A and Part B
  - Limiting Coverage Under Medicare Part C, Medicare Part D, and Cost Plans to Certain Individuals
  - Termination of Entitlement
  - Proposed Termination Process
  - Enrollment Pathway for Individuals Who Gain or Regain Eligibility

- Medicare Shared Savings Program
  - Beneficiary Engagement: Proposal to Allow Accountable Care Organizations to Reduce or Eliminate Part B Cost Sharing
  - Beneficiary Notification Requirements

- CY27 Modifications to the Quality Payment Program Reporting
  - Transforming Merit-Based Incentive Payment System: MIPS Value Pathways Strategy
  - Proposals to Adopt New Improvement Activities: Clinician Use of AI to Improve Patient Care
  - Proposals to Modify Existing Improvement Activities: IA_BMH_4 Depression Screening, Treatment, and Prevention
  - Proposals to Remove Existing Improvement Activities: IA_CC_16 Care Coordination: Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients

- Additional comments
  - Access to Mental Health Services Provided by Independent Clinical Social Workers to Skilled Nursing Facility Residents under Medicare Part B
  - CSW Reimbursement Rate
  - Medicare Parts A and B Payment for Dental Services Inextricably Linked to Other Covered Services

NASW's comments follow.

Determination of Practice Expense (PE) Relative Value Units (RVUs) (Section II.B)

NASW appreciates CMS's efforts to improve the practice expense methodology. We encourage CMS to explore several different evidence-based models prior to making any changes. The Physician Practice Information (PPI) Survey data completed by multiple specialty societies and submitted to CMS in January 2025 may be helpful as the agency considers change.

Payment for Medicare Telehealth Services (Section II.C)

Changes to the Medicare Telehealth Services List: CMS Proposal to Add New Codes to the List

Advance Care Planning (ACP)

NASW appreciates CMS's continued attention to the topic of ACP. We recognize that adding ACP HCPCS codes GACP1 and GACP2 to the Medicare telehealth services list for CY27, as CMS has proposed, could enhance access to ACP services. We also recognize that ACP can be a complex process requiring intense discussion of each beneficiary's health conditions, values, and goals of care. This process often involves creating, reviewing, and updating advance directives, Do Not Resuscitate/Do Not Intubate orders, or forms based on the POLST (Physician Orders for Life-Sustaining Treatment) paradigm. In all situations, comprehensive communication is needed to ensure the beneficiary (and, if applicable, their family, however defined) understands their health conditions and care options. Conversely, a professional who engages a beneficiary in ACP needs to assess the beneficiary's understanding and to comprehend fully the beneficiary's values and goals.

Given these considerations, NASW supports CMS's proposal to add ACP HCPCS codes GACP1 and GACP2 to the Medicare list of telehealth services. We recommend that CMS collaborate with practitioners and beneficiaries to identify and disseminate best practices for ACP services. These practices should include guidance for assessing potential barriers to telehealth delivery of ACP services (such as cognitive impairment, communication challenges, complexity of health condition) and strategies to help mitigate these barriers (such as online or in-person presence of a beneficiary's health care agent or other trusted individual). Additionally, we encourage CMS to solicit input from beneficiaries and practitioners throughout the CY on the efficacy of engaging in ACP via telehealth. Using this feedback, CMS could identify and address educational needs—for practitioners and beneficiaries alike—that would promote person-centered engagement throughout the ACP process.

Voluntary, Group-Based Medical Session Involving Multiple Patients with Common Medical Condition(s)

NASW supports CMS's proposal to add shared medical appointment (SMA) HCPCS code GSMAS to the list of telehealth services for CY27. The addition of this code as a telehealth service will allow for participation in SMA sessions by beneficiaries with limited mobility and transportation or who live in rural communities.

Telehealth Flexibilities and Modifiers

NASW supports the proposal to conform regulatory text changes that implement sections of the Consolidated Appropriations Act (P.L. 119-75, 2026) which delay the in-person visit requirements for mental health services furnished through telehealth and extend the flexibilities to allow audio-only Medicare telehealth services.

NASW encourages Medicare to make these changes permanent. According to the U.S. Department of Health and Human Services Office of Inspector General (2022), Medicare beneficiaries used telehealth for a larger share of their behavioral health services compared to other health services during the COVID-19 public health emergency (PHE). This included individual therapy, group therapy, and substance use disorder treatment as well as preventative services, including tobacco use counseling.

Telehealth flexibility for these services has continued since the end of the COVID-19 PHE, broadening access to mental health services for individuals with transportation barriers and geographic restrictions. Making them permanent would offer continued access and long-term continuity of care for beneficiaries in underserved communities. Furthermore, it would advance the administration's top priority of chronic disease prevention, reflecting the connection between addressing behavioral health needs and improving chronic health conditions, as outlined in the current NPRM.

Telehealth Originating Site Facility Fee Payment Amount Proposed Update

NASW supports CMS's proposed increase in the telehealth originating site facility fee (HCPCS Q3014) to $32.65. This proposal supports broader access to care by ensuring originating sites are adequately reimbursed.

Valuation of Specific Codes (Section II.D)

Remote Monitoring

NASW supports CMS's efforts to ensure remote therapeutic monitoring (RTM) services are used appropriately. We agree with the proposed established beneficiary requirements, as the use of these services for cognitive behavioral therapy necessitates an ongoing therapeutic relationship to develop and monitor an individualized treatment plan for goal progress and achievement.

We encourage CMS to consider flexibility for clinical social workers (CSWs) in two areas. First, regarding the proposal to require a separate, billable face-to-face initiating visit before starting RTM, we suggest that an ongoing psychotherapy

visit should satisfy this requirement. Second, in relation to the proposal that services can only be billable when performed by clinical staff directly, we urge CMS to take into consideration the needs of small psychotherapy practices that may use third-party software to legitimately reduce administrative burden, ultimately improving behavioral health outcomes.

While we support the proposed reduction in billing codes for remote monitoring services, the overall proposal to bundle psychotherapy codes into G-codes is not in the best interest because CSW psychiatric services differ from other health services.

Smoking and Tobacco Use Cessation; Screening, Brief Intervention, and Referral to Treatment (SBIRT)

NASW supports CMS's proposal to finish implementing the increase in the valuation for timed behavioral health services and extend similar adjustments for smoking and tobacco use cessation (CPT codes 99406 and 99407) and for SBIRT services (HCPCS codes G2011, G0396, and G0397). These codes cover evidence-based services used to support beneficiaries in managing chronic disease and behavioral health conditions. NASW agrees with CMS's proposal that the valuation should be raised to more accurately reflect the intensity and work associated with these services.

Psychiatric Collaborative Care Management (CoCM)

NASW appreciates CMS's acknowledgment that CoCM services have been undervalued and agrees with the proposal to increase payment for the services.

NASW also agrees with the proposal to benchmark behavioral health care managers to social workers and psychologists in comprehensive outpatient rehabilitation facilities and to increase the labor rate for their services. This higher reimbursement rate will make participation in collaborative care more financially viable for behavioral health providers and better reflects their highly skilled work. NASW encourages CMS to reconsider adopting the full RVU increase requested by stakeholders.

Shared Medical Appointment (SMA)

NASW appreciates the administration's interest in the prevention and management of chronic illnesses. We recognize that addressing behavioral and lifestyle factors associated with chronic illness is an important component of prevention and management.

Thus, NASW supports CMS's proposal to establish a coding and payment pathway for SMAs provided for medical conditions that are modifiable with lifestyle change. We believe such group visits may promote interdisciplinary care while reducing loneliness and social isolation among beneficiaries.

NASW offers the following feedback on CMS's detailed proposals for SMA sessions.

We agree that SMA participation must be limited to beneficiaries who have received a professional service within the previous 12 months from one of the following practitioners: (1) the billing physician or other qualified health professional or (2) another physician or other qualified professional of the same specialty and subspecialty who belongs to the same group practice. This established relationship is essential to personalized care.

We concur that no more than 10 beneficiaries may participate in an SMA per session. We believe this is the maximum number of participants who can benefit from a session and whom practitioners can serve at one time.

We support CMS's proposal to add SMA to the Medicare telehealth list at this time; please refer to our comments on Section II.C for rationale.

NASW agrees wholeheartedly that beneficiaries must consent to SMA participation and to confidentiality terms. We recommend strongly that CMS strengthen these requirements in the following manner:

- Require one of the following professionals to meet with the beneficiary in a scheduled one-on-one appointment (whether in person or via telehealth) to explain the group visit concept and to obtain the beneficiary's live consent to participate in one or more group visits: the treating practitioner, the billing physician, or other qualified health professional; *or* another physician or other qualified professional of the same specialty and subspecialty who belongs to the same group practice who has provided a professional service within the 12 months preceding an SMA. Communication via phone message or a health portal, for example, would not provide sufficient opportunity for dialogue with the beneficiary about the SMA option.

- Require this practitioner to provide written information about the SMA option to supplement (but not supplant) live dialogue with the beneficiary. Following such discussion, this consent form should be signed and dated by both the practitioner and the beneficiary. (NASW believes that electronic signatures on such a form would be acceptable.)

- Require language in the consent form and live dialogue specifying that beneficiary participation in SMAs is voluntary; that group visits can supplement one-on-one appointments with the practitioner or a practitioner of the same specialty and subspecialty within the practice; that participation in SMAs does not prevent the beneficiary from scheduling individual appointments with the practitioner or an equivalent professional within the practice; and that the beneficiary may discontinue SMAs at any time, without jeopardizing access to care provided by the practitioner or a practitioner of the same specialty and subspecialty within the practice.

- Provide more details in the final rule regarding the terms of confidentiality, including a prohibition on beneficiaries' posting information about other participants on social media; require that these details be conveyed in the beneficiary–practitioner live dialogue and written consent form.

- Require consent language (written and live) explaining the risk that the practitioner and practice cannot guarantee all participants will abide by the terms of the confidentiality agreement; specify that failure to honor the agreement will result in discharge from SMAs provided by the practitioner or a practitioner of the same specialty and subspecialty within the practice.

NASW agrees that sessions of 60 minutes may be beneficial in many circumstances. At the same time, we recommend that CMS consider creating coding and valuation for SMA sessions of 75 to 120 minutes, depending on the number of participants. Such sessions would require two practitioners. During these longer group visits, one practitioner would be available to meet privately for at least five minutes with each participant. This individual time would enable the practitioner to assess each beneficiary's understanding of the material covered during the session; provide necessary clarifications; discuss the concordance of the recommended behavioral–lifestyle changes with the beneficiary's values, goals, resources, and abilities; and to recommend an individual follow-up appointment with the practitioner if the beneficiary has more detailed questions or concerns their health condition(s) and/or implementing the suggested behavioral changes.

We concur with CMS's proposal to require documentation of each SMA session in each participating beneficiary's medical record. We agree that each beneficiary's record should reflect services provided to the group and to each participant during each session. We urge CMS to provide indicators for individualized clinical care provided to each beneficiary, particularly (but not exclusively) if only one practitioner provides the SMA session.

We agree that each practitioner providing SMA sessions should identify—and document in each beneficiary's clinical record—key outcomes and goals that are

established in shared decision making during the session. We also agree strongly that the practitioner providing intervention during the group visit be trained in the intervention, and we recommend that this information be documented in each beneficiary's medical record.

The NPRM does not address beneficiary cost sharing for SMA sessions. We urge CMS to address this essential topic in the final rule. We encourage CMS to set beneficiary copayment for each SMA session at a rate no higher than that charged for an individual appointment.

Moreover, NASW offers the following comments specific to the role of CSWs in SMA sessions. Drawing on a holistic approach to care, CSWs are uniquely positioned to participate in interdisciplinary teams (IDTs) to assess biopsychosocial factors that may contribute to chronic illness. These professionals routinely address issues related to loneliness, social isolation, and social engagement and are trained to counsel and educate clients regarding lifestyle changes required to manage mental and behavioral health conditions. Additionally, CSWs are trained in facilitation of group education and therapy, positioning them to address these issues individually as well as during the SMA.

As such, NASW encourages CMS to allow CSWs to serve as the billing practitioner during ambulatory SMAs when the primary focus is mental or behavioral health intervention. NASW also recommends that CMS pay for CSW participation as SMA providers akin to the Health Behavior Assessment and Intervention (HBAI) CPT codes 96156 through 96167.

Health Coaching

NASW reminds CMS of our feedback regarding motivational interviewing and health coaching in our comments on the Medicare PFS NPRM for CY26 (https://www.socialworkers.org/LinkClick.aspx?fileticket=JvzEp0TDRhU%3d&portalid=0). 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 seemed fitting that coding and payment would be similar to that of the HBAI codes.

RFI: Redesigning Primary Care to Make America Healthy Again (Section II.E)

Care Management Code "Family"

NASW appreciates CMS's continued focus on enhancing care management services within primary care. We have expressed support repeatedly for primary care–based care management services, including chronic care management, principal care management, transitional care management, advanced primary care management, chronic pain management, and behavioral health integration (BHI) services. (Please refer, for example, to NASW's comments on the PFS NPRM for CY25 [https://www.socialworkers.org/Practice/Tips-and-Tools-for-Social-Workers/NASW-Comment-Letter-to-CMS-2025-Physician-Fee-Schedule] and CY26.)

In the current proposed rule, CMS acknowledges, once again, limited uptake of care management services in primary care settings. NASW offers the following comments for CMS's consideration.

Primary care practices may lack staff and resources to deliver care management services to beneficiaries. With expertise in assessing and delivering social care in health settings, social workers are natural partners in interdisciplinary health care teams (National Academies of Sciences, Engineering, and Medicine [NASEM], 2019). Social workers lead care management and coordination services outside of evaluation and management (E/M) visits in various health settings, engaging beneficiaries (and, when applicable and appropriate, family caregivers) in the processes of biopsychosocial assessment and person-centered care planning and implementation; enabling smooth care transitions and coordinating home- and community-based services; and facilitating asynchronous communication among provider organizations, practitioners, beneficiaries, and family caregivers. Furthermore, research has shown that inclusion of social workers in integrated primary care teams reduces preventable hospital admissions and emergency department use (Rowe et al., 2016) (Cornell et al., 2020).

Yet, many primary care practices do not employ social workers. Moreover, the current classification of care management as E/M services precludes independent provision and billing by practitioners other than physicians, physician assistants–associates, clinical nurse specialists, nurse practitioners, and clinical nurse-midwives.

Thus, NASW urges CMS to provide incentives for primary care practices to engage social workers as auxiliary personnel in the provision of care

management services. Furthermore, we encourage CMS to explore opportunities for CSWs to provide care management services independently within primary care practices and to bill Medicare directly for those services. Such flexibility would be particularly useful because many beneficiaries receive services for mental and behavioral health conditions solely through primary care practices. CSWs are already able to furnish and bill independently for Caregiver Training Services (CTS), Community Health Integration (CHI), and Principal Illness Navigation (PIN) services when CTS, CHI, or PIN are part of a care plan for a beneficiary's mental health or behavioral health condition. We recommend that CMS build on this progress by enabling CSWs to bill Part B for care management services, at least when serving beneficiaries living with mental health or behavioral health conditions.

Lastly, NASW encourages CMS to explore the intersection among primary care–based care management, BHI, CHI, and PIN. For example, analysis of the prevalence of mental and behavioral health conditions within the population of Medicare beneficiaries that receives care management services could yield useful data.

Payment Implications of Technology Enablement of Primary Care; Technology and Artificial Intelligence (AI) Augmentation in Primary Care via the Medicare Annual Wellness Visit

NASW does not have data specific to AI use by social workers in primary care settings. However, a recent survey conducted by the Moritz Center for Societal Impact at University of Texas (UT) at Austin School of Social Work in collaboration with NASW found that AI use among social workers is widespread, uneven, and cautious (Borah et al., 2026). (More than half of survey respondents reported working in clinical mental health, with another 20 percent reporting working in health care.) Approximately 60 percent of respondents specializing in mental health or in health care reported using AI. Varying numbers of survey respondents (across practice specialties) reported using AI to improve efficiency in tasks such as correspondence, research, data analysis, reporting, administrative support; some respondents reported using AI to support clinical documentation and client intervention; and a sizable number reported that AI was not pertinent to their work or that they were not interested in using AI. Ethical concerns about AI were a major finding of the survey. Common themes included client safety; data privacy and security; perpetuation of bias and inequities; preservation of professional judgment and relational practice; and environmental impact.

Likewise, in our work on behalf of Medicare beneficiaries, NASW has become increasingly concerned about AI use as it relates to supplantation of practitioners' professional judgment; clinical accuracy of AI tools; payer and

provider accountability for errors; growth of fraud and scams; and restriction or denial of services.

Based on the UT–NASW findings and on NASW's other considerations of AI, we offer the following recommendations for how CMS should evaluate and monitor the impact of AI-enabled primary care, including the Medicare annual wellness visit:

- Prioritize the experiences and perspectives of Medicare beneficiaries. As stated in the UT–NASW report, "Understanding how clients perceive AI involvement in their care, particularly with regard to trust, safety, transparency, and cultural responsiveness, is essential for ethical implementation and informed consent" (Borah et al., 2026, p. 32). We recommend that CMS gather self-reported data from beneficiaries about their understanding of how AI is used within their primary care practice; their degree of choice in the use of AI to supplement their care; how practice-initiated AI has affected their ability to have live interactions with professionals in the practice; and how practice-initiated or recommended AI tools have influenced their understanding of their health conditions, their plan of care, and their ability to manage their health conditions.

- Require all Medicare-reimbursed primary care practices to convey to beneficiaries: ways in which the practice uses AI; safeguards in place to protect beneficiary data and privacy; methods by which practitioner judgment remains primary when AI is used; beneficiary choice in the use of AI for their care; methods by which beneficiaries can report concerns about or problems with AI; redress available to beneficiaries who experience harm when engaging with AI tools designed or recommended by the practice; and the practice's policies and procedures for monitoring and withdrawing AI tools for bias, clinical errors, and privacy breaches. We recommend that CMS require practices to provide this information to beneficiaries in writing during each visit and in live conversation with beneficiaries once a year.

- We recommend that CMS require practices to provide this information in writing, using user-friendly language and formats, to beneficiaries each year.

NASW urges CMS to proceed cautiously in relation to AI, focusing on robust information gathering, monitoring, and evaluation rather than on Medicare incorporation of and payment for AI. We encourage and welcome engagement with CMS on the role of AI not only in integrative and other primary care settings, but also in other health care settings, including mental and behavioral health.

Please refer to NASW's comments on Section IV of this NPRM for our feedback on the incorporation of AI in quality measurement.

Supporting Beneficiaries Planning for Future Medical Decisions (Section II.G)

Advance Care Planning (ACP) Services

NASW strongly supports CMS's proposal to create new HCPCS G-codes GACP1 and GACP2. We agree wholeheartedly with CMS that ACP services are provided by various members of IDTs, including social workers. The proposed G-codes would reflect this team involvement and could boost utilization of ACP services.

Moreover, NASW respectfully reiterates a recommendation from our comments on the PFS NPRMS for CY16 (available upon request) and CY26: that CMS enable CSWs to furnish ACP services independently to beneficiaries and to bill Medicare Part B accordingly. Using their understanding of culture and family dynamics, social workers provide "person-centered, family focused-care to overcome barriers associated with the use of advance directives" (Bullock-Johnson & Bullock, 2022). Likewise, a recently published systematic review of the literature concluded:

> Across studies, clinical social workers demonstrated strong knowledge of advance directives and reported high levels of confidence in facilitating ACP discussions. Most participants expressed positive attitudes towards ACP and viewed ACP facilitation as a core professional responsibility. Intervention studies suggested that social worker-led ACP initiatives may increase patient engagement in ACP, particularly completion of formal ACP documentation. The available evidence highlights social workers' substantial contributions to ACP and suggests their potential effectiveness in improving ACP engagement. These findings support ongoing policy discussions regarding the inclusion of social workers in ACP reimbursement frameworks. (Zhang et al., 2026, p. 1)

This call for direct reimbursement of CSWs for ACP services dates back more than a decade (please refer, for example, to The Editorial Board, 2015). Likewise, legislative efforts to authorize direct Medicare reimbursement to CSWs for ACP services have been underway for many years (e.g., Improving Access to Advance Care Planning Act [S. 2865] and a supporting statement by the Coalition to Transform Advanced Care [C-TAC], 2025b). Furthermore, some commercial payers have been reimbursing social workers for ACP services for more than 10 years (Belluck, 2014). Thus, NASW urges CMS to create new ACP

codes that are not linked to E/M services and to authorize CSWs to bill Medicare independently using those new codes.

RFI: Community-Based Palliative Care

NASW commends CMS for its attention to palliative care provided in outpatient clinics, beneficiaries' homes, and other nonhospital settings. We concur with CMS's finding that "a comprehensive approach to palliative care, including access to interdisciplinary teams, home visits, and shared decision-making[,] could improve beneficiary care" (Center for Medicare & Medicaid Innovation, 2022, p. 1).

Eligibility for Serious Illness Care

NASW believes that eligibility for community-based palliative care should *not* be restricted to certification of a likely life expectancy duration, such as one year. At least 13 million adults live with serious illness (C-TAC, 2025a), and some of those illnesses are chronic—that is, "conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both" (Centers for Disease Control and Prevention [CDC], 2026, "Definition" section). Moreover, chronic conditions are the primary cause of illness, disability, and death in the United States (CDC, 2026, "Key Points" section). Examples of serious chronic illnesses include, but are not limited to,

- Alzheimer's disease and other forms of dementia;
- arthritis;
- autoimmune conditions, such as myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) and lupus
- cancer;
- cardiovascular conditions, such as congestive heart value and coronary artery disease;
- digestive disorders, such as Crohn's disease and ulcerative colitis;
- epilepsy and other seizure disorders;
- HIV/AIDS;
- kidney disease;
- neuromuscular conditions, such as multiple sclerosis (MS), cystic fibrosis, and Parkinson's disease;
- pulmonary conditions, such as emphysema and chronic obstructive pulmonary disease;
- serious mental illnesses, such as schizophrenia and severe presentations of bipolar disorder and major depression; and
- sickle cell anemia.

According to the NASW-endorsed *Clinical Practice Guidelines for Quality Palliative Care* (4th ed.) (National Consensus Project for Quality Care [NCP], 2018), palliative care is

> *appropriate at any stage in a serious illness*, … beneficial when provided along with treatments of curative or life-prolonging intent, … *provided over time* to patients based on their needs and not their prognosis, … [and] *offered in all care settings* and by various organizations, such as physician practices, health systems, cancer centers, dialysis units, home health agencies, hospices, and long-term care providers. (p. i; emphases in original)

Palliative care helps people living with chronic, serious illness in multiple ways. An interdisciplinary, comprehensive assessment of the beneficiary living with chronic, serious illness and the person's family (however defined) is the cornerstone of palliative care. The NCP guidelines (2018) list the following assessment components:

a. Patient and family understanding of the serious illness, goals of care, treatment preferences, and a review of signed advance directives, if available
b. A determination of decision-making capacity or identification of the person with legal decision-making authority
c. A physical examination including identification of current symptoms and functional status
d. A thorough review of medical records and relevant laboratory and diagnostic test results
e. A review of the medical history, therapies, recommended treatments, and prognosis
f. The identification of comorbid medical, cognitive, and psychiatric disorders
g. A medication reconciliation, including over-the-counter medications
h. Social determinants of health, including financial vulnerability, housing, nutrition, and safety
i. Social and cultural factors and caregiving support, including caregiver willingness and capacity to meet patient needs
j. Patient and family emotional and spiritual concerns, including previous exposure to trauma
k. The ability of the patient, family, and care providers to communicate with one another effectively, including considerations of language, literacy, hearing, and cultural norms
l. Patient and family needs related to anticipatory grief, loss, and bereavement, including assessment of family risk for prolonged grief disorder (p. 3)

Drawing on this assessment, the guidelines continue, and "in collaboration with the patient and family, the IDT develops, implements, and updates the care plan to anticipate, prevent, and treat physical, psychological, social, and spiritual needs" (NCP, 2018, p. 3). Integral to palliative care is care coordination,

particularly during transitions within care settings, between care settings, and between care providers (NCP, 2018, p. 7).

This brief excerpt from the NCP guidelines makes clear the value of palliative care for any beneficiary living with serious illness, regardless of the person's life expectancy. Consequently, NASW urges CMS not to require a limited prognosis for palliative care eligibility.

Eligibility for Palliative Services

The definition of *palliative care* in the NCP guidelines (2018) includes this text:

> Palliative care is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family. (p. i)

Given this definition, NASW strongly encourages CMS to consider the complex array of factors that may inform a beneficiary's need for community-based palliative care.

For example, although a person may not need hands-on assistance with any activities of daily living (ADLs), they may need cuing and monitoring to complete such activities. Similarly, serious illness may necessitate assistance with, cuing for, and monitoring of instrumental ADLs. On the other hand, some beneficiaries with serious illness may be able to perform all ADLs and IADLs independently, engaging in these or other activities may result in periods of significantly impaired function (as can be the case with ME/CFS). By the same token, a person with a serious illness may manage day-to-day job responsibilities but be unable to engage in activities outside of work (such as family or recreational activities). Likewise, a beneficiary's symptoms may fluctuate significantly over time. For example, people with relapsing–remitting MS (the most common form of the condition) experience alternating exacerbations and recovery (partial or complete) of symptoms (National Multiple Sclerosis Society, n.d.). Moreover, a person's MS symptoms can vary within relapse and remission periods. Thus, NASW urges CMS to consider the *patterns* of each beneficiary's symptoms and function in determining the person's need for community-based palliative care.

Another essential consideration for community-based palliative care eligibility is the psychosocial impact of serious illness:

- For example, a person with Crohn's disease or ulcerative colitis may be unable or reluctant to engage in social activities and relationships because of incontinence; a person with epilepsy may forgo outings because of seizure risk; and people with HIV/AIDS or sickle cell anemia may limit or avoid social engagement because of stigma. In turn, loneliness and social isolation can

exacerbate existing health conditions and contribute to new ones (Office of the Surgeon General, 2023).
- The ability of a beneficiary and family to cope with serious illness may also be affected by their access to community-based supports and financial resources, including housing.
- Challenges with health care decision making are also common among people with serious illness, even in the absence of a potentially reduced life expectancy.
- Health problems—and some factors commonly associated with health problems, such as functional disability, high levels of stress, and limited social support—can increase a person's risk of experiencing elder abuse, neglect, or exploitation (National Center on Elder Abuse, n.d.).

Consequently, NASW urges CMS to consider a variety of psychosocial factors in determining eligibility for community-based palliative care.

We appreciate CMS's recognition of caregiver strain as a potential criterion for community-based palliative care, and we recommend that this factor be considered. Yet, we don't believe such strain should be required for a beneficiary to qualify for palliative care; on the contrary, integration of palliative care may help prevent caregiver strain. For example, palliative care IDTs incorporate caregivers throughout the care process, offer guidance to support care provision, help caregivers manage stress, and connect caregivers with community resources (Center to Advance Palliative Care, 2023). Conversely, we believe severe caregiver strain may warrant a referral to palliative care; such strain often points to a combination of other factors described in the preceding paragraphs, though those factors may not be evident immediately.

To summarize, NASW recommends that CMS consider a variety of variables in determining beneficiary eligibility for community-based palliative care:
- Patterns of symptoms and function
- Psychosocial factors, such as social connection and engagement; community support and financial resources; health care decision making; and experience of abusive behavior
- Caregiver strain

At the same time, NASW believes that none of the psychosocial factors should be prerequisites for community-based palliative care. Rather, we believe eligibility should be based on consideration of each beneficiary's physiological and psychosocial factors, to the extent such information is available. (We oppose means testing and are not suggesting mandatory elder abuse screening for every beneficiary considering palliative care, for example.)

Recognizing that palliative care IDTs are most qualified to assess the need for and potential benefits of palliative care, we recommend that CMS authorize Medicare reimbursement for a palliative care consultation for any beneficiary with a serious illness. Ideally, this consultation would include a review of the beneficiary's health care records and would be available upon request by the beneficiary, a family member (recognizing "family" as defined by each beneficiary), or any member of the beneficiary's health care team, including a social worker.

Furthermore, we urge CMS to require all palliative care IDTs to employ at least one social worker, as defined in NASW's (2026b) *Practice Standards for Serious Illness Care,* and to offer social work services to each beneficiary. This requirement would be consistent with a stipulation in the NCP guidelines (2018): "The IDT includes a social worker to maximize patient functional capacity and achieve patient and family goals" (p. 26).

RFI: Intensive Lifestyle Interventions (ILIs) to Slow Progression of Alzheimer's Disease

NASW thanks CMS for its attention to this critical topic.

We encourage CMS to include the following domains in Medicare-funded ILIs to reduce the risk of cognitive decline for older adults at risk for developing Alzheimer's disease or related dementias (ADRD):

- Social connection and engagement (NASEM, 2020; Office of the Surgeon General, 2023)
- Stress management
- Mood
- Sleep
- Nutrition
- Exercise and physical activity
- Cognitive stimulation

NASW recommends that each ILI be available to beneficiaries on a recurring basis. For all people, behavior change and habit formation take time and often require intermittent reinforcement; for people living with memory loss or experiencing other cognitive changes, reinforcement is even more important. Frequency may vary depending on the nature and length of the ILI. Although we are not recommending specific time frames, we believe that making ILIs available on an annual basis would not be excessive.

NASW recommends that eligibility for these ILIs be available to any interested beneficiary rather than being restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI) or early-stage dementia. The Alzheimer's Association

(n.d.) has explained, "Though research is still evolving, evidence is strong that people can reduce their risk by making key lifestyle changes, including participating in regular activity and maintaining good heart health" (para. 4). Thus, ILI participation by beneficiaries who have MCI or no cognitive impairment may help prevent or delay ADRD onset.

Given that ILIs include multiple domains—likely comprising some domains related to psychosocial health and well-being—NASW recommends that CMS designate social workers as essential members of the IDT.

CPT RFI (Section II.H)

NASW supports the CPT coding process and has been a member of its Health Care Professional Advisory Committee for many years. Social workers have found the process clear and helpful. As a single national coding vocabulary system, there is one code for the same service, provider, payer, and government agency. To avoid confusion in the coding system, NASW is advocating for the retention of CPT.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Section III.B)

Payment for Certain Preventive Services

NASW supports CMS's proposal to recognize Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) as qualified preventive services that are covered and paid the all-inclusive rate as stand-alone billable visits under the RHC benefit. We agree that aligning payment for these services in RHCs with DSMT and MNT payment in FQHCs would help expand access to care for Medicare beneficiaries in rural areas.

Services Furnished Using Telecommunication Technology

NASW supports the proposal to conform regulatory text changes that implement sections of the Consolidated Appropriations Act (CAA, 2026) which extend the abeyance of the RHC–FQHC in-person requirements for mental health services furnished through telecommunication technology through December 31, 2027. As noted previously within these comments, NASW encourages CMS to make all telehealth flexibility changes permanent. Doing so would broaden access to mental health services for vulnerable populations and advance CMS's top priority

of chronic disease prevention, reflecting the connection between addressing behavioral health needs and improving chronic health conditions.

Proposed Changes to the Ambulatory Specialty Model (ASM): Voluntary Data Submission for the Development of Patient-Reported Outcome-Based Performance Measures (PRO-PMs) (Section III.D)

NASW concurs with CMS that PRO-PMs are an important component of quality measurement. Pro-PMs boost beneficiary engagement with care by enabling beneficiaries to express their perspectives on the care they receive. At this time, NASW is not commenting on specific measures to be used in the ASM.

Limiting Medicare Coverage of Certain Individuals (Section III.E)

Amending the Eligibility Criteria for Part A and Part B; Limiting Coverage Under Medicare Part C, Medicare Part D, and Cost Plans to Certain Individuals

NASW strongly opposes the statutorily mandated changes to eligibility criteria for Medicare Part A, Part B (including the Part B Immunosuppressive Drug benefit), Part C (Medicare Advantage, or "MA"), Part D prescription drug plans (PDPs), and cost plans.

As CMS is aware, immigrants without documentation were ineligible for Medicare (among other publicly funded programs) before P.L. 119-21 was enacted in July 2025 (Altman et al., 2025). As a result of P.L. 119-21, countless immigrants residing lawfully in the United States are no longer eligible for Medicare or will lose their coverage. These groups include—but are not limited to—refugees and asylees; people who have experienced trafficking or domestic violence; people with Temporary Protected Status (TPS); and people under the Deferred Action for Childhood Arrivals (DACA) program (Altman et al., 2025; Bers, 2025). NASW wholeheartedly agrees with statements made in 2025 by our colleagues at the Medicare Rights Center, Justice in Aging, and the National Immigrant Law Center:

- "This [change] is a significant departure from current, longstanding policy, which recognizes eligibility for everyone who has paid sufficient Social Security and Medicare taxes" (Carter, 2025, para. 14).
- "This reconciliation bill sends a chilling message to all Americans: Congress is willing to take Medicare from people who pay into the program" (Kean & D'Avanzo, 2025, para. 6).

Our remaining comments on Section III.E address CMS's specific proposals to implement eligibility criteria processes associated with P.L. 119-21.

Termination of Entitlement and Proposed Termination Process

The Medicare coverage provisions of P.L. 119-21 have created much confusion within immigrant communities. More robust notification processes are critical to reach affected individuals and groups. NASW urges CMS to increase its outreach, resources, and training to the following groups:

- Health care professionals
- Health care provider organizations, such as FQHCs and RHCs
- Community-based organizations, such as Aging and Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and State Health Insurance Programs (SHIPs)
- Medicaid offices, which enroll beneficiaries in Medicare Savings Programs (MSPs)
- Social Security offices, which enroll beneficiaries in Medicare and process applications for the Part D Low-Income Subsidy (LIS, or "Extra Help") program
- Program of All-Inclusive Care for the Elderly (PACE) sites, which serve beneficiaries dually eligible for Medicare and Medicaid

Moreover, NASW urges CMS to require MA plans, PDPs, and PACE sites to inform beneficiaries of impending coverage termination through written notices and other outreach (all available in multiple languages).

Enrollment Pathway for Individuals Who Gain or Regain Eligibility

CMS has proposed a special enrollment period (SEP) of six months for the following groups who gain or regain eligibility for Medicare under the criteria specified in P.L. 119-21:

- People who met all Medicare eligibility criteria except those specified by P.L. 119-21 at the time of application
- People whose Medicare enrollment is terminated because they do not or no longer meet the eligibility criteria in P.L. 119-21

NASW urges CMS to increase the proposed SEP to at least eight months. Six months will not allow eligible individuals enough time to contact the Social Security Administration (SSA) to verify their eligibility for Medicare, especially given widespread delays caused by SSA office closures, staffing reductions, and administrative funding shortages.

Furthermore, NASW encourages CMS to enable a retroactive coverage option for individuals who are terminated from the Medicare program but are subsequently able to verify their eligibility under P.L. 119-21. This retroactive option would help offset the harm of losing Medicare coverage.

Medicare Shared Savings Program (Section III.G)

Beneficiary Engagement: Proposal to Allow Accountable Care Organizations (ACOs) to Reduce or Eliminate Part B Cost Sharing

NASW has a long history of advocating for reduced health care costs for individuals and families. Accordingly, we support the concept of enabling ACOs to reduce or eliminate Part B cost sharing. We forgo comment on CMS's proposed ACO application procedures for this process. Should CMS move forward with this proposal, we urge careful monitoring of utilization patterns within ACOs that are approved to reduce or eliminate Part B cost sharing. Such monitoring would enable CMS to discourage, identify, and address restrictions on care.

Beneficiary Notification Requirements

NASW recognizes that ACOs have the potential to improve communication among health care professionals and practices, thereby enhancing coordination of care. At the same time, we believe that beneficiaries deserve to know when their personal health information (PHI) will be shared with other professionals and practices, particularly when mental and behavioral health records are involved. Timely notification of a health care professional's or practice's ACO affiliation is essential to informed decision making by beneficiaries.

Consequently, NASW disagrees with CMS's proposal to revise the distribution timing of standardized written notices for beneficiaries. We believe that it remains important for beneficiaries to be informed of their primary care practitioner's participation in an ACO during the time frame outlined in the current regulation: before or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant.

Likewise, we are concerned about CMS's proposal to remove the beneficiary follow-up communication about the standardized written notice addressed in the previous paragraph. Beneficiaries may not read or understand the initial notice and may not be able to initiate inquiries. Live or written follow-up by the ACO or

ACO participant is important, therefore, and NASW believes the current 180-day time frame for such follow-up is reasonable.

For these reasons, we encourage CMS to retain the notification requirements currently in effect and withdraw its proposals to amend those requirements.

CY27 Modifications to the Quality Payment Program Reporting (Section IV)

Transforming Merit-Based Incentive Payment System (MIPS): MIPS Value Pathways (MVP) Strategy

NASW appreciates CMS's continued support for mental health–focused MVPs. This emphasis continues to allow CSWs and other behavioral health professionals the ability to be evaluated on quality metrics that align with their clinical specialty.

Proposals to Adopt New Improvement Activities: Clinician Use of AI to Improve Patient Care

NASW urges CMS to delay implementation and allow additional time for the evaluation of AI tools and best practice before incorporating AI use into MIPS performance activities. We are concerned that this proposal is being introduced before the workforce is adequately ready and before national regulations or governance models addressing privacy and security of records have been fully developed and adopted for use in behavioral health. We are also concerned that it lacks consideration of emerging state-by-state regulations that may prohibit some professionals from participating, now or in future years.

Proposals to Modify Existing Improvement Activities: IA_BMH_4 Depression Screening, Treatment, and Prevention

NASW agrees with CMS's proposal to modify this improvement activity by incorporating elements of IA_BMH_5 "Major depressive disorder (MDD) prevention and treatment interventions." We agree with the proposed language regarding the use of a coordinated, team-based approach to screening for depression and assessing suicide risk. However, we believe that CMS should modify the reference to "follow-up care" and instead explicitly say "evidence-based depression treatment." We also agree with the proposal to add this improvement activity to Mental Health and Substance Use Disorders core measures and remove IA_BMH_5 for that set.

Proposals to Remove Existing Improvement Activities: IA_CC_16 Care Coordination: Primary Care Physician and Behavioral Health Bilateral Electronic Exchange of Information for Shared Patients

NASW opposes CMS's proposal to remove this improvement activity, as it rewards the systems that make effective information exchange between providers possible. Many individuals with a mental or behavioral health diagnosis receive care from both primary care and behavioral health providers. Having processes in place for the routine exchange of information between providers can improve a beneficiary's management of both their mental and physical health.

Access to Mental Health Services Provided by Independent CSWs to Skilled Nursing Facility (SNF) Residents under Medicare Part B

NASW has been working for years to remove the restriction that prohibits beneficiaries who receive SNF services under Medicare Part A from accessing mental health services provided by independent CSWs under Medicare Part B. This restriction limits beneficiary access to mental health services in two ways:

- A beneficiary who resides in a nursing home (paid for by sources other than Medicare) and receives mental health services from an independent CSW is unable to continue working with that CSW when they transfer to a SNF. As CMS is aware, beneficiaries can transition from nursing home to SNF services both quickly and unexpectedly, even without having moved into a different building, room, or bed. Similarly, a beneficiary residing in a community-based setting (such as assisted living) or at home is unable to continue mental health treatment with their CSW of choice when they transfer to a SNF. In either situation, services must stop abruptly, depriving the beneficiary of mental health services with a familiar provider. Consequently, the beneficiary feels abandoned during a time when continuity of mental health treatment is critical.

- A beneficiary who is not receiving mental health services before SNF admission may require such assessment and treatment during the SNF stay. When this occurs, the pool of practitioners to which the beneficiary has access is limited because of the restriction on CSW billing.

The importance of these access barriers has been underscored by a recommendation published in a recent NASEM nursing home study (2022):

> Recommendation 2D: To enhance the available expertise within a nursing home:
> • Nursing home administrators, in consultation with their clinical staff, should establish consulting or employment relationships with *qualified licensed clinical social workers at the M.S.W. or Ph.D. level* [emphasis added], advanced practice registered nurses (APRNs), clinical psychologists, psychiatrists, pharmacists, and others for clinical consultation, staff training, and the improvement of care systems, as needed.
> • The Centers for Medicare & Medicaid Services should create incentives for nursing homes to *hire qualified licensed clinical social workers at the M.S.W. or Ph.D. level as well as APRNs for clinical care* [emphasis added], including allowing Medicare billing and reimbursement for these services. (p. 512)

Moreover, NASW respectfully reminds CMS of its commitment to reconsidering the restriction on independent CSW services provided to beneficiaries receiving SNF services. In 2000, the Health Care Financing Administration (HCFA) released a proposed rule that "would permit separate Medicare Part B payment for certain psychotherapy services of clinical social workers furnished to a skilled nursing facility resident whose stay is covered by Medicare" in CY01 (Medicare Program; Clinical Social Worker Services). NASW submitted comments supporting this proposal. The proposal was not finalized; instead, CMS indicated in the proposed Medicare PFS rule for CY03 that it would address, within the final PFS rule for CY03, comments received on the CY01 CSW proposed rule. Yet, the CY03 PFS final rule stated: "Upon further review, we have determined that we will not include this issue in this final rule, but will address it in future rulemaking."

Nearly 25 years later, this rulemaking has not occurred. In the meantime, CMS has implemented regulations permitting marriage and family therapists and mental health counselors to provide Part B–reimbursed independent mental health services to Medicare beneficiaries simultaneously receiving SNF services under Part A. NASW urges CMS to build on this step in the CY27 PFS final rule by permitting CSWs to do the same.

CSW Reimbursement Rate

NASW continues to encourage 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 nonphysician practitioners, such as audiologists, occupational therapists, physical therapists, and speech–language pathologists. As key specialty practice professionals who assess, diagnose, and treat beneficiaries with mental and behavioral health conditions, CSWs are valued providers. The Medicare reimbursement rate for CSW services has not been

adjusted since CSWs received Medicare Part B standing in the early 1990s (NASW, 2026a). This low reimbursement rate discourages CSWs from participating in insurance networks, impacting the ability of Medicare beneficiaries to access critical mental and behavioral health care.

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

NASW thanks CMS for its work in recent years to clarify and implement inextricably linked, medically necessary (ILMN) oral health coverage in Medicare. We commend CMS for including in the CY26 PFS final rule adoption of Integrating Oral Health Care in Primary Care (IA_PM_28) as an activity MIPS-eligible clinicians can use to improve care delivery. Use of this quality measure will facilitate integration of dental assessment, education, and referrals within primary care delivery, thereby improving the overall health of Medicare beneficiaries.

We urge CMS to continue its work on ILMN dental coverage. Such coverage is essential to beneficiaries whose (nondental) medical treatment would be complicated, compromised, delayed, and even denied because of unresolved dental conditions. As we noted in our comments on the CY26 PFS NRPM (2025), leading health care advocates have presented strong evidence demonstrating how diabetes-associated retinopathy and diabetes-associated nephropathy are complicated by chronic oral infections, such as periodontitis. We encourage CMS to reconsider this recommendation from previous commenters, as addressed in the CY25 PFS NPRM. Likewise, we encourage CMS to reconsider prior recommendations supporting payment for dental care that is vital to the effective management and treatment of autoimmune conditions that require immunosuppressive therapy; hemophilia chromatoses; oral graft host disease; and sickle cell anemia.

Moreover, we respectfully reiterate our CY26 recommendation that CMS strengthen its efforts to elaborate on, operationalize, and educate medical and dental practitioners about Medicare's ILMN dental coverage rules. We believe the following actions are essential to making ILMN dental coverage available to beneficiaries with complex health conditions:

- 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 ILMN 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 ILMN dental coverage policy. (3) Assign designated

trained staff to answer inquiries from practitioners about ILMN 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 conduct their statutory obligation (under 42 C.F.R. § 411.15(i)) to provide coverage for ILMN 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 ILMN 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 ILMN dental services and about how to obtain prior authorization (if necessary) and submit claims for these services.

- Implement one of two actions to enable Medicare beneficiaries enrolled in MA plans, Dual Special Needs Plans (D-SNPs), and PACE to receive all of the covered care they need from the in-network dental provider of their choice: (1) Enable in-network dental providers to submit claims for reimbursement by the MA plan, D-SNP, or PACE when they furnish ILMN services to enrollees, even if those dental providers have formally opted out of Medicare. (2) Reinstate CMS's 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 ILMN 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 criteria not limit access to payment to a defined window of time.

Furthermore, NASW encourages CMS to undertake the following actions:

- Update the Medicare Managed Care Manual and educate plans and staff on how ILMN dental coverage should be coordinated with any supplemental dental coverage offered by plans. Require plans to incorporate clear explanations of this coverage in the evidence of coverage and member

handbooks, as well as to add to provider directories dental providers who can bill Medicare for ILMN dental services.

- Provide guidance, best practices, educational templates, and technical assistance to states—such as through letters to state Medicaid directors—on how Medicaid coverage interacts with Medicare ILMN dental coverage, both for beneficiaries enrolled in original Medicare and for MA enrollees. These materials need to address the intersection of Medicare coverage of ILMN dental services with MA supplemental dental benefits and Medicaid dental coverage.

- Issue to D-SNPs and PACE plans guidance addressing best practices in other areas of overlapping coverage (such as for durable medical equipment) in which the Medicare standard or coverage is different from or more restrictive than Medicaid, illustrating how these practices may be modified for ILMN dental coverage.

- Track all ILMN implementation efforts by analyzing Medicare claims data for covered dental services across original Medicare and various Medicare managed care plans; pair these data with demographic characteristics (such as dual eligibility status, age, disability, ethnicity, gender, and race) of beneficiaries receiving services; and report these data publicly on CMS data dashboards and in future rulemaking.

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 need more information.

Sincerely,

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[References follow on the next page.]

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