750 First Street NE, Suite 700, Washington, DC 20002-4241
202.408.8600 » FAX 202.336.8331 » SocialWorkers.org

NASW
National Association of Social Workers

September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
Mail Stop: C4-26-05
750 Security Boulevard
Baltimore, MD 2144-1850

Re: File Code-CMS-1631-P: Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2015 NPRM

Dear Mr. Slavitt:

Thank you for the opportunity to provide comments on CMS-1631-P. I am writing to you on behalf of 130,000 professional social workers who are members of the National Association of Social Workers (NASW) which is the largest, professional, organization of social workers in the United States. NASW promotes, develops and protects the practice of social work and social workers.

NASW appreciates the opportunity to submit comments on CMS-1631-P in the following areas: Physician Quality Reporting System, Value-Based Modifier, Opting Out, Skilled Nursing Facility, and Advance Care Planning Services.

Physician Quality Reporting System (PQRS)

In the list of PQRS proposed measures for 2016, NASW observed that the measures used by clinical social workers to report PQRS in 2015 may have been deleted from claims reporting. The measures not included in the proposed rule included, but not limited to, "Documentation of Current Medications in the Medical Record," " Elder Maltreatment Screen and Follow-Up Plan," and "Preventive Care and Screening for Clinical Depression." The association is concerned it will be difficult for clinical social workers, who work in small solo or group

independent private practices, to report PQRS without available measures. This would also subject clinical social workers to the PQRS penalty for not reporting measures they are not qualified to report. NASW requests CMS to restore the individual claims measures used by clinical social workers to avoid being inappropriately fined by not reporting measures. Depending on the denominator criteria, NASW also observed there were only two registry reporting measures that may apply to clinical social workers. Reporting registry measures requires the employment of a qualified registry which is very expensive (ranging from $150 and up) to report two measures, especially for a small private practice providing mental health services. NASW asks that you consider special cost-effective registry requirements for the smaller practices so that clinical social workers would be able to meet the registry reporting requirements without suffering a financial burden.

Value-Based Modifier

NASW has questions about the deletion of the value-based modifier for non-physician practitioners and its implications on reimbursement and the performance of mental health services for Medicare beneficiaries. Does the deletion of the value-based modifier also delete performance increases? Will there be another mechanism established to assist non-physician practitioners in obtaining performance increases. If the value-based modifier is deleted, how would CMS value performance for non-physician practitioners, especially mental health providers? NASW requests CMS to provide additional information and clarification about the deletion of the value-based modifier prior to making a final decision about this implementation.

Private Contracting/Opt-Out

NASW is pleased by CMS proposal to automatically renew opt-out affidavits every two years unless the practitioner properly cancels opt-out. This reduces paper work and provides additional time to spend with patient care.

Skilled Nursing Facility

NASW reminds CMS of an outstanding issue to address Medicare beneficiaries inability to continue mental health treatment with a clinical social worker when they are transferred to a skilled nursing facility from a nursing home. As you may be aware, a Medicare beneficiary in a nursing home bed can be transferred unexpectedly to a skilled nursing bed within the same

building, room, and bed within a short period of time. When Medicare beneficiaries are receiving mental health treatment from a clinical social worker, treatment must stop abruptly causing Medicare beneficiaries to suffer the loss of mental health services and their provider during a critical time when continuous mental health treatment is needed. Despite explanation, Medicare beneficiaries do not understand why the services were withdrawn and feel abandoned during a critical time of their recovery.

In June 28, 2002, proposed rule (67 FR 43845), CMS indicated it would address comments received on the October 29, 2000 proposed rule entitled, "Clinical Social Worker Services," (65 FR 62681) in the final physician rule dated December 31, 2002, of the Federal Register, Vol. 67, No. 251. However, CMS announced that it would not address this issue in the final rule, but in future rulemaking. NASW encourages CMS to address this issue. Continuity of mental health services is very important in the recovery of Medicare beneficiaries and many suffer when they are unable to continue with their Medicare provider of choice. Medicare beneficiaries prefer social workers because of their holistic treatment approach. NASW requests the restoration of reimbursement to clinical social workers who provide mental health services to Medicare beneficiaries in a skilled nursing facility.

Advance Care Planning Services

NASW commends CMS for its reconsideration of Medicare reimbursement for advance care planning. Beneficiaries' engagement in advance care planning varies widely. However, research indicates that adults are more likely to engage in advance care planning when (1) they have adequate information about, and understanding of, advance directives (Bressi Nath, Hirschman, Lewis, & Strumpf, 2008) and (2) health care professionals inquire about advance directives (Clark, Boehmer, Rogers, & Sullivan, 2010).

Recognizing the need for consumer education about advance care planning, NASW was an original participating organization in National Healthcare Decisions Day and continues to promote the initiative. National Healthcare Decisions Day promotes advance care planning as an ongoing conversation among individuals, families, and health care professionals, of which completing written advance directives is just one component.

Similarly, the Institute of Medicine's (IOM's) *Dying in America* report (2014) emphasized the need for greater access to advance care planning services, stressing the need for "clinicians to initiate high-quality conversations about advance care planning . . . [and] to continue to revisit advance care planning discussions with their patients because individuals' preferences and circumstances may change over time" (Institute of Medicine, 2014, pp. 190–191).

To that end, NASW supports CMS's proposal to assign to the two CPT codes for advance care planning, 99497 and 99498, Physician Fee Schedule (PFS) status indicator ''A,'' making these codes separately payable under the PFS. Consistent with NASW's 2010 comments to CMS, the association also supports Medicare payment for advance care planning as an optional element,

at the beneficiary's discretion, of the annual wellness visit (AWV) under section 1861(hhh)(2)(G) of the Social Security Act. Whether advance care planning activities take place during the AWV or in other contexts, reimbursed activities should include discussion not only of beneficiaries' advance directives (living will and appointment of health care agents) but also, if applicable, of Do Not Resuscitate orders and forms based on the National Physician Orders for Life-Sustaining Treatment (POLST) Paradigm. The POLST paradigm, which has been endorsed by a growing number of states and is known by different names across states, refers to an individualized, portable set of medical orders to guide treatment of people living with serious or life-limiting illnesses. Although these orders are not intended to replace advance directives, POLST can be a valuable component of the advance care planning process (Bomba, Morrissey, & Leven, 2011; Pile & Pole, 2013).

CPT codes 99497 and 99498 may be used only by physicians and the "other qualified health professionals" eligible to use Evaluation/Management codes: certified nurse-midwives, clinical nurse specialists, nurse practitioners, and physician assistants. Yet, other health care professionals also play integral roles in the advance care planning. Social workers often facilitate advance care planning discussions with individuals and families (Baughman, Aultman, Hazelett, Palmisano, O'Neill, Ludwick, & Sanders, 2012; Bern-Klug, 2014; Bomba, Morrissey, & Leven, 2011; Csikai, 2008), recognizing that "family" is defined by each individual and may include both legally recognized family and family of choice. Such conversations clarify beneficiaries' values and goals, helping beneficiaries to consider which health care options are most congruent with those values and goals. At the same time, social workers promote informed decision making by helping beneficiaries to understand the full range of health care options available and the potential risks and benefits (functional, psychosocial, and financial) associated with each option. In so doing, social workers' promote client self-determination—which includes the right either to choose or to forego life-sustaining treatments.

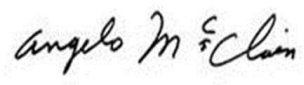
Research has demonstrated that a variety of biopsychosocial factors influence advance care planning behavior. To facilitate advance care planning effectively, therefore, health care professionals must understand each individual's and family's values and biopsychosocial context and tailor interventions accordingly (Herman, 2013). Social workers operate from a person-in-environment perspective and are trained in ethics, cultural competence, and systems theory. They effectively facilitate communication both within families (Cohen Fineberg & Bauer [in Altilio & Otis-Green], 2010) and between families and the interdisciplinary team throughout the health care decision-making process. Moreover, they can help to decrease disparities, such as those associated with ethnicity and race, by elucidating cultural factors that can influence advance care planning (Bressi Nath et al., 2008; Bullock, 2011; del Río, 2010; Ko & Berkman, 2012; Ko, Cho, Perez, Yeo, & Palomino, 2013; Wittenberg-Lyles, Villagran, & Hajek, 2008).

Recognizing the integral role social workers play in advance care planning, some payers have already begun reimbursing social workers for such services (Belluck, 2014). NASW supports the development of new CPT codes that would reflect the advance care planning role of nonphysician practitioners, such as clinical social workers, who are not eligible to use CPT codes 99497 and 99498. Such development is congruent with recent calls for Medicare

reimbursement for clinical social worker facilitation of advance care planning conversations (*Boston Globe* editorial board, 2015).

Thank you again for the opportunity to respond to CMS-1631-P. If you have any questions about NASW's comments, please do not hesitate to contact me at 202-336-8200.

Sincerely,



Angelo McClain, PhD, LICSW
Chief Executive Officer