

September 6, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1770-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1770-P; Medicare Program; CY 2023 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment Policies; (July 29, 2022)

Dear Administrator Brooks-LaSure:

I am writing to you on behalf of 110,000 members of the National Association of Social Workers (NASW), the largest professional social work organization in the nation. We appreciate the opportunity to make comments on the revisions to the Medicare Physician Payment Policies Under the Physician Payment Schedule for the calendar year (CY) 2023.

NASW would like to make the following comments regarding the provisions of the 2023 Proposed Rule under the Medicare Fee Schedule, CMS-1770-P.

- 2023 Conversion Factor
- Telehealth Services
- Behavioral Health Services
- Opioid Treatment Programs
- Caregivers Management Training
- Dental and Oral Health
- Medical Necessity and Documentation for Ambulance Services
- Rural Health Clinics and Federally Qualified Health Centers
- Chronic Pain Management Services
- Quality Payment Program
- Medicare Shared Savings Program
- Colorectal Cancer Screening

2023 CONVERSION FACTOR

At 75% of the Physician Fee Schedule, clinical social workers (CSWs) are reimbursed at a lower rate than other mental health providers (psychologists and psychiatrists, which are reimbursed at 100%) as well as most other non-physician providers, which are reimbursed at 85%. This reimbursement rate serves as a disincentive to CSW participation in the Medicare program, and NASW has steadfastly supported legislative and regulatory actions to increase CSW reimbursement. Considering the current reimbursement rate, CMS' proposed 4.4% conversion factor reduction for 2023 will have a significant, negative impact on CSWs and the beneficiaries they serve. NASW appreciates CMS' obligation to maintain budget neutrality in the Medicare Physician Fee Schedule; however, CSWs have faced sustained reimbursement cuts throughout the pandemic, and now during a period of historic inflationary pressures. As such, NASW urges CMS to work with Congress to explore policy solutions that will provide stability for the Medicare Physician Fee Schedule and ensure CSWs' ability to participate in the Medicare program and provide vital mental health services to beneficiaries.

TELEHEALTH SERVICES

NASW appreciates the proposal to temporarily extend telehealth services not listed during the public health emergency as Category I, II, or III, for a period of 151 days following the end of the public health emergency. We agree that this will allow additional time for collection of important data that would support their inclusion on a permanent list of Medicare telehealth services. Telehealth services offer advantages that are in accordance with CMS' goals to provide cost effective options that increase access to care for beneficiaries and improve health equity. Telehealth can be particularly beneficial to beneficiaries with mobility limitations, or those in rural areas who don't have access to health care.

NASW plans to participate in open telehealth work group meetings led by the American Medical Association to determine appropriate coding and valuation of office visits performed by telehealth. We recommend that telehealth coding be considered for evaluation and management and non-evaluation and management services during the same period. NASW also urges appropriate reimbursement for telemental health services, by continuing reimbursement at the non-facility rate. We also urge the agency to confirm, either in the final rule or any subsequent guidance document, that telemental health providers will be able to continue providing and billing for covered telehealth services furnished from a beneficiary's home.

NASW remains steadfast in its opposition to the in-person service requirement applicable to telemental health services. We believe that this requirement imposes an unnecessary barrier to care, is not supported by clinical evidence, and undermines the essential purpose of telehealth – expanding access to care. We also believe that such a policy will disproportionately impact access to care for people of color, older Americans, people with disabilities, people with low incomes, those living in rural or underserved areas, those with childcare challenges, and more. NASW appreciates CMS' delay of this requirement for 151 days post COVID-19 public health emergency (PHE) in accordance with the Consolidated Appropriations Act, 2022; however, we will continue advocating for Congress to repeal this requirement and urge CMS to support the same.

BEHAVIORAL HEALTH SERVICES

NASW applauds CMS' proposal to develop a new code (GBH11) for behavioral health integration services performed by CSWs. CSWs play a crucial role in integrated care. NASW recommends competencies to

ensure services are provided that meet the complex needs of beneficiaries in a coordinated and timely way.

NASW also appreciates CMS' efforts to mobilize the behavioral health workforce by giving providers the ability to connect with beneficiaries in different ways. To improve access to behavioral health care, we acknowledge that adding licensed marriage and family therapists, and licensed professional counselors as incident to providers, does help alleviate a shortage of mental health providers and extend behavioral health services. In addition, as you consider changing the incident to supervision requirement from direct to general, NASW recommends that clinical social workers be included as one of the non-physician practitioners eligible to provide general supervision to this group.

In response to CMS' request to seek ideas regarding opportunities for improvement in behavioral health integration and other areas, NASW recommends improved education and marketing strategies that promote awareness of available programs and resources that advance health equity and quality of care, especially when changes are implemented.

OPIOID TREATMENT PROGRAMS (OTPS)

NASW agrees with CMS' proposed payment increase for the non-drug component of bundled services, which would result in an individual therapy increase from 30 to 45 minutes. NASW believes this extended time would be beneficial to beneficiaries who have complex biopsychosocial needs.

NASW encourages CMS to allow periodic assessment to continue to be furnished using audio-only communication technology following the end of the COVID-19 PHE for patients receiving treatment via buprenorphine, methadone, and naltrexone. Doing so improves outreach efforts in all geographic locations especially in rural areas and to those who lack access to a computer and other technology tools.

When addressing concerns in health equities, NASW strongly supports CMS' proposal to pay for services furnished in mobile units. This helps to provide access to care for those who may be homeless and/or lack access to transportation. Lack of housing, unemployment, limited family supports, and lack of health insurance can all impact quality of care. The time required to resolve these complex concerns should be considered when establishing relative values in coding.

In response to CMS request for detailed information about Intensive Outpatient Programs (IOPs) services, such as settings, range of services, and other relevant information, NASW provides the following information:

- IOPs' may take place in a free-standing outpatient therapeutic setting or a hospital or partial hospitalization program. These services may also be provided in an outpatient private office setting where the patient is seen several times a week for psychotherapy services.
- Social workers play a vital role in providing services in IOPs which may include individual, group, and family psychotherapy, case management and coordination, vocational counseling, and psychoeducational services.
- The length of treatment may vary and is often contingent on insurance coverage. As a result, patient care may end before patient is ready for discharge and community referrals are implemented.

Other relevant matters:

- Discharge planning should be ongoing to improve care.
- Identifying and determining social determinants of health early on in treatment would improve care and help prevent readmission.
- Programs that assist patients in accessing technology for health purposes would be helpful.

CAREGIVERS BEHAVIOR MANAGEMENT TRAINING

NASW appreciates CMS' consideration of Caregiver Behavior Management Training as part of its commitment to equitable access to reasonable and necessary medical services. Caregiver education about strategies to modify beneficiary behavior can support beneficiaries in multiple ways. For example, many beneficiaries who live with Alzheimer's disease or another form of dementia experience symptoms and behaviors such as memory loss, confusion, repetition, delusions, hallucinations, anxiety, agitation, depression, sundowning, and difficulty eating. If a caregiver does not know how to respond effectively (using strategies such as redirection, reassurance, affirmation, social engagement, daily planning, and meal set-up), they may inadvertently exacerbate those symptoms and behaviors, thereby affecting beneficiary health and quality of life.

Caregiver education can also improve the health of beneficiaries living with advanced illnesses such as cancer or chronic obstructive pulmonary disease. Such beneficiaries often experience pain and shortness of breath (dyspnea) at the end of life. These symptoms can cause fear and anger in beneficiaries and manifest in behaviors that can be challenging for caregivers, especially when assisting beneficiaries with activities of daily living (ADLs). Educating caregivers about psychosocial and environmental strategies to help manage pain and dyspnea (such as guided visualization, adjusting pillows, and using ventilation fans) can complement the use of medication by beneficiaries and even help reduce medication use. Similarly, when beneficiaries with advanced illness experience restlessness, anxiety, and mental changes, caregiver education about potential underlying causes, effective communication, and psychosocial responses can help mitigate such symptoms. Furthermore, emotional and social withdrawal are also common during advanced illness. Education can help caregivers not only to understand the reasons for such experiences, but also to engage in daily planning and provide or modify ADL assistance and assistive devices to accommodate fatigue.

As the previous examples illustrate, Medicare policy restricting payment for services that are furnished to parties other than the beneficiary—such as the Caregiver Behavior Management Training services described by CPT codes 96X70 and 96X71—can have an adverse effect on beneficiary health, quality of life, and quality of care. Social workers frequently provide Caregiver Behavior Management Training services in home, community-based, and facility settings. Such services are sometimes bundled within per-diem payments, such as in skilled nursing facility (SNF), home health, and hospice settings. Enabling clinical social workers (CSWs) to bill Medicare independently for Caregiver Behavior Management Training services—similar to enabling CSWs to bill Medicare for Health and Behavior Assessment and Intervention (HBAI) services—would also improve beneficiary health.

DENTAL AND ORAL HEALTH SERVICES

NASW applauds CMS for recognizing that “medically necessary” dental care can be necessary in order to treat other diagnosed medical conditions, such as cancer, diabetes, and organ transplants. Medicare coverage for oral health needs for individuals with serious medical conditions is currently extremely limited. For example, Medicare typically does not cover care to address dental problems that are caused

by a medical condition or treatment or that could jeopardize a beneficiary's medical condition or treatment. Such gaps in care can have catastrophic consequences for beneficiaries in regard to medical treatment, quality of life, and overall health outcomes. Moreover, Medicare's lack of dental coverage makes oral health care unaffordable for millions of Americans¹ and exacerbates underlying disparities related to disability² and to race and ethnicity.³

Consequently, NASW strongly supports CMS's proposal to clarify and codify the existing examples of "medically necessary dental services" that qualify for Medicare coverage. We encourage CMS to apply this authority in as broad a range of clinical settings and circumstances as possible. We also support CMS's proposal to recognize, as additional examples, dental examinations and necessary treatment performed as part of a comprehensive work-up for organ transplant surgery, cardiac valve replacement, or valvuloplasty procedures. Furthermore, NASW concurs with CMS's proposal to implement this Medicare coverage and payment in either an inpatient or outpatient setting as is clinically appropriate and in line with CMS's statutory authority. We also strongly support CMS's proposal to implement a process for review and addition of additional clinical scenarios that meet the criteria laid out in CMS's proposed medically necessary dental coverage authority.

MEDICAL NECESSITY AND DOCUMENTATION REQUIREMENT FOR AMBULANCE SERVICES

NASW agrees with CMS that access to nonemergency, scheduled, repetitive ambulance services is integral to the health and economic security of Medicare beneficiaries who are "bed confined" (as defined by CMS in the proposed rule and existing regulation) and for whom ambulance transportation is medically necessary (such as for dialysis, chemotherapy, or radiation treatments). We recognize the particular importance of such ambulance services for beneficiaries with modest incomes and those who live in underserved communities, including communities of color and rural communities. Moreover, NASW supports the role of social workers in signing the nonphysician certification statement if the ambulance provider or supplier is unable to obtain the attending physician's signature within 48 hours of the transport, as specified in the November 15, 2019, final rule (84 F.R. 62568).

NASW supports CMS's proposals to clarify regulatory language, thereby promoting consistent application of payments for medically necessary, nonemergent, repetitive, scheduled ambulance services.

- retaining existing language at § 410.40(e)(2)(ii) stating that, in all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to CMS
- maintaining the language that states that the ambulance service must meet all program coverage criteria, including vehicle and staffing requirements

¹ Justice in Aging. (2021). *Adding dental to Medicare Part B: 31 million low-income enrollees would gain access to Medicare coverage* [Fact sheet]. <https://justiceinaging.org/wp-content/uploads/2021/09/Who-Benefits-from-Medicare-Part-B.pdf>

² Christ, A., & Goldberg, J. (2020). *Adding a dental benefit to Medicare: Address oral health inequity based on disability* [Issue brief]. Justice in Aging. <https://justiceinaging.org/wp-content/uploads/2020/10/Adding-a-Dental-Benefit-to-Medicare-Disability.pdf>

³ Christ, A., Burke, G., & Goldberg, J. (2019). *Adding a dental benefit to Medicare: Addressing racial disparities* [Issue brief]. Justice in Aging. <https://justiceinaging.org/addressing-oral-health-equity-by-adding-a-dental-benefit-to-medicare/>

- clarifying that the physician certification statement (PCS) and additional documentation from the beneficiary’s medical record may be used to support a claim that transportation by ground ambulance is medically necessary
- clarifying that the PCS and additional documentation must provide detailed explanations, consistent with the beneficiary’s current medical condition, that explains the beneficiary’s need for transport by an ambulance, as described at § 410.41(a)
- clarifying that coverage includes observation or other services rendered by qualified ambulance personnel, as described in 410.41(b).

NASW is, however, concerned about CMS’ proposal to maintain the language stating that a signed PCS does not, alone, demonstrate the medical necessity of transportation by ground ambulance. This language seems to extend beyond the proposal addressing repetitive, scheduled, nonemergency ambulance transportation. When hospitals and other health care facilities order ambulances in nonrepetitive circumstances, beneficiaries often believe they have no choice in the matter and that the ambulance service will be covered. Such perceptions are reasonable, especially during stressful transitions of care. Expecting beneficiaries in such situations to assume ambulance costs because providers have not met checked coverage requirements or provided appropriate documentation is neither fair nor appropriate.

RURAL HEALTH CLINICS (RHCs) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs)

NASW supports CMS’ proposal to implement policies under the Consolidated Appropriations Act of 2022 which includes delaying the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare until the 151 days after the COVID-19 PHE ends. NASW is concerned that in person requirement may continue to pose a challenge for some beneficiaries due to various social determinate of health and encourages CMS to take this into consideration when implementing the in-person requirement.

CHRONIC PAIN MANAGEMENT SERVICES

NASW appreciates the addition of the new E/M codes for chronic pain. CMS efforts to extend several of the telehealth flexibilities has been valuable. Such flexibilities have been transformational in addressing the health needs of millions of beneficiaries. NASW recognizes the complexities of chronic pain and supports continuation of video and audio-only devices as a telehealth modality for visits, per the provider’s discretion. NASW encourages CMS to consider the biases of assessment tools for pain when proposing a validated pain scale.

NASW would also like CMS to consider the role clinical social workers (CSWs) play in the care of patients with chronic pain. The comprehensive framework and existing evidence-based interventions of CSWs are effective for chronic pain management and co-occurring psychosocial problems.

NASW agrees with the new definition of chronic pain, “Persistent or recurrent pain lasting longer than 3 months.” It is an appropriate definition providing clarity for beneficiaries and health care providers.

QUALITY PAYMENT PROGRAM (QPP)

NASW appreciates the inclusion of CSWs in the QPP. NASW appreciates CMS continuing their existing policy of reweighing the Promoting Interoperability Performance Category for CSWs for CY 2023 performance period through CY 2025 MIPS payment year.

NASW supports the additional improvement activities to advance CMS' goal of health equity. The most notable being the creation and Implementation of a plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA+) beneficiaries. Significant obstacles exist due to the lack of data for this population and NASW appreciates efforts made to address this matter.

NASW supports the addition of a telehealth indicator to the Medicare Compare Tool, as it would include information on how beneficiaries access care.

NASW is pleased to see the inclusion of the proposed Screening for Social Drivers of Health measure in the clinical social work specialty set. The association agrees with CMS that social drivers of health can be a key component to a beneficiary achieving health equity within all clinical settings and clinician types. NASW also encourages CMS to continue to include measures pertinent to social work practice such as measures in behavioral health.

MEDICARE PROVIDER AND SUPPLIER OF DMEPOS PAYMENT

NASW applauds CMS for its proposals in Section III.J.2.f of the proposed rule regarding categorical risk designation for skilled nursing facility (SNFs). We share CMS's concern about abuse of residents by nursing home staff and fraud or improper billing among nursing homeowners or operators, as described in the proposed rule. Consequently, NASW strongly supports CMS's proposal to revise § 424.518, which currently classifies all SNFs at the low level of categorical screening, in two ways: (1) by moving initially enrolling SNFs into the high level of categorical screening and (2) by subjecting revalidating SNFs to moderate risk level screening. We are, however, concerned about the following statement in the proposed rule: "Notwithstanding our foregoing concerns about felonious activity by nursing home owners, we emphasize that our authority under §§ 424.530(a)(3) and 424.535(a)(3) is discretionary, meaning that we are not required to exercise it in every case" (p. 46236). The sections cited in this statement reference CMS's authority to revoke or deny a SNF's participation in Medicare based on a conviction of state or federal felony within the preceding 10 years. This statement leaves a loophole that could be dangerous both to beneficiaries and to the health of the Medicare Trust Funds. NASW urge CMS to remove this loophole and to enforce all Medicare enrollment requirements across SNFs on a consistent basis.

Furthermore, NASW urges CMS to examine more closely the accuracy of information provided by SNFs and to exercise its authority (under 42 C.F.R. §424.535(a)(4)) to deny or revoke Medicare certification for SNFs that provide false or misleading information. Practices such as creating new companies and using multiple names can decrease the transparency of SNF owners and shield them from accountability

for wrongdoing, as various media articles illustrate.^{4,5,6,7} NASW also encourages CMS to revoke Medicare certification for SNFs that abuse billing privileges by engaging in “a pattern or practice of submitting claims that fail to meet Medicare requirements” (42 C.F.R. §424.535(a)(8)(ii)).

MEDICARE SHARED SAVINGS PROGRAM

NASW strongly supports CMS’ focus on advancing equity within the Medicare Shared Savings Program. Consequently, we concur with the proposal to add two new structural measures to the APP measure set. Incorporation of the Screening for Social Drivers of Health measure, which assesses the rate at which providers screen beneficiaries 18 years and older for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety, would improve person-centered assessment of and treatment planning for beneficiaries. Similarly, the Screen Positive Rate for Social Drivers of Health measure, which assesses the percentage of beneficiaries who screened positive for health-related social needs, would be a useful indicator of how meeting beneficiary’s social needs affects the quality of care provided by an ACO.

NASW also agrees with CMS that communication between accountable care organizations (ACOs) and assigned beneficiaries is critical to informed health care decision making by beneficiaries. Accordingly, we support CMS’s proposal to add § 425.312(a)(2)(ii), thereby clarifying that ACO participants are required to post beneficiary notification signs in all of their facilities—whether or not primary care services are provided in every facility.

In contrast, NASW urges CMS to withdraw its proposal to reduce standardized beneficiary notification once yearly to once per agreement period (every five years). NASW concurs wholeheartedly with CMS that it is essential for beneficiaries to “understand the advantages of their participation in ACOs, that their data is secure, that only the minimum necessary data is collected, and how this data is used for purposes of improving the quality of care for beneficiaries in the Shared Savings Program.” Likewise, we appreciate CMS’s efforts “to improve the beneficiary notice to ensure that the content of the notice utilizes plain

⁴ Laise, E. (2020, August 6). *As the pandemic struck, a private-equity firm went on a nursing-home buying spree.* Barron’s. https://www.barrons.com/articles/as-the-pandemic-struck-a-private-equity-firm-went-on-a-nursing-home-buying-spre-51596723053?mod=hp_DAY_Theme_1_1

⁵ Meadows, J. (2018, October 29). *Watchdog group says applicant to buy county nursing home switched companies.* Illinois Public Media. <https://will.illinois.edu/news/story/watchdog-group-says-applicant-to-buy-county-nursing-home-switched-companies>

⁶ Simmons-Ritchie, D. (2018, November 15). *Special investigation: Worst nursing homes continue to fail the frail despite lawsuit, promises.* Penn Live Patriot-News. <https://www.pennlive.com/news/2018/11/pennlive-special-investigation-still-failing-the-frail.html>

⁷ Tan, R., & Chason, R. (2020, December 22). *An investment firm snapped up nursing homes during the pandemic. Employees say care suffered.* *The Washington Post*. https://www.washingtonpost.com/local/portopiccolo-nursing-homes-maryland/2020/12/21/a1ffb2a6-292b-11eb-9b14-ad872157ebc9_story.html

language and is beneficiary-friendly, as well as affirming patient choice and clarifying the beneficiary’s opportunity to decline claims data sharing” (p. 46204); as the Center for Medicare Advocacy observed in a 2020 analysis of hospital observation status and coverage of SNF services,

Federal law authorizes waiver of the three-day inpatient requirement under various circumstances, including participation in an Accountable Care Organization (ACO). However, neither federal law nor federal regulations require ACOs to give beneficiaries sufficient information on how to use and benefit from the waiver. Telling beneficiaries that nothing changes for them when they are in an ACO is inaccurate and misleading.⁸

Yet, lack of clarity within written beneficiary notifications is not a sufficient cause to reduce the frequency of such notifications. As the preceding example makes clear, assignment to an ACO has significant health and economic consequences for beneficiaries. These consequences can affect beneficiary decision making during the Medicare annual enrollment period. Furthermore, during any given five-year period, many beneficiaries experience significant changes in their health status—changes that could affect the services they use within an ACO. Therefore, decreasing communication with beneficiaries is not an effective strategy to reduce confusion about ACO enrollment. Instead, NASW strongly urges CMS to retain the current notification requirements for ACOs while collaborating with beneficiaries, family caregivers, health care professionals, ACOs, and other stakeholders to improve the quality of communication about the health and economic implications of ACO enrollment for beneficiaries.

Similarly, NASW disagrees with CMS’s proposal to remove the requirement that ACOs submit marketing materials for review and approval before disseminating them to beneficiaries (section III.G.6.b). We agree that marketing materials and activities are important communications between an ACO and its beneficiaries and participants. Therefore, continued review by CMS of marketing materials before use is essential.

COLORECTAL CANCER SCREENING (CRC)

NASW supports CMS’ proposals to expand coverage of colorectal cancer (CRC) screening, as enumerated in Section III.D:

- reducing the minimum age from 50 to 45 for stool-based tests (gFOBT, iFOBT, and sDNA), barium enema test, blood-based biomarker tests, and direct visualization test of flexible sigmoidoscopy
- continuing to forgo a minimum age limitation for screening colonoscopies
- including, as part of CRC screening, a follow-on screening colonoscopy after a noninvasive stool-based test returns a positive result, and waiving beneficiary cost sharing (coinsurance and deductible) for both

⁸ Edelman, T. (2020). *Accountable care organizations and observation status*. Center for Medicare Advocacy. <https://medicareadvocacy.org/accountable-care-organizations-and-observation-status/> [Quote from para. 2]

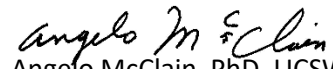
We concur with CMS that the preceding proposals will expand access to quality care and improve health outcomes for beneficiaries through prevention, early detection, more effective treatment, and reduced mortality.

We agree with CMS that the preceding proposals will expand access to quality care and improve health outcomes for beneficiaries through prevention, early detection, more effective treatment, and reduced mortality.

We encourage CMS to maintain coverage for a screening colonoscopy as the first step in CRC screening when determined appropriate by the beneficiary and their health care professional, thereby realizing CMS's goal as stated in the proposed rule: "that the patient and their healthcare professional make the most appropriate choice in CRC screening, which includes considerations of the risks, burdens and barriers presented with an invasive screening colonoscopy in a clinical setting as their first step."

Thank you for your consideration of NASW's comments on the proposed Medicare payment policies under the Physician Payment Schedule for 2023. If you have any questions, please do not hesitate to contact me at naswceo@socialworkers.org

Sincerely,


Angelo McClain, PhD, LICSW
NASW Chief Executive Officer