750 First Street NE, Suite 800, Washington, DC 20002-4241
202.408.8600 » SocialWorkers.org

November 17, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Electronic Submission: CMMI_NewDirection@cms.hhs.gov

Re: Center for Medicare & Medicaid Services: Innovation Center New Direction

Dear Ms. Verma:

The National Association of Social Workers (NASW), representing 125,000 social workers, submits comments on a new direction for the Centers for Medicare and Medicaid Innovation Center (CMMI).

NASW commends the Innovation Center for its effort in promoting new innovative models of care during the past several years. Many models have included professional social workers and have led to better, coordinated care for Medicare and Medicaid beneficiaries, including those living with chronic physical and mental health conditions. The inclusion of social work staff to address psychosocial needs of beneficiaries not only eases the burden on other health care providers within the team but influences better health outcomes and coordinated care. Social workers are health care professionals who have the training and expertise to address the psychosocial needs of beneficiaries and their caregivers in any health care setting.

As CMMI moves forward in developing innovative models of care, NASW recommends the implementation of team-based models that include Medicare and Medicaid coverage for professional social work services within all interdisciplinary models. Such coverage may not be accessible in existing models of care because of barriers to reimbursement. For example, reimbursement barriers exist for beneficiaries who wish to access health and behavior assessment and intervention services or advance care planning services provided by independent clinical social workers.[1,2] Similarly, beneficiaries receiving Medicare Part A coverage in a skilled nursing facility (SNF), cannot access mental health services provided by independent clinical social workers.[3] Therefore, teams that wish to contract with independent clinical social workers to provide these critical functions may face challenges in obtaining reimbursement for those services.

NASW encourages the Innovation Center to evaluate staffing patterns (including, but not limited to, the use of professional social workers) both within team-based models for which social work staffing is not required, such as

---

[1] National Association of Social Workers. (2016). *Enable Medicare beneficiaries' access to health and behavior assessment and intervention services from clinical social workers* [Issue brief]. Retrieved from http://www.socialworkers.org/LinkClick.aspx?fileticket=EMkwjGy3NH8%3d&portalid=0

[2] McClain, A. (2015, Sept. 8). *NASW comments to the Centers for Medicare & Medicaid Services regarding the Medicare Physician Fee Schedule proposed rule for calendar year 2016 (CMS–1631–P)* [Letter]. Retrieved from http://www.socialworkers.org/LinkClick.aspx?fileticket=sNrU8pmSw3g%3d&portalid=0

[3] National Association of Social Workers. (2017). Improve Medicare beneficiaries' access to clinical social work services [Issue brief]. Retrieved from http://www.socialworkers.org/Advocacy/Policy-Issues/Medicare-Reimbursement

Independence at Home, and in models that require social work staffing. Without such data, CMS will be limited in its ability to evaluate the factors contributing to success within and across demonstration sites.[4] Consideration of models that integrate training to enhance the health care workforce's capacity to serve specific populations, such as dually eligible beneficiaries and older adults, would also be useful.[5,6]

NASW offers the following comments regarding the focus areas included in the Innovation Center's request for information.

Advanced Alternative Payment Models

INDEPENDENCE AT HOME: NASW has long maintained that coordinated, team-based care can improve health outcomes for all beneficiaries, especially for older adults. At this time, social work participation in Independence at Home (IAH) model varies, and limited data exist about such participation. NASW urges incorporation of professional social workers in all future IAH demonstration sites and integration of professional social work in other models providing home-based primary care to older adults. Please refer to NASW's comments to sponsors of the *Independence at Home Act of 2016*, which outline NASW's concerns regarding the current IAH design.[7]

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE): PACE has helped numerous beneficiaries age 55 years and older to maintain independence in their homes and communities. Program outcomes (as compiled by the National PACE Association[8]) include effective and efficient processes for complex primary care, high participant and family caregiver satisfaction, improved participant health status, lower mortality rates, reduction in nursing home admissions and preventable hospitalizations, and cost savings to Medicare. NASW encourages CMS to continue studying innovations to the PACE model.

MEDICARE SHARED SAVINGS PROGRAM (MSSP): As noted in NASW's recent comments to CMS regarding the Medicare Physician Fee Schedule proposed rule for calendar year 2018, NASW supports reduction of documentation submission requirements included in MSSP participants' application for use of the SNF three-day rule waiver.[9] Many Medicare beneficiaries who need SNF services are unable to access them because of the three-day rule; when this happens, the coordination and quality of care decreases. NASW encourages CMS to explore innovations, both within and beyond the MSSP, to enhance Medicare beneficiaries' timely access to SNF services.

As noted in NASW's comments to the Senate Finance Committee Bipartisan Chronic Care Working Group in 2016, NASW supports clarification that Accountable Care Organizations (ACOs) participating in the MSSP may

---

[4] The importance of workforce analysis is demonstrated, for example, by a recent systematic review examining the impact of social work interventions in aging (Rizzo & Rowe, 2014). In an examination of 42 studies published between 2004 and 2012, the authors found that 71% of the studies reported significant outcomes in improving quality of life. Of the 21 studies that addressed cost outcomes, 15 (71.4%) documented significant cost savings; of that subset, 12 studies (80%) addressed health-related social work interventions, such as care coordination and end-of-life or palliative care. Rizzo, V. M., & Rowe, J. M. (2014). Cost-effectiveness of social work services in aging: An updated systematic review. *Research in Social Work Practice.* Advance online publication. doi:10.1177/1049731514563578

[5] Eldercare Workforce Alliance. (2014). *Quality care through a quality workforce: A toolkit for advocates of older adults who are dually eligible for Medicare and Medicaid.* Retrieved from https://eldercareworkforce.org/files/DUALS/EWA_Duals_Tookit_-_FINAL_v1_-_October_2014.pdf

[6] Eldercare Workforce Alliance. (2015). *Public policy priorities.* Retrieved from https://eldercareworkforce.org/files/EWA_Public_Policy_Priorities_FINAL_7.7.15.pdf

[7] McIntosh, H. (2016, Sept. 1). *NASW comments to Senators Markey, Cornyn, Bennet, and Portman regarding the Independence at Home Act of 2016 (S. 3130)* [Letter]. Retrieved from http://www.socialworkers.org/LinkClick.aspx?fileticket=hEyhwzAS-Cc=&portalid=0

[8] National PACE Association. (2017). *Key research findings*. Retrieved from http://www.npaonline.org/policy-advocacy/state-policy/research

[9] McClain, A. (2017, Sept. 8). *NASW comments to the Centers for Medicare & Medicaid Services regarding the Medicare Physician Fee Schedule proposed rule for calendar year 2018 (CMS–1676–P)* [Letter]. Retrieved from http://www.socialworkers.org/LinkClick.aspx?fileticket=STt-X1ICu_s%3d&portalid=0

furnish a social service or transportation service for which payment is not made under original Medicare. Such services can be helpful in improving health outcomes for beneficiaries. At the same time, NASW has expressed concern that monitoring is needed to ensure that ACOs and the community-based organizations with which they collaborate (such as Area Agencies on Aging) have the infrastructure and resources to provide such supplemental services. NASW encourages the Innovation Center to implement a demonstration along these lines and to consider similar flexibility within original Medicare.

Consumer-Directed Care

NASW concurs with the CMS's prioritization of beneficiary choice as a guiding principle for Innovation Center models. Accordingly, the association urges CMS to maximize each Medicare beneficiary's choice of providers, regardless of whether the beneficiary participates in an Innovation Center model. For example, NASW has long maintained that a beneficiary aligned (whether voluntarily or by assignment) with an ACO should retain access to any Medicare provider, even those outside the ACO. Such flexibility is a central feature of the original Medicare program and is valued highly by most Medicare beneficiaries.

Similarly, NASW urges CMS to support the following actions related to beneficiaries' voluntary alignment with any Innovation Center model:

- guidance on how the models and participating providers may educate beneficiaries regarding voluntary alignment
- safeguards to ensure transparency about provider incentives and to prevent discriminatory practices that result in risk avoidance by providers participating in each model
- CMS-initiated education to beneficiaries about each model (potential benefits, participating providers, and beneficiary rights)
- clear delineation of opt-out processes and education to beneficiaries regarding the same.

Increased resources to State Health Insurance Assistance Programs (SHIPs), which frequently field beneficiary inquiries about ACOs and other Innovation Center pilot programs, would also promote informed decision making by beneficiaries about participating in Innovation Center models.

At the same time, NASW is concerned about CMS's proposal to "promote consumerism and transparency" by enabling Medicare beneficiaries to participate in arrangements that would enable them to keep some of the savings when they choose a lower-cost option. NASW upholds that it is the role of the federal government (and, in the case of Medicaid, the state government) to establish fees with providers. Likewise, it is the responsibility of providers to inform beneficiaries of those fees. Although such information may inform a beneficiary's choice of providers and of services, no beneficiary should be put in the position of needing to negotiate fees with providers. Moreover, providing a financial incentive for a beneficiary to use a lower cost provider or service may not result in the best health care outcome for the beneficiary. Health care decision making should be based on each beneficiary's unique values, goals, and needs. Beneficiaries who are incentivized to choose a lower cost option might feel pressured to select options that are not consistent with their values, goals, and needs—or that are not of high quality. A shift toward beneficiary negotiation of fees and payment arrangements would likely exacerbate health disparities among beneficiaries. Furthermore, long-term costs both to beneficiaries and to CMS could actually increase if beneficiaries do not access the comprehensive, high-quality care they need in a timely manner.

NASW is also concerned about the establishment of preferred provider networks within Medicare. As noted previously, choice of Medicare providers is essential to most Medicare beneficiaries and is a hallmark of the original Medicare program.

Prescription Drug Models
Access to affordable, effective prescription drugs is an integral component of health care for Medicare and Medicaid beneficiaries. As a member of the Leadership Council of Aging Organizations (LCAO), NASW supports restoration of Medicaid-level drug rebate prices for Medicare beneficiaries who are dually eligible for Medicare and Medicaid, as well as for Medicare beneficiaries who are eligible for the low-income subsidy (extra help). Please refer to the LCAO issue brief *Building on What Works: Restoring Medicare Drug Rebates* for additional information on this issue.[10]

Medicare Models
As noted in a recent LCAO sign-on letter to CMS, NASW is concerned that the administration has been overemphasizing Medicare Advantage during the Medicare open enrollment period.[11] NASW has observed that this bias has also affected CMS's hold message on 1-800-MEDICARE. Although Medicare Advantage works well for some beneficiaries, traditional Medicare is a better option for others. In fact, two-thirds of beneficiaries continue to receive coverage through traditional Medicare.[12] Thus, innovations to strengthen not only Medicare Advantage but also original Medicare are essential. NASW recommends that the Innovation Center test potential changes both to the Medicare Advantage and traditional Medicare programs, keeping in mind the beneficiary protections articulated in the second paragraph of these comments.

NASW believes the Community-based Care Transitions Program (CCTP) was extremely beneficial. Discontinuation of funding prevented CCTP participants from realizing the program's goals fully. NASW urges CMS to reactivate this program.

The growing use of observation status by hospitals poses a substantial barrier to Medicare beneficiaries' use of the Part A SNF benefit. NASW encourages the Innovation Center to explore strategies to decrease this barrier.

The Medicare Care Choices Model has the potential to increase access to palliative care among Medicare beneficiaries and dually eligible beneficiaries who seek curative care simultaneously. NASW encourages the Innovation Center to continue this program and to explore other methods of promoting timely access to palliative and hospice care.

State-Based and Local Innovation, Including Medicaid-Focused Models
NASW encourages the Innovation Center to pursue advances in state-based programs that address social determinants of health. Social determinants affect significantly the health of Medicare and Medicaid beneficiaries. Working in collaboration with other members of interdisciplinary teams, social workers play an integral role in addressing the social determinants of health in health care settings and across the continuum of long-term services and supports (LTSS).

NASW applauds the intent of the Accountable Health Communities Model in addressing social determinants of health and in promoting access to LTSS. Access to available funds would enable community-based organizations to meet the needs of beneficiaries who are referred for services. NASW encourages CMS to consider strategies by which this resource gap might be addressed.

---

[10] Leadership Council of Aging Organizations. (2016). *Building on what works: Restoring Medicare drug rebates* [Issue brief]. Retrieved from http://www.lcao.org/lcao-drug-rebates-issue-brief-april2016/

[11] Leadership Council of Aging Organizations. (2017, Nov. 9). *Sign-on letter to the Centers for Medicare & Medicaid Services (CMS) expressing concerns with information disseminated during the Medicare Annual Coordinated Election Period (Open Enrollment) and requesting immediate corrective action be taken.* Retrieved from http://www.lcao.org/open-enrollment-letter-cms/

[12] Jacobson, G., Damico, A., Neuman, T., & Gold, M. (2017). *Medicare Advantage 2017 spotlight: Enrollment market update* [Henry J. Kaiser Family Foundation issue brief]. Retrieved from https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/

NASW supports innovations that enhance the delivery of LTSS, especially home and community-based services (HCBS). Medicaid covers more than 50% of reimbursed LTSS in the United States.[13] Thanks to various rebalancing initiatives, such as Money Follows the Person, the proportion of Medicaid funds spent on HCBS has grown significantly; however, much work remains in improving communication within Medicaid-covered LTSS.

Medicaid waivers are innovative models that can play a critical role in enhancing access to HCBS. HCBS availability under Medicaid waivers and state plan amendments (SPAs) varies greatly by state, and access to such services is both limited and inequitable.[14] Moreover, although waivers and SPAs may enhance LTSS access for certain beneficiaries, they may also introduce other changes that can negatively affect beneficiaries.[15] For example, NASW is disappointed that CMS recently approved elimination of three-month retroactive coverage for nearly all new applicants to the Medicaid program as part of the Iowa Section 1115 demonstration waiver. Elimination of the three-month retroactive coverage may decrease access to health care for all Medicaid beneficiaries and to LTSS for people with disabilities and older adults.[16, 17] Thus, NASW encourages CMS to exercise caution in testing Medicaid models to ensure that beneficiary access to care is not jeopardized.

Financial pressures have contributed to the continued growth of managed care within Medicaid, including within Medicaid-funded LTSS. Managed care plays a particularly prominent role in initiatives to improve care and decrease costs for dually eligible beneficiaries. However, the implementation of these initiatives has raised ethical concerns, such as elimination of beneficiary choice.[18,19] NASW urges CMS to heed these concerns as it considers new Medicaid models.

Mental and Behavioral Health Models

The advancement of integrated models of care has accelerated across health care settings, and health systems are recognizing the benefits of integration. NASW has supported models that have integrated mental and behavioral health practitioners, including clinical social workers, psychologists, and psychiatrists, within health care teams.

NASW encourages the Innovation Center to promote Medicare and Medicaid financing mechanisms that support integrated care. Such mechanisms should also support assessment, care coordination, and intervention by an interdisciplinary team that includes professional social workers. NASW encourages CMS to collect data on the

---

[13] Paradise, J. (2017). *10 things to know about Medicaid: Setting the facts straight* [Henry J. Kaiser Family Foundation issue brief]. Retrieved from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/

[14] Isaacson, E., Carlson, E., & Rich, A. (2012). *Medicaid long-term services and supports: Emerging opportunities and challenges* [Advocate's guide from the National Senior Citizens Law Center, now Justice in Aging]. Retrieved from http://nsclcarchives.org/wp-content/uploads/2012/09/Medicaid-LTSS-Guide-Final.pdf

[15] Mahan, D. (2012). *State plan amendments and waivers: How states can change their Medicaid programs* [Families USA issue brief]. Retrieved from http://familiesusa.org/product/state-plan-amendments-and-waivers-how-states-can-change-their-medicaid-programs

[16] Aging Life Care Association, Altarum Institute Center for Elder Care and Advanced Illness, American Federation of State, County and Municipal Employees (AFSCME), Community Catalyst, Disability Rights Education and Defense Fund, Jewish Federations of North America, . . . Special Needs Alliance (2017, Sept. 5). *Sign-on letter to the Centers for Medicare & Medicaid services, regarding Iowa's proposed amendment of Section 1115 waiver to eliminate retroactive coverage.* Retrieved from http://naela.informz.net/NAELA/data/images/PDFs/Natl%20Org%20Comments%20Iowa%201115%20Waiver%20Sept%205%202017.pdf

[17] Musumeci, M.B., & Rudowitz, R. (2017). *Medicaid retroactive coverage waivers: Implications for beneficiaries, providers, and states* [Henry J. Kaiser Family Foundation issue brief]. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/

[18] Community Catalyst. (2012). *Dual eligible demonstration projects: Top ten priorities for consumer advocates.* Retrieved from http://www.communitycatalyst.org/doc-store/publications/Top_Ten_Duals_Projects_Guide_Advocates.pdf

[19] Musumeci, M. B. (2013, November). *Long-term services and supports in the financial alignment demonstrations for dual eligible beneficiaries* [Henry J. Kaiser Family Foundation issue brief]. Retrieved from http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8519-long-term-services-and-supports-in-the-financial-alignment-demonstrations.pdf

integration of mental and behavioral health within Accountable Care Organizations, Independence at Home, and other primary care models.

Other Models

As CMS contemplates new innovations, NASW encourages consideration of the following successful models.

BRIDGE MODEL OF TRANSITIONAL CARE. As described on the model's Web site,

> The Bridge Model is a person-centered, social work-led, interdisciplinary model of transitional care. Bridge emphasizes collaboration among hospitals, community-based [health care] providers, and the Aging Network to promote a seamless continuum of health and community care across settings. . . . The model emphasizes six principles, including social determinants of health, community-specific focus, and hospital-community collaboration.[20]

In addition to receiving CCTP funding from the Innovation Center, Bridge has been recognized by the Administration for Community Living (ACL) as an evidence-based care transition model[21] and has been featured in the Agency for Healthcare Research and Quality's Health Care Innovations Exchange.[22] The model, which is being replicated in multiple sites across the United States,[23] has been found to lower hospital readmission rates, to increase attendance at post-discharge physician appointments, and to decrease stress among the family caregivers and older adults who participate in the program.[24,25,26,27,28]

GERIATRIC RESOURCES FOR ASSESSMENT AND CARE OF ELDERS (GRACE). The GRACE model of primary care includes a nurse practitioner–social worker care coordination team, which works closely with primary care physicians and a geriatrician.[29] The program, which is being replicated nationally,[30] has been featured in the Agency for Healthcare Research and Quality's Health Care Innovations Exchange,[31] recognized by ACL as an

---

[20] Bridge Model. (n.d.) *The Bridge model.* Retrieved from http://www.transitionalcare.org/the-bridge-model/

[21] Administration for Community Living. (2017). *Evidence-based care transitions program.* Retrieved from https://www.acl.gov/programs/care-transitions/evidence-based-care-transitions-program

[22] *Hospital-based social workers follow up with recently discharged older adults to resolve transition problems, reducing readmissions and deaths* [AHRQ Service Innovation Delivery Profile]. (2014). Retrieved from https://innovations.ahrq.gov/profiles/hospital-based-social-workers-follow-recently-discharged-older-adults-resolve-transition

[23] Bridge Model. (n.d.). *Bridge Model Collaborative: Replication sites.* Retrieved from http://www.transitionalcare.org/bmc/bridge-replication-sites/

[24] Alvarez, R., Ginsburg, J., Grabowski, J., Post, S., & Rosenberg, W. (2016). *Journal of Gerontological Social Work, 59*, 222–227. doi:10.1080/01634372.2016.1195781

[25] Boutwell, A. E., Johnson, M. B., & Watkins, R. (2016). Analysis of a social work-based model of transitional care to reduce hospital readmissions: Preliminary data. *Journal of the American Geriatrics Society, 64*, 1104–1107. doi:10.1111/jgs.14086
Analysis of a Social Work-Based Model of Transitional Care to Reduce Hospital Readmissions: Preliminary Data.

[26] Altfeld, S., Pavle, K., Rosenberg, W., & Shure, I. (2012–2013). Integrating care across settings: The Illinois Transitional Care Consortium's Bridge model. *Generations, 36*(4), 98–101.

[27] Altfeld, S. J., Shier, G. E., Rooney, M., Johnson, T. J., Golden, R. L., Karavolos, K., . . . Perry, A. J. (2013). Effects of an enhanced discharge planning intervention for hospitalized older adults: A randomized trial. *Gerontologist, 53*, 430–40. doi:10.1093/geront/gns109

[28] Fabbre, V. D., Buffington, A. S., Altfeld, S. J., Shier, G. E., & Golden, R. L. (2011). Social work and transitions of care: Observations from an intervention for older adults. *Journal of Gerontological Social Work, 54*, 615–626. doi:10.1080/01634372.2011.589100
Social work and transitions of care: observations from an intervention for older adults.

[29] Butler, D. E., Frank, K. I., & Counsell, S. R. (2015). The GRACE model. In M. L. Malone, E. Capezuti, & R. M. Palmer (Eds.), *Geriatrics models of care: Bringing 'best practice' to an aging America* (pp. 125–138). New York: Springer International Publishing.

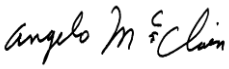
[30] Counsell, S. R. (2011, October). *GRACE team care: Geriatric Resources for Assessment and Care of Elders.* Presentation at National Health Policy Forum, Washington, DC. Slides retrieved from http://www.nhpf.org/uploads/Handouts/Counsell-slides_10-28-11.pdf

[31] *Team-developed care plan and ongoing care management by social workers and nurse practitioners result in better outcomes and fewer emergency department visits for low-income seniors* [AHRQ Service Innovation Delivery Profile]. (2014). https://innovations.ahrq.gov/profiles/team-developed-care-plan-and-ongoing-care-managementsocial-workers-and-nurse-practitioners

evidence-based care transition model,[32] and highlighted as a promising model by the American Hospital Association. [33] A randomized controlled trial of GRACE demonstrated decreased use of the emergency department, lower hospitalization rates, and enhanced quality of life among older adults participating in the program, as compared with those in control groups.[34] Moreover, the program yielded cost savings in the third year of the three-year clinical trial, preceded by two years of cost neutrality.[35] Research involving GRACE model participants has found that a variety of nonmedical factors influence early hospital readmissions among older adults with low incomes.[36] It is not surprising, therefore, that the integration of medical and social care is cited as one of the keys to GRACE's success. [37]

Thank you for your consideration of NASW's comments. Should you have questions about the association's comments, please contact my office at naswceo@socialworkers.org or (202) 336-8200.

Sincerely,



Angelo McClain, PhD, LICSW
Chief Executive Officer

[32] Administration for Community Living. (2017). *Evidence-based care transitions program.* Retrieved from https://www.acl.gov/programs/care-transitions/evidence-based-care-transitions-program
[33] American Hospital Association, Committee on Research. (2011). *Caring for vulnerable populations.* Retrieved from http://www.aha.org/research/cor/content/caring_vulnerable_populations_report.pdf
[34] Counsell, S. R., Callahan, C. M., Clark, D. O., Tu, W., Buttar, A. B., Stump, T. E., & Ricketts, G. D. (2007). Geriatric care management for low-income seniors: a randomized controlled trial. *JAMA, 298*, 2623–2633. doi:10.1001/jama.298.22.2623
[35] Counsell, S. R., Callahan, C. M., Tu, W., Stump, T. E., & Arling, G. W. (2009). Cost analysis of the Geriatric Resources for Assessment and Care of Elders care management intervention. *Journal of the American Geriatrics Society, 57*, 1420–1426. doi: 10.1111/j.1532-5415.2009.02383.x
[36] Iloabuchi, T. C., Mi, D., Tu, W., & Counsell, S. R. (2014). Risk factors for early hospital readmission in low-income elderly adults. *Journal of the American Geriatric Society, 62*, 489–94. doi:10.1111/jgs.12688
[37] American Hospital Association, Committee on Research. (2011). *Caring for vulnerable populations.* Retrieved from http://www.aha.org/research/cor/content/caring_vulnerable_populations_report.pdf