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National Association of Social Workers
Office of the Executive Director

Elizabeth J. Clark, PhD, ACSW, MPH
Executive Director

June 6, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1345–P
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Proposed Rule on Medicare Shared Savings Program and Accountable Care Organizations; CMS–1345–P

Dear Dr. Berwick:

On behalf of the 145,000 members of the National Association of Social Workers (NASW), I am pleased to submit our comments on the Notice of Proposed Rule Making for the Medicare Shared Savings Program and Accountable Care Organizations (ACOs).

NASW is a strong supporter of the 2010 Affordable Care Act. We support the concept of ACOs because shared accountability for beneficiary health will address both gaps in quality and unnecessary costs caused by fragmented and poorly coordinated care. Moreover, shared savings will support activities that improve care and lower health care costs—namely, care coordination services—which are not currently reimbursed under the Medicare fee-for-service program. We offer, for your consideration, the following recommendations to strengthen the Shared Savings Program.

Meeting the Core Objectives of the Shared Savings Program

NASW supports the three core objectives of the Shared Savings Program: better care for individuals, better health for populations, and lower growth in health care expenditures. We believe these goals cannot be achieved, however, without the participation of a broader array of providers in the ACO health care team. In particular, we recommend greater specificity regarding the types of psychosocial supports and services that ACOs must provide. In the absence of such requirements, ACOs may fail to address the social determinants of health and the roles access and adherence play in individual and population health outcomes.

Inclusion of professional social workers as ACO participants

The proposed rule limits ACO participants to doctors of medicine or osteopathy, physician assistants, nurse practitioners, and clinical nurse specialists [§425.4(1)(2)]. The Agency for Healthcare Research and Quality (AHRQ) suggests that the ACO model is based on the interdisciplinary team model of the primary care medical home. According to AHRQ (2010,

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2011a), a medical home provides comprehensive, team-based care that meets the majority of each patient's physical and mental health care, including prevention and wellness, acute care, and chronic care. AHRQ notes that the medical home team for most patients in a primary care practice might include nurses, pharmacists, nurse practitioners, physicians, physician assistants, medical assistants, **social workers**, care coordinators, and others.

NASW strongly recommends that professional social workers be included as ACO participants. Social workers play key roles in interdisciplinary care teams across a broad array of health care settings and as such, constitute essential members of ACOs. **Social workers are also the only health care professionals devoted exclusively to addressing the psychosocial needs of Medicare beneficiaries and family caregivers**. In its 2008 report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, the Institute of Medicine (IOM) defined psychosocial health services as "psychological and social services and interventions that enable patients, their families, and health care providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of illness and its consequences, so as to promote better health" (p. 9).

Equally importantly, the presence of social workers on the medical home team extends the reach of the physician and nursing staff—allowing all team members to practice at the top of their licenses.

Roles and qualifications of professional social workers participating in ACOs

Professional social workers fulfill distinct but complementary roles in health care. ***Clinical social workers*** work in behavioral and mental health settings, including as independent practitioners. ***Medical social workers*** work in settings such as hospitals, primary care, long-term care, hospice and palliative care, and rehabilitation.

CLINICAL SOCIAL WORKERS: Mental and behavioral health care should be a strong component of ACO services. More than 240,000 clinical social workers in the United States diagnose and treat mental illness (Substance Abuse and Mental Health Services Administration, 2010). Of that number, more than 37,000 clinical social workers are currently Medicare providers. NASW recommends the inclusion of clinical social workers in all ACO programs providing mental and behavioral health services. A *clinical social worker* is an individual who possesses a master's or doctor's degree in social work; has performed at least two years of supervised clinical social work; and is either licensed or certified as a clinical social worker by the State in which the services are performed; or, in the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic (CMS, 2009). (Since 2009, all states license social workers at the clinical level.)

For decades, clinical social workers have been recognized for their expertise in providing services to Medicare beneficiaries who experience emotional, behavioral, psychological, and social problems related to health and mental health conditions. NASW recommends the expansion of Medicare-reimbursed clinical social work services to include the prevention,

assessment, and treatment of mental, emotional, and behavioral disturbances as fee-for-service providers. This change would accurately reflect the services clinical social workers currently provide to Medicare beneficiaries. The expansion of the Medicare definition of clinical social work services would also promote greater continuity across the health care continuum. NASW supports the fee-for-service model currently used within the Medicare payment system for clinical social workers participating in ACOs. At present, clinical social workers are the only group of non-physician practitioners who are paid 75% of the physician fee schedule. NASW recommends reimbursement of clinical social workers at 85% of the physician fee schedule, in keeping with reimbursement rates for other non-physician practitioners.

MEDICAL SOCIAL WORKERS: Medical social workers perform multiple roles within interdisciplinary health care teams: case management and care coordination, medically related social services, patient and family education, discharge planning, advance care planning, and community outreach and engagement. Consistent with NASW's Standards for Social Work Practice in Health Care Settings (2005), medical social workers participating in ACOs should have a social work degree from a school accredited by the Council on Social Work Education. Social workers functioning in leadership roles within ACOs, such as managers or directors, should be licensed at the advanced practice level and be able to provide supervision for licensure (NASW, 2005).

Benefits of social work involvement in ACO-type programs

As indicated below, social work involvement in ACO-type projects have shown positive trends in a number of performance measures:

- Reduction in 30-day hospital readmissions
- Delays in permanent nursing home placement
- Reductions in avoidable emergency room visits
- Improved access to primary care providers
- Improved adherence to treatment plans

For your reference, we have provided examples of a few of these programs below.

Care Management Program: An Initiative to Reduce Unnecessary Emergency Department Utilization

This program addresses the needs of the most frequent users of emergency departments and hospitals in Camden, New Jersey. These individuals lack consistent primary care and often have complex medical, psychiatric, and substance abuse disorders, compounded by an array of social concerns. A team consisting of a social worker, medical assistant, and nurse practitioner helps program participants address a variety of social, environmental, and health conditions. The team also facilitates participant access and on-going involvement in a medical home (Camden Coalition of Healthcare Providers, 2011).

Enhanced Discharge Planning Program (Rush University Medical Center)

In the Rush University Enhanced Discharge Planning Program, social workers work with older adults and family caregivers following discharge from the hospital. Social workers help patients avoid adverse events, encourage follow-up with primary care providers, and connect patients and caregivers to community-based resources. Data from the project show statistically significant increases in older adults' understanding of their medications, decreased stress over managing their health care needs, and improved communication with their physicians post-discharge (American Hospital Association, 2010).

Project SAFe: University of Southern California, Los Angeles, CA
Project SAFe (Screening Adherence Follow-Up Program) is a system of patient navigation counseling and case management designed to help low-income, ethnic-minority women overcome barriers to timely breast cancer screening and follow-up after receiving an abnormal mammogram. The service involves a structured interactive telephone assessment of screening-adherence risk (barriers), health counseling, and follow-up services, including patient tracking, appointment reminders, and referral to community resources. Low-income, ethnic-minority women are more likely than other women to delay or miss follow-up appointments after receiving an abnormal mammogram. This disparity can be attributed to barriers such as cultural norms, language, low health literacy, lack of insurance, irregular sources of medical care, uncoordinated treatment services, and psychological distress. Patient navigation counseling and case management that is sensitive to the challenges faced by low-income, ethnic-minority women may improve adherence to recommendations for regular screening and treatment follow-up after an abnormal mammogram (Ell, 2007).

Geriatric Resources for Assessment and Care of Elders
The GRACE (Geriatric Resources for Assessment and Care of Elders) medical home project includes a nurse practitioner–social worker care coordination team, which works closely with primary care physicians and a geriatrician. The program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolls low-income older adults with multiple diagnoses. Data from the project show decreased use of the emergency department and lower hospitalization rates among seniors receiving the GRACE intervention, compared with those in control groups (Counsell et al., 2007).

Commonwealth Care Alliance
Serving older adults and medically fragile individuals on Medicaid, the Commonwealth Care Alliance (CCA) uses nurse practitioner-led teams in 25 community-based medical practices. These teams, which include social workers, assume primary responsibility for the ambulatory care needs of patients assigned to each practice. Teams provide intake and assessment, ongoing care coordination, and in-home assistance with activities of daily living. The physicians on the team, on the other hand, focus on inpatient care. According to the Commonwealth Fund, the number of hospital days per year per CCA member who is dually eligible for Medicare and Medicaid was 2.0, compared to 3.6 days per dually eligible patient enrolled in the Medicare fee-for-service program. The study also found the percentage of nursing home–certifiable patients permanently placed in the nursing

home per year was 8.5%, compared with the overall Massachusetts rate of 12% (Commonwealth Fund, 2010).

Processes to Promote Evidence-based Medicine, Patient Engagement, Quality Reporting, and Coordination of Care

Evidence-based medicine

The Affordable Care Act states that ACOs need to have processes to promote the use of evidence-based medicine. NASW recommends that CMS broaden this term to evidence-based medicine *and practices*, because it is critical that ACOs implement evidence-based psychosocial interventions not generally included as *medicine*. ACOs should incorporate the following definition for both evidence-based medicine and evidence-based practice: "bringing together the best available research evidence, with practitioner knowledge and values and patient/client preferences" (Social Work Policy Institute, 2010, p. 10). The following databases may be valuable to ACOs in identifying evidence-based psychosocial interventions and care coordination programs:

- Evidence Database on Aging Care, maintained by the Social Work Leadership Institute at the New York Academy of Medicine: www.searchedac.org/
- The Guide to Community Preventive Services, maintained by the Centers for Disease Control & Prevention (CDC): www.thecommunityguide.org
- National Registry of Evidence-Based Programs, maintained by the Substance Abuse and Mental Health Services Administration: www.nrepp.samhsa.gov
- Research-tested Intervention Programs, maintained by the National Cancer Institute: http://rtips.cancer.gov/rtips/index.do

Care coordination and case management

The National Transitions of Care Coalition (NTOCC) recommends increased use of case management and professional care coordination as essential to improving communication of health care information (NTOCC, 2010b). Although the proposed rule focuses heavily on care coordination and case management, CMS provides no clear definition of either term. Effective care coordination and case management must address not only communication among primary care providers and physician specialists but also the psychosocial needs of beneficiaries and family caregivers (Herman, 2009).

The proposed rule proposes telehealth, remote monitoring, and enabling technologies as tools for care coordination. Although these tools may monitor changes in health status, they cannot replace the role person-centered care coordination and case management play in ACOs. Case management is not a "free" service, as indicated on page 19547 of the propose rule. Rather, case

management and coordination constitute essential services that must be included in the cost of care.

NTOCC's Transitions of Care Compendium (2011a) provides a wealth of information about strategies and programs to improve transitional care. The compendium, which is listed on the webpage for CMS's Community Based Care Transition Program, would be a useful resource for ACOs.

Quality and cost metrics

NASW supports the proposed use of quality measures in ACOs and views measures as an important avenue in the provision of effective health care services. NASW recommends additional measures in the area of mental health, cancer and hospice and palliative care. Participation in the measure approval/endorsement process is restricted because of the National Quality Forum's expensive annual membership dues. NASW recommends an approval/endorsement process that would be opened to all interdisciplinary health providers through their professional organizations, regardless of each organization's ability to pay membership dues.

Patient-centeredness criteria [§425.5 (d)(15)(ii)]

NASW strongly recommends inclusion of all nine proposed criteria and proposes addition of a new criterion. Our specific comments follow.

1) Beneficiary experience of care survey. NASW concurs with CMS that use of one survey is important to ensure consistency across ACOs and to facilitate measurement over time. The Consumer Assessment of Health Care Providers and Systems (CAHPS) Clinician and Group survey addresses many areas fundamental to patient-centered care. On the other hand, the survey items focus solely on doctors and support staff. This limitation makes the survey inapplicable not only to services provided by non-physician primary care providers (physician assistants, nurse practitioners, and clinical nurse specialists) but also to services provided by other health care professionals, such as social workers. NASW proposes a simple but significant modification to CAHPS: Replace *doctor* with *health care provider* throughout the survey. This change would ensure applicability of the survey across ACO providers.

2) Patient involvement in ACO governance. NASW supports CMS's proposal to include at least one ACO beneficiary in the governing body of each ACO. We also support inclusion of a beneficiary advisory panel or committee. The panel should not replace beneficiary participation in the governing body, however. As CMS notes in the proposed rule, without voting power the influence of a consumer representative would be extremely limited. At the same time, the input of the advisory panel would enable a broader group of beneficiaries to influence the focus and processes of the Shared Savings Program. Ideally, the voting representative would participate not only in the governing body but also in the advisory panel.

3) Diversity and population needs evaluation/health planning. Medicare beneficiaries vary in age, race, ethnicity, biological sex, gender identity, sexual orientation, geographic region, socioeconomic status, and physical, mental, and cognitive ability. The literature identifies health care disparities related to each of these cultural factors (AHRQ, 2011b; Centers for Disease Control and Prevention & Merck Foundation, 2008; IOM, 2011). Given this context, NASW affirms CMS's proposed incentives for rural health clinics and federally qualified health centers to participate in the ACO program (§425.7(c)(4); 425.7(c)(7); 425.7(d)(2); 425.7(d)(6)). We also support CMS's proposal to establish partnerships between ACOs and state or local health departments.

We encourage CMS to discourage avoidance of high-risk beneficiaries and exacerbation of health disparities by requiring ACOs to take the following steps:

- Add people from medically underserved racial and ethnic groups and individuals with low incomes to the list of at-risk beneficiaries (§425.(4)) and consider these characteristics when adjusting for per capita Medicare expenditures
- Collect and report quality data related to race, ethnicity, and income
- Monitor degree of ACO nonparticipation among health care providers for beneficiaries from medically underserved racial and ethnic groups

NASW also supports integration of the *National Standards on Culturally and Linguistically Appropriate Services* (CLAS) (U.S. Department of Health & Human Services, 2007) in ACO practice. Social workers are well prepared to provide culturally and linguistically appropriate services:

- Content addressing cultural diversity, human rights, and social and economic justice constitutes a core component of the social work curriculum (Council on Social Work Education, 2008).
- The NASW standards (2001) and indicators (2007) for cultural competence in social work practice guide social workers in developing and maintaining cultural competence—an ethical responsibility outlined in the Association's *Code of Ethics* (2008). (The Association's standards and indicators also form the basis for the National Transitions of Care Coalition's cultural competence tool for interdisciplinary health care teams [2010a]).
- The NASW standards for social work practice in health care settings (2005) specify that social workers need the knowledge and skills to identify and address health disparities.
- NASW's HIV/AIDS Spectrum: Mental Health Training and Education of Social Workers Project (NASW, n.d.-a) strives to promote culturally competent practice skills with individuals, families, and communities affected by HIV/AIDS. The Project is supported through a five-year contract with the Center for Mental Health Services of SAMHSA.

4) High-risk individuals, individualized care plans, and integration of community resources. Comprehensive biopsychosocial assessment and care planning guide social work practice in health care settings (NASW, 2005) and are included in the accreditation standards of both the

Commission on Accreditation of Rehabilitation Facilities (CARF) (2010) and the Joint Commission (2011). NASW asserts that individualized assessment and care planning should drive health care not only for targeted beneficiary populations, but for *every* ACO beneficiary. Assessment and care planning tailored to each person's health and psychosocial preferences, values, and needs forms the cornerstone of safe, appropriate, timely health care. For high-risk beneficiaries and individuals with multiple chronic conditions, the need for person-centered assessment and care planning is even more pressing.

The importance of this principle is illustrated by considering the variety of options available for end-of-life care. Life-prolonging medical treatments may be welcomed by one person and declined by another, even if the two have the same diagnosis and prognosis. In the absence of individualized assessment and care planning, health care providers risk not only wasting scarce health care resources but also—and even more importantly—disregarding beneficiaries' choices. The challenges associated with medication adherence also demonstrate the centrality of individualized assessment and care planning. A beneficiary cannot benefit from a prescribed medication if her or his health care provider does not ascertain whether the prescription is affordable, for example. Similarly, failing to assess if an individual understands how to take the medication can lead to dangerous, costly errors.

NASW concurs with CMS that community resources are critical in supporting beneficiary adherence to the health care plan. Social workers have long played an integral role in helping clients identify and connect with appropriate community resources (NASW, 2009); the profession is well equipped to help fulfill this responsibility as members of ACOs. NASW encourages CMS to include nonprofit social service organizations among community stakeholders in the ACO development and governance process.

5) Coordination of care. As previously noted, care coordination is essential to improving health care for Medicare beneficiaries, especially during transitions between health care providers or settings. NASW supports CMS's proposal requiring ACOs to outline care coordination mechanisms. NTOCC (2010b) recommends that "providers must have accountability for sending *and* receiving information about patients during care transitions [emphasis added]" (p. 20). Thus, each ACO's process of communicating care information must take into account this dual emphasis.

6) Communicating clinical knowledge/evidence-based medicine in a way that is understandable to beneficiaries. NASW affirms inclusion of this criterion for patient-centered care. Wide variation in literacy and health literacy exists among Medicare beneficiaries. The most recent National Assessment of Adult Literacy found that adults aged 65 and older—who constituted almost 83% of Medicare beneficiaries in 2009 (CMS, 2009)—were almost three times less likely to possess basic health literacy than 16- to 64-year-olds (Kutner, Greenberg, Jin, & Paulsen, 2006). Regardless of age, Hispanic adults had the lowest health literacy of all racial and ethnic groups; moreover, American Indian/Alaska Native, Black, and multiracial adults had lower health literacy than White (non-Hispanic) and Asian/Pacific Islander adults (Kutner et al., 2006).

Low health literacy may influence Medicare beneficiaries' ability to understand health information and treatment options, participate in assessment and care planning, and follow

through on the plan of care (such as taking medications and following up with health care providers). Clear beneficiary-provider communication is fundamental to patient engagement in health care, as demonstrated by its inclusion in the *Consumer Bill of Rights and Responsibilities* adopted by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry (1998, Appendix A).

7) Beneficiary engagement and shared decision making that reflects beneficiaries' unique needs, preferences, values, and priorities. NASW affirms inclusion of this criterion of patient-centeredness. The aforementioned *Consumer Bill of Rights and Responsibilities* (President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1998) devotes an entire chapter to consumer participation in treatment decisions. This topic is also emphasized in multiple other publications addressing consumer health care rights:

- The American Hospital Association (2003) specifies involvement in care—including discussion of medically appropriate treatment choices, treatment plan, consumer goals and values, and surrogate decision making—as one of six rights consumers can expect to be met during hospitalization.
- The National Hospice and Palliative Care Organization (2008) affirms patients' right to be involved in developing the plan of care and to decline care or treatment.
- The National Pain Foundation (2011) lists participation in pain treatment decisions in its bill of rights.
- NTOCC's consumer bill of rights for transitions of care (2011b) encourages consumers to participate in planning care transitions and underscores respect for the culture, goals, needs, and strengths of each individual.
- CARF's accreditation standards for person-centered long-term care communities (2010) emphasize self-determination and cultural competence as fundamental to care provision. Moreover, the standards require programs to "implement a written procedure that . . . minimizes barriers to decision making by the persons served" (CARF, 2010, p. 155).

8) Written standards and process for beneficiary communication and access to medical records. NASW supports this criterion. The need for written standards and processes reflects the evolution of the Joint Commission's standards for home care (2011), which now require organizations to develop, put in writing, and adhere to processes related to care provision and information management.

9) Internal processes for measuring clinical or service performance by physicians; using results to improve care and service. NASW supports inclusion of this criterion as a way to demonstrate patient-centeredness.

In addition to supporting CMS's proposed criteria, NASW recommends adding a 10th criterion: Collaboration in care provision with family caregivers, as guided by the beneficiary
Family caregivers—who include, but are not limited to, spouses, partners, significant others, family of origin, extended family, and friends (NASW, 2010)—play a critical role in supporting Medicare beneficiaries. Family caregivers provide physical, psychosocial, financial, and even medical support to people with disabilities and older adults. They also help beneficiaries communicate with health care providers and navigate service delivery systems.

No health care system can be patient-centered without recognizing and supporting the family caregivers' role in supporting patients' biopsychosocial health and well-being. Opportunities for family collaboration include participation in the assessment process, care planning, service delivery and monitoring, and performance measurement (NASW, 2010). Identification of family members and decision making regarding their involvement in care is the right of each competent beneficiary. If the beneficiary is unable to identify whom she or he wants involved in care, the ACO should follow appropriate legal processes (for example, honoring the beneficiary's choice of health care agent).

Lack of clarity regarding beneficiary assignment to ACOs

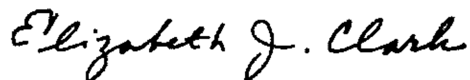
The proposed rule [§ 425.6 (c)] specifies that ACO participants must notify beneficiaries in writing that their ACO providers/suppliers have chosen to participate in an ACO. Such notification should take place not only in writing but also in person by ACO providers or staff.

Need for safeguards to preserve beneficiary choice of providers

The proposed rule specifies that beneficiaries have the right to use health care providers who do not participate in the ACO. NASW encourages CMS to specify the processes by which beneficiaries may exercise this right and other protections to preserve beneficiary freedom of choice. In the absence of such protocol, we are concerned that ACOs—which, as noted in the rule, must pay for all care provided to their beneficiaries—will enact barriers to external providers.

Thank you for your consideration of these comments. NASW looks forward to collaborating with you to make ACOs successful in achieving better care, better health, and lower costs for Medicare beneficiaries.

Sincerely,



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