



**NASW Comments on a Request for Information (RFI)
from the Centers for Medicare & Medicaid Services (CMS)**
[Make Your Voice Heard: Promoting Efficiency and Equity Within CMS Programs](#)
Submitted via [web-based comment form](#) on November 4, 2022
[Full text of CMS RFI](#)

Challenges accessing comprehensive and timely healthcare services and medication

Primary care: Many older adults are at risk for HIV and other sexually transmitted infections (STIs) and are reluctant to discuss their sexual activity with health care providers. Although Medicare covers such screening for people identified as being at risk for acquiring HIV or other STIs, many providers do not initiate such conversation.

Elder abuse (including neglect, abandonment, financial exploitation, and emotional, psychological, physical, and sexual abuse) affects millions of older adults each year. Although the Merit-based Incentive Payment System (MIPS) includes elder maltreatment screening and follow-up, screening for elder abuse (including intimate partner violence [IPV] toward older adults) is not routinely included as a Medicare preventive service.

Home and community-based services (HCBS): Many individuals who live in nursing facilities (NFs) and other institutional settings and have predictable, consistently high medical costs, are allowed to project those costs and are deemed Medicaid eligible on the first day of the month. This “medically needy” enrollment pathway is not currently available to people who use HCBS. Moreover, people who leave the hospital or post-acute care, often must wait months while a service plan is established before they can obtain Medicaid coverage for HCBS (<https://bit.ly/3SV1Twh>). They have no choice but to enter a NF, where retroactive Medicaid coverage prompts rapid admissions.

Home health: NASW is concerned about the increased reliance of home health agencies (HHAs) on computer models, rather than clinical judgment, to determine the number of visits each home health discipline was allowed. We are also concerned that the prospective payment system and patient-driven groupings model disadvantage beneficiaries by incentivizing HHAs to “cherry pick” the most profitable beneficiaries:

those who are referred following a stay in an inpatient hospital, inpatient rehabilitation facility, long-term care hospital, or skilled nursing facility and who have short-term needs.

Challenges in accessing care in underserved areas, including rural areas: Individuals in rural areas often encounter barriers that limit their ability to access healthcare. Those living in poorer areas can face challenges with transportation, finances, stigma around seeking help, and health literacy (<http://bit.ly/3h9Pfg1>). Systematic barriers such as accessing and understanding insurance coverage and locating an available provider due to provider shortage and limited availability can also be challenging.

Social determinants of health (SDOH) are associated with at least 80% of a person's health outcomes, whereas medical services account for 20% or less of an individual's health status (<https://bit.ly/nasw-health-social-PP>). NASW recommends that CMS foster the inclusion of social workers on health care teams and in primary care settings, to address SDOH and other psychosocial needs among vulnerable populations with complex physical and mental health conditions.

Receiving culturally and linguistically appropriate care (e.g., tailoring services to an individual's culture and language preferences): Challenges occur, and quality of care suffers when cultural and linguistic factors are not considered. Providers should engage in safeguards to ensure that the patient understands their plan of care and that the provider understands the patient's concerns.

Challenges with health plan enrollment: Medicaid, Medicare, and marketplace enrollment processes can pose many challenges for consumers. Enrollment policies can be complicated with strict timeframes to select plans and penalties. Comparing plans can also be challenging. These issues are compounded for those with low literacy and for whom English is a second language. NASW supports CMS's proposed changes to streamline Medicaid and CHIP eligibility, enrollment, and renewal processes to promote continuity of health insurance coverage and health care services. NASW also appreciates efforts to assist beneficiaries with its Medicare Plan Finder website and the *Medicare & You* handbook, particularly in regard to providing more balanced information regarding original Medicare and Medicare Advantage (MA).

Recommendations for how CMS can address these challenges through our policies and programs

NASW recommends the following to address challenges through policies:

- Continuing efforts to provide services to uninsured or underinsured patients are important
- Conducting data-driven assessments to identify high need populations and using these data to strategically place healthcare resources and government programs as recommendations to strategically target disinvested communities
- Increasing enforcement actions for those who misrepresent Medicare's brand and information. NASW offered multiple recommendations along these lines in its

comments on CMS's RFI regarding MA (<https://bit.ly/NASW-Medicare-Advantage-2022>). We also encourage CMS to update the Medicare Plan Finder website to eliminate lingering bias toward MA and to provide more complete out-of-pocket cost information for MA plans.

Primary care: Many older people remain sexually active and are, therefore, at risk for HIV and other STIs. NASW encourages CMS to engage in dialogue with the Centers for Disease Control and Prevention (CDC) and U.S. Preventive Services Task Force (USPSTF) regarding removal of age limits for HIV screening. We also encourage CMS to remove its annual limit on preventive services in relation to screening for HIV and other STIs. For a Medicare beneficiary beginning preexposure prophylaxis (PrEP), for example, HIV screening would be appropriate both before beginning PrEP and on a quarterly basis during the rest of the year.

People of all genders (including transgender and nonbinary individuals) experience IPV throughout the life span, and a federally funded demonstration project has shown the value of screening for elder abuse in primary care settings (<https://bit.ly/3Um1LXO>). Consequently, NASW encourages CMS to engage with USPSTF and CDC about the importance of routine IPV screening for adults of all genders and ages and of routine elder abuse screening for all older adults. We also recommend that CMS covers, as part of the Welcome to Medicare visit and annual wellness visit, routine screening of all adults (regardless of age or gender) for IPV and routine screening of all older adults for elder abuse, neglect, and exploitation.

Nursing home care: Although the 2019 final rule precludes LTC facilities from *requiring* residents to sign pre-dispute and binding arbitration agreements, NASW believes that the most significant factor in ensuring that arbitration is voluntary is that the resident agrees to arbitration after the dispute has occurred. Consequently, we urge CMS to forbid facilities to use pre-dispute arbitration agreements. NASW's Practice Alert on this topic (<http://bit.ly/NASW-LTCarbitration19>) provides additional information regarding the association's perspective.

HCBS: NASW encourages CMS to allow individuals who use HCBS and have predictable, consistently high medical costs, to project those costs using the medically needy enrollment pathway. Furthermore, NASW encourages CMS to enable individuals using HCBS to receive retroactive coverage to the Medicaid application date, as is currently allowed in nursing facilities.

Home health: PDGM payment incentives decrease not only home health access for beneficiaries admitted from the community who have not had a recent inpatient stay, but also beneficiaries who are eligible under the *Jimmo v. Sebelius* settlement agreement for occupational therapy (OT), physical therapy (PT), speech–language pathology services (SLP), or skilled nursing services, to maintain function or slow decline. These are commonly referred to as “maintenance goals”; the Center for Medicare Advocacy's *Jimmo* microsite (<http://bit.ly/3h0pXAJ>) provides detailed context on this issue. NASW urges CMS to review

PDGM and develop payments, policies, and enforcement practices that support home health care for all individuals who qualify for Medicare coverage under the law. NASW also encourages CMS to broaden the definition of “homebound”; the current definition is unnecessarily restrictive, eliminating many beneficiaries who cannot access ambulatory care.

Key factors that impact provider well-being and experiences of strained healthcare workers (e.g., compassion fatigue, attrition, maldistribution)

Key factors such as compassion fatigue, attrition, maldistribution, and burnout are common dilemmas that are seen in healthcare professionals. Providers have continuously faced the challenge of having high caseloads and treating complex patient needs with limited resources, which can hinder quality of care. Nursing home and hospital social workers are among the health care providers affected by strain, given the disproportionate impact of COVID-19 on nursing home residents and those hospitalized.

Feedback regarding compliance with payment policies and quality programs, such as provider enrollment requirements on healthcare worker participation in underserved populations, and what improvements can be made

NASW appreciates CMS’ efforts to improve provider participation in underserved areas. Challenges persist with access to clinical social workers (CSWs) as it relates to low reimbursement rates and scope of practice. It should be noted that CSWs are only reimbursed 75% of the Medicare Physician Fee Schedule compared to other non-physician practitioners who receive 85% (<https://bit.ly/nasw-access-bill-2021>). As Medicare Part B providers, CSW services are also restricted to the diagnosis and treatment of mental illness. This limits their ability to independently provide services for Health and Behavior Assessment and Intervention (HBAI) in integrated care settings and services provided in a skilled nursing facility. NASW requests CMS to take steps to mitigate reimbursement inequities by increasing CSW rate to 85% of the physician fee schedule. Consideration should also be given to allowing CSWs to bill independently for HBAI and mental health services in SNFs.

Nursing homes and HHAs continue to reinforce a false “improvement standard” despite efforts by CMS and advocates to implement the *Jimmo v. Sebelius* settlement. This practice disenfranchises beneficiaries with chronic conditions who would benefit from continued skilled care to maintain function or prevent decline. NASW encourages CMS to engage in robust education of providers and fiscal intermediaries to mitigate this problem. We also encourage CMS to gather more thorough information about beneficiaries whom HHAs decline to serve.

Recommendations for CMS policy and program initiatives that could support provider well-being and increase provider willingness to serve certain populations.

NASW recommends continuing efforts to reduce provider burden related to non-clinical activities such as streamlining reporting processes for value-based payment models.

As noted in comments on the RFI regarding nursing home staffing (<https://bit.ly/NASW-CMS-staff-RFI-June2022>), NASW encourages CMS to implement minimum staffing requirements

for nurses (certified nursing assistants, licensed practical nurses, licensed vocational nurses, and registered nurses [RNs]). Staffing should include one RN onsite, and care should be provided to residents 24 hours per day, 7 days per week. We also reiterate our two recommendations regarding social work staffing in nursing homes: (1) that CMS improve the 121:1 staffing ratio and (2) that CMS require nursing homes to hire only social workers with a baccalaureate or master's degree in social work, eliminating the option of "other human services fields."

Identifying CMS policies that can be used to advance health equity: Recommendations on how CMS can better promote and support accommodations, including those from providers and health plans, for people with disabilities and/or language needs or preferences

NASW supports continued efforts to improve data collection in order to better measure and analyze health disparities across program policies. Social workers have comprehensive skills to address factors that contribute to health disparities. Thus, NASW encourages CMS to strengthen the inclusion of social workers on care teams as it works to improve health equity for its beneficiaries. NASW also recommends continuing efforts to provide educational materials geared towards individuals with disabilities and language needs.

Moreover, NASW refers CMS to its prior comments on home health (<https://bit.ly/NASW-home-health-2022>) and MA (<https://bit.ly/NASW-Medicare-Advantage-2022>) for additional input regarding health equity.

Understanding the effects on underserved and underrepresented populations when community providers leave the community or are removed from participation with CMS programs.

Providers leaving communities or removing their participation in Medicare can have a significant impact on underserved populations. Establishing rapport and trust is the foundation of the patient-provider relationship. When this is lost, it can take time to re-establish. There is also no guarantee that patients will be able to find other providers in their area in a timely manner. In the event patients are able to establish themselves with other providers, there is the concern that the provider be attuned to the unique need of the patient to include cultural and environmental factors that can be pertinent to quality of care.

Recommendations for how CMS can promote efficiency and advance health equity through our policies and programs.

Using Section 1115 demonstration waivers may also be another approach in addressing SDOH as it could allow states to test broad changes in Medicaid benefits, eligibility, payment, cost-sharing, and delivery systems (<http://bit.ly/3UnLrWr>). Community-based organizations are a vital part of the continuum of care and serve populations with complex needs. NASW encourages CMS to consider policies and programs that incentivize communication and bidirectional data sharing between health systems and community-based organizations. NASW refers CMS to its comments addressing home health (<https://bit.ly/NASW-home-health-2022>), Medicare Advantage (<https://bit.ly/NASW-Medicare-Advantage-2022>), and streamlining Medicaid and CHIP enrollment (<https://www.socialworkers.org/Advocacy/Sign-On-Letters-Statements>) for additional feedback regarding efficiency and equity.

Impact of COVID-19 public health emergency (PHE) waivers and flexibilities and preparation for future health emergencies (e.g., unintended consequences, disparities) on health care providers, suppliers, patients, and other stakeholders.

NASW greatly appreciates CMS' continued leadership during the Public Health Emergency with the extension of several telehealth flexibilities. These flexibilities have been critical in addressing the mental and behavioral health needs of millions of beneficiaries.

Recommendations for CMS policy and program focus areas to address health disparities, including requested waivers/flexibilities to make permanent; any unintended consequences of CMS actions during the PHE; and opportunities for CMS to reduce any health disparities that may have been exacerbated by the PHE.

NASW continues to advocate for telehealth flexibilities to be permanent as it has helped to expand patient access to care. Telehealth services offer several advantages that are in accordance with CMS' goals to provide cost effective options that increase access to care for beneficiaries. Telehealth can be particularly beneficial to beneficiaries with mobility limitations, or those in rural areas who don't have access to a local doctor or clinic. NASW also emphasizes the importance of telehealth parity to ensure payment reimbursement is the same as in person services. Payment parity allows for more access to underserved communities (<http://bit.ly/3U2PJmq>).

Hospital observation status creates a barrier for Medicare beneficiaries who need skilled nursing facility (SNF) services following hospitalization. CMS now requires hospitals to inform all hospitalized beneficiaries that they are in observation status, and some beneficiaries now have the ability to appeal a transition from inpatient status to outpatient observation status (<http://bit.ly/3WpSPCI>). Moreover, numerous beneficiaries are surprised by high out-of-pocket costs for SNFs because their time in hospital observation status does not count toward the three-day minimum required for Medicare coverage of SNF services. CMS's waiving of the three-day minimum during the PHE has increased beneficiary access to SNF care and reduced out-of-pocket costs. NASW encourages CMS to make permanent the COVID-19 waiver of the three-day inpatient hospitalization requirement for SNF coverage.

NASW also suggests that CMS make permanent the following COVID-19 waivers and flexibilities: (1) enabling nurse practitioners, clinical nurse specialists, and physician assistants to order Medicare home health services, establish and periodically review a plan of care for home health services, and certify and recertify that the beneficiary is eligible for home health services; (2) enabling home health beneficiaries to obtain COVID-19 testing within the context of the home health benefit, given their homebound status and ongoing COVID-19 risk; and (3) waiving the once-per-lifetime limit for certain beneficiaries to participate in the Medicare Diabetes Prevention Program. We also suggest that CMS extend the new § 483.80(h) requirement that LTC facilities test staff and residents for COVID-19 for at least one year following the end of the PHE and continue to evaluate the need for extension throughout that first post-PHE year.

NASW recommends that CMS reinstate the following requirements at the end of the PHE: (1) pre-admission screening and annual resident review (PASRR) for LTC facilities, which is essential to ensure that people with serious mental illness receive services in the most appropriate setting; (2) detailed information sharing by HHAs for discharge planning, which is necessary to facilitate smooth care transitions; and (3) allowing HHAs to provide a beneficiary a copy of their medical record at no cost during the next visit or within 10 business days (when requested by the beneficiary), which can adversely affect care transitions. NASW also recommends that CMS reinstate three HHA requirements that affect quality of care: (1) annual onsite supervisory visit (direct observation) by an RN, PT, OT, or SLP for each home health aide that provides services on behalf of the HHA; (2) 12 hours of in-service training for each home health aide in a 12-month period; and (3) development, implementation, evaluation, and maintenance of an effective, ongoing, HHA-wide, data-driven QAPI program.