

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1784–P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore MD 21244-1850

Electronic submission: <https://www.regulations.gov/document/CMS-2023-0121-1282>

RE: Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (proposed August 7, 2023)

Dear Administrator Brooks-LaSure:

I am writing to you on behalf of the 110,000 members of the National Association of Social Workers (NASW). We are the largest and oldest professional social work organization in the United States. NASW promotes, develops, and protects the practice of social work and professional social workers. Social workers are the largest provider of mental, behavioral, and social care services in the nation and serve a critical role in connecting individuals and families to health care services.

NASW appreciates the opportunity to submit comments on CMS–1784–P, Notice of Proposed Rule Making on the revisions of Medicare payment policies on the Physician Fee Schedule (PFS) for the calendar year (CY) 2024, and other changes to Part B Payment and Coverage Policies. The association supports CMS' strategy to create an equitable health care system that results in better access to care, quality, affordability, and innovation.

NASW is providing comments on the following subjects:

- Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (Section II.D)
 - CMS Proposal to Add New Codes to the Medicare Telehealth Services List: Social Determinants of Health Risk Assessment
 - Proposed Clarifications and Revisions to the Process for Considering Changes to the Medicare Telehealth Services List
 - Implementation of Provisions of the Consolidated Appropriations Act, 2023: In-Person Requirements for Mental Health Telehealth, Originating Site Requirements, and Audio-Only Services
 - Place of Service for Medicare Telehealth Services
 - Other Non-Face-to-Face Services Involving Communications Technology Under the PFS: Direct Supervision via Use of Two-Way Audio/Video Communications Technology
- Valuation of Specific Codes (Section II.E)
 - Payment for Caregiver Training Services
 - Community Health Integration Services
 - Social Determinants of Health—Proposal to Establish a Stand-Alone G-Code
 - Principal Illness Navigation Services
- Advancing Access to Behavioral Health Services (Section II.J)
 - Implementation of Section 4123 of the CAA, 2023: Crisis Services
 - Health Behavior Assessment and Intervention Services
 - Adjustments to Payment for Timed Behavioral Health Services
 - Updates to the Payment Rate for the PFS Substance Use Disorder Bundle (HCPCS Codes G2086–G2088)
 - Comment Solicitation on Expanding Access to Behavioral Health Services
 - Request for Information on Digital Therapies, Such as, But Not Limited to, Digital Cognitive Behavioral Therapy
- Rural Health Clinics and Federally Qualified Health Centers (Section III.B)
- Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (Section III.F): Additional Flexibilities for Periodic Assessments Furnished via Audio-Only Telecommunications
- Medicare and Medicaid Provider and Supplier Enrollment (Section III.K)
- Changes to the Hospice Conditions of Participation (Section III.O): Information Collection Requirements (ICRs) Related to Permitting MFTs and MHCs to Serve as Members of the Interdisciplinary Group (IDG) in Hospices
- A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (Section III.S)
- Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services (Section II.K)
- Drugs and Biological Products Paid Under Medicare Part B (Section III.A)
- Medicare Shared Savings Program (Section III.G)
- Medicare Part B Payment for Preventive Vaccine Administration Services (Section III.H)
- Medicare Diabetes Prevention Program (Section III.I)

- Expand Diabetes Screening and Diabetes Definitions (Section III.L)
- Quality Payment Program

Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act (the Act) (Section II.D)

CMS Proposal to Add New Codes to the Medicare Telehealth Services List: Social Determinants of Health Risk Assessment

NASW is pleased to see that CMS has proposed to add new codes to the Medicare Telehealth Services List for the Social Determinants of Health (SDOH) Risk Assessment. Social workers have been aware of the importance of addressing social determinants of health as part of a comprehensive approach to patient care. This will enable providers to better use their resources to provide more targeted interventions to meet the patients' needs.

CMS proposal to revise the process for analyzing requests for adding services to the Medicare Telehealth Services List

NASW supports CMS' proposal to revise the process for analyzing requests for the addition of services to the Medicare Telehealth Services List. The association believes having a more streamlined process for determining which services should be added permanently or provisionally will create consistency and clarity in the procedure.

Implementation of Provisions of the Consolidated Appropriations Act, 2023 (In-Person Requirements for Mental Health Telehealth, Originating Site Requirements, and Audio-Only Services) and Place of Service for Medicare Telehealth Services

NASW supports CMS' decision to continue to delay the in-person requirement and allow telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, and allowing certain services to be furnished via audio-only telecommunications. The association also advocates that telehealth reimbursement be on par with in-person care. Telehealth provides a convenient and cost-effective way for beneficiaries to receive care, particularly those with limited access to transportation, childcare and those who reside in rural areas. It also affords greater access to specialized care, which can often be difficult to receive due to long wait times or distance. In addition, telehealth allows for a higher volume of patients to be treated in a timelier manner, which in turn, can help reduce healthcare costs. Telehealth also provides the opportunity for providers to gain valuable insight into patient behavior and health status in their natural environment. This information is especially critical in helping providers understand the various factors that can impact health outcomes. NASW also recognizes that beneficiaries may face barriers when accessing services via telehealth. These barriers may include lack of broadband access, limited financial resources, and limited digital literacy. NASW believes it is necessary for providers to work jointly with beneficiaries to assess appropriate telehealth services. NASW encourages the continued evaluation of telehealth services to ensure its efficacy and mitigate gaps in care.

Other Non-Face-to-Face Services Involving Communications Technology Under the PFS: Direct Supervision via Use of Two-Way Audio/Video Communications Technology

NASW appreciates CMS' efforts to increase accessibility to services and welcomes the proposal to extend the virtual supervision flexibility through 2024. Virtual supervision of clinicians such as clinical social workers has several potential benefits. For starters, it can be very cost-effective, which is especially beneficial for agencies and organizations who do not have a supervisor on-site. Virtual supervision also allows for more flexibility in scheduling, making it easier for supervisors to monitor their employees, especially in multiple locations. In addition, virtual supervision eliminates geographic barriers, which can be especially important in rural or underserved areas.

In terms of program integrity, patient safety, and quality concerns, it is also important to remember that virtual supervision should be treated similarly to in-person supervision and that the same level of oversight should be applied to ensure that services are being provided appropriately. NASW believes measures can be taken to prevent potential fraud and abuse. CMS should consider implementing safeguards to ensure that any virtual supervision is conducted in a secure environment and in accordance with all HIPAA and Medicare requirements. Utilizing appropriate privacy and security protocols are essential to protect patient information within the supervision relationship. The use of video-conferencing on HIPAA compliant platforms provides an additional layer of safety for both the supervisors and supervisees. The association also believes it is necessary to consider the complexity of the service, the skills and training of the personnel performing the service when determining requirements for the type of supervision.

Valuation of Specific Codes (Section II.E)

Payment for Caregiver Training Services (CTS)

NASW commends CMS for its continued consideration of Medicare reimbursement for CTS. We concur not only that caregivers can play a key role in developing and carrying out the treatment plan established for the beneficiary by the treating practitioner, but also that CTS could be reasonable and necessary to treat the beneficiary's illness or injury.

NASW strongly supports, in multiple respects, CMS' proposed definition of the term "caregiver" (for the purpose of CTS payment):

- We agree that caregivers include not only family (legally defined), but also friends, neighbors, and guardians.
- We affirm that caregivers support not only beneficiaries living with a disability or chronic condition, but also beneficiaries experiencing a short-term illness or condition.
- We concur that caregivers may be involved on an episodic, daily, or occasional basis.
- We agree that caregiving responsibilities may include not only helping to manage a beneficiary's complex health care and assistive technology activities at home, but also helping to navigate the beneficiary's transition between care settings.

- We also agree with CMS that this definition would enable holistic care of the beneficiary with people who know and understand the beneficiary, their condition, and their environment.

Similarly, NASW supports CMS' proposals to establish an active payment status for two sets of CPT codes associated with CTS. We agree wholeheartedly with CMS that circumstances exist in which CTS, when provided without the beneficiary present, are necessary both to reduce the negative impact of the patient's physical or mental health diagnosis on the patient's daily life and to assist the patient in carrying out a treatment plan associated with that diagnosis. We recommend that CMS clarify the definition of "face-to-face" regarding the mode by which group CTS may be provided. Moreover, we urge CMS to include two-way audio-video technology as a face-to-face option for CTS focused on management of a mental health condition and reflected in CPT codes 96202 and 96203. Inclusion of telehealth for this purpose would make CTS accessible to a greater number of caregivers than would in-person CTS alone.

NASW concurs with CMS that the treating practitioner must obtain consent from the beneficiary before providing CTS. Such consent maintains the beneficiary's self-determination. At the same time, we support CMS' inclusion that the beneficiary's representative may provide such consent if the beneficiary is unable to do so. Moreover, we support CMS' proposal that the treating practitioner must document in the beneficiary's medical record the identified need for CTS and the beneficiary's (or representative's) consent for one or more specific caregivers to receive CTS.

NASW agrees that several types of professions can provide CTS. On page 52323 of the NPRM, CMS noted that the treating practitioners eligible to seek reimbursement for CTS using CPT codes 96202–96203 and 9X015–9X016–9X017 could include a physician or a qualified health professional such as a nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS), or clinical psychologist (and, for therapy plans of care associated with the latter family of codes, a physical therapist, occupational therapist, or speech–language pathologist). NASW respectfully urges CMS to add clinical social workers to this list within the final rule. Clinical social workers are actively involved with the interdisciplinary team planning for home services and providing resources and support services with the patient and caregiver. They routinely diagnose and treat beneficiaries living with anxiety, bipolar disorder, depression, schizophrenia, and other mental health conditions. They frequently provide group-based and individual CTS in a variety of settings, including acute care hospitals, psychiatric hospitals, outpatient mental health settings, federally qualified health centers (FQHCs), rural health clinics (RHCs), home health agencies, hospice programs, nursing homes, private practice, and community-based organizations such as Area Agencies on Aging.

For example, clinical social workers frequently teach caregivers of beneficiaries living with various mental health conditions how to manage and modify a beneficiary's behavior. These CTS not only improve the quality of life for beneficiaries and caregivers, but also facilitate beneficiary participation in and adherence to the mental health treatment plan. As professionals who diagnose and treat such conditions, clinical social workers should be eligible to receive independent reimbursement for CTS associated with CPT codes 96202 and 96203:

multiple-family group behavior management/modification training services for caregivers of beneficiaries with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s).

As CMS has repeatedly stressed, interdisciplinary collaboration and care are integral to effective health care delivery. Clinical social workers not only bring psychosocial expertise and long-standing experience to CTS delivery, but also expand capacity to serve beneficiaries and caregivers. Thus, clarification within the final rule that clinical social workers are eligible to bill independently for CTS would provide helpful clarification to beneficiaries, caregivers, practitioners, and provider organizations.

Services Addressing Health-Related Social Needs

NASW applauds CMS for accelerating innovation by encouraging attention to the Social Determinants of Health (SDOH) through health care service delivery. These efforts will have a profound impact on health outcomes and advance health equity in the United States. NASW's comments on this subsection address three topics: Community Health Integration Services, SDOH Stand-Alone G-Code, and Principal Illness Navigation.

Community Health Integration (CHI) Services

- NASW supports the proposed G codes for CHI services. NASW agrees that staff who provide CHI services must have adequate competency-based training and preferably relevant certification or credentials before working with patients and families. Health systems also have a responsibility to provide comprehensive training to staff who assess and document social needs and risk factors to avoid unintended consequences. NASW supports a mechanism for patients and families to consent to CHI services and understand the way in which social needs will appear in the Electronic Medical Record.
- Social workers are key members of interdisciplinary health care teams and have expertise in addressing social needs and reducing health disparities.¹ They help patients with complex and chronic physical, mental, and behavioral health conditions resolve barriers to health care access and local support services. Social workers often serve as a bridge between health institutions and community resources. In the proposed rule, CMS mentions community health workers as eligible auxiliary personnel who will use CHI. NASW encourages CMS to clarify all eligible personnel, including social workers who may serve as case managers and care coordinators.
- NASW hopes that CHI services will be available to use at a range of visit types including evaluation and management (E/M) visits, annual wellness visits, and other visits including mental and behavioral health visits that social workers conduct. NASW

¹ De Saxe Zerden, L., Cadet, T. J., Galambos, C., & Jones, B. (2020). Social Work's Commitment and Leadership to Address Social Determinants of Health and Integrate Social Care into Health Care. *Journal of Health and Human Services Administration*, 43(3), 309–323. <https://www.jstor.org/stable/27202914>

encourages CMS to allow flexibility for CHI services to be delivered during in-person encounters, audio-video communication, and two-way audio to maximize accessibility for populations with a range of needs.

- NASW is also pleased to see that a code is available to contracted third-party services or community organizations that have clinical integration with the billing practitioner. NASW encourages CMS to allow more than one practitioner per beneficiary to use the CHI code within a month. For example, if a social worker in a health care institution is coordinating with a case manager in a contracted community nonprofit, it would be feasible that staff in both settings would benefit from using this code in a month.

Social Determinants of Health (SDOH)—Proposal to Establish a Stand-Alone G-Code

- NASW is pleased to see CMS propose a new code that recognizes the importance of SDOH-specific assessments to health care practices and patients. NASW agrees that the time to complete a SDOH assessment and discuss sensitive topics related to social risk factors is not yet reflected in current coding and payment options. Unaddressed social needs interfere with medical treatment, impact patient health and mental health, and can lead to physician burnout.²
- NASW urges CMS to add clinical social workers to the list of providers who may complete risk assessments. The social work profession was founded on a perspective that takes environmental factors into consideration and seeks to mitigate social risk.³ The National Academy of Medicine has recognized social work expertise in assessing and addressing social needs.⁴ In many settings across the health care continuum, social workers are responsible for taking social histories and using evidence-based SDOH risk assessment tools. Social workers are knowledgeable about community referral networks and recognize that follow-up is essential to ensure that individuals successfully connect with local supports. In addition to the suggested SDOH categories of food insecurity, housing insecurity, transportation needs, and utility difficulties, NASW agrees that practitioners should be culturally responsive and attend to other presenting issues, which may require attention to additional domains.
- On page 52331 of the NPRM, CMS has stated that the standardized, evidence-based SDOH Risk Assessment tool should be tested and validated through research and should include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties. NASW urges CMS to add “safety needs” to the list of required domains. This domain is included in multiple SDOH screening tools, including the

² Kung, A., Cheung, T., Knox, M., Willard-Grace, R., Halpern, J., Olayiwola, J.N., & Gottlieb, L. (2019). Capacity to Address Social Needs Affects Primary Care Clinician Burnout. *Ann Fam Med*. 2019 Nov;17(6):487-494. doi: 10.1370/afm.2470. PMID: 31712286; PMCID: PMC6846269.

³ De Saxe Zerden et al.

⁴ National Academies of Sciences, Engineering, and Medicine. 2019. *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25467>.

Accountable Health Communities Social Needs Screening Tool (AHC-SN),^{5,6} the Core Determinants of Health Screening Tool (Core5),^{7,8} the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE),⁹ and the Social Needs Screening Tool.¹⁰ Notwithstanding CMS' note that billing practitioners may choose to assess for additional domains, NASW believes that safety concerns are among the core issues that inform medical decision making, diagnosis, care, and treatment. For example, some physical, emotional, and cognitive symptoms may be signs of physical abuse, psychological abuse, sexual abuse, neglect, or other types of elder mistreatment¹¹ (including intimate partner violence¹²). A beneficiary may be reluctant to pursue medical treatment for fear of incurring resentment or even punishment from someone close to them. Similarly, a beneficiary may be unable to obtain necessary health care because of neglect by a close individual. Moreover, given the high prevalence and low reporting rate of elder abuse,¹³ increased detection of the problem would enhance the health of beneficiaries.

- NASW hopes that the SDOH Risk Assessment Code will be available to use at a range of visit types including E/M visits, annual wellness visits, and other visits including mental and behavioral health visits that social workers conduct. NASW encourages CMS to allow

⁵ Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). *Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool* [Discussion paper]. National Academy of Medicine. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>

⁶ Centers for Medicare & Medicaid Services. (n.d.). *The accountable health communities health-related social needs screening tool*. <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

⁷ Bradywood, A., Leming-Lee, S., Watters, R., & Blackmore, C. C. (2021). Implementing screening for social determinants of health using the Core 5 screening tool. *BMJ Open Quality*, 10(3), e001362. <https://doi.org/10.1136/bmj-oq-2021-001362>

⁸ Ohio Action Coalition. (2019). *Core determinants of health screening tool, aka the "Core 5."* https://cdn.ymaws.com/www.ohioleaguefornursing.org/resource/resmgr/ohio_action_coalition/ph_nurse_leader_project/Attachment_B_CDH_Screening_T.pdf

⁹ National Association of Community Health Centers & Association of Asian Pacific Community Health Organizations. (2022). *PRAPARE: Protocol for responding to & assessing patients' assets, risks & experiences*. <https://prapare.org/>

¹⁰ The EveryONE Project. (n.d.). *Social needs screening tool*. American Academy of Family Physicians. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-short-print.pdf

¹¹ National Center on Elder Abuse. (2017). *Red flags of abuse*. Administration for Community Living. Retrieved August 24, 2023, from the University of Southern California Center for Elder Justice website: http://eldermistreatment.usc.edu/wp-content/uploads/2018/03/NCEA_RedFlagsEA_508.pdf [Temporary link posted by USC (NCEA grantee) while the NCEA site, <https://ncea.acl.gov/>, is undergoing revision]

¹² National Clearinghouse on Abuse in Later Life. (2021). *Domestic violence across the lifespan: Supporting older survivors*. https://s3useast2.amazonaws.com/ncall/wpcontent/uploads/2021/10/25110836/DVLL_Final_October2021.pdf

¹³ National Center on Elder Abuse. (2017). *The facts of elder abuse*. Administration for Community Living. Retrieved August 24, 2023, from the University of Southern California Center for Elder Justice website: <https://drive.google.com/file/d/1PigKkBjmtGtxJsWUuzNwMZ49PiBYitWY/view> [Temporary link posted by USC (NCEA grantee) while the NCEA site, <https://ncea.acl.gov/>, is undergoing revision]

flexibility for the SDOH Risk Assessment Code to be used during in-person encounters or via telecommunications as appropriate.

- Additionally, NASW encourages CMS to reconsider its limitation of billing for administration of an SDOH Risk Assessment tool no more than once every six months. Many Medicare beneficiaries have limited income and assets: More than 15 percent have incomes below the federal poverty level (FPL), and another 25 percent have incomes between 100 and 200 percent of FPL.¹⁴ At least 18 percent of beneficiaries are dually enrolled in Medicaid.¹⁵ Nearly 3 million beneficiaries are eligible for, but not enrolled in, a Medicare Savings Program or the Part D Low-Income Subsidy (Extra Help).¹⁶ Out-of-pocket health care costs create a significant burden for the average Medicare beneficiary,^{17,18} and about 9 percent of beneficiaries (5.7 million people) have no prescription drug coverage.¹⁹ Given these realities, even one hospital bill or new medication can significantly alter a beneficiary's financial situation. Consequently, NASW urges CMS either to remove the billing limitation for SDOH risk assessment or to increase the frequency by which such assessments may be billed (such as on a quarterly basis).
- Health systems that implement SDOH Risk Assessments must ensure that staff are adequately trained and prepared to respond to identified needs. Social workers have a unique skillset in assessment and supporting individuals with unmet social needs--and health care teams should strive to include social work staff. Embedded social work

¹⁴ Tarazi, W., Welch, W. P., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., & Sommers, B. D. (2022). *Medicare beneficiary enrollment trends and demographic characteristics* [Issue brief] (HP-2022-08). U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy.

<https://aspe.hhs.gov/sites/default/files/documents/f81aafbb0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>

¹⁵ Centers for Medicare & Medicaid Services. (2022). *Medicare beneficiaries at a glance: 2022 edition*.

<https://data.cms.gov/infographic/medicare-beneficiaries-at-a-glance>

¹⁶ National Council on Aging. (2022). *Take-up rates in Medicare Savings Programs and the Part D Low-Income Subsidy*. <https://www.ncoa.org/article/take-up-rates-in-medicare-savings-programs-and-the-part-d-low-income-subsidy>

¹⁷ Ochieng, F., Fuglesten Biniek, J., Freed, M., Damico, A., & Neuman, T. (2023). *Medicare Advantage in 2023: Premiums, out-of-pocket limits, cost sharing, supplemental benefits, prior authorization, and star ratings*. KFF. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/>

¹⁸ Noel-Miller, C. (2023). *Beneficiaries in traditional Medicare: Out-of-pocket spending for health care* (Spotlight 1563402). AARP Public Policy Institute.

<https://www.aarp.org/content/dam/aarp/ppi/2023/3/beneficiaries-in-traditional-medicare-out-of-pocket-spending-for-health-care.doi.10.26419-2fppi.00184.001.pdf>

¹⁹ Tarazi, W., Welch, W. P., Nguyen, N., Bosworth, A., Sheingold, S., De Lew, N., & Sommers, B. D. (2022). *Medicare beneficiary enrollment trends and demographic characteristics* [Issue brief] (HP-2022-08). U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy.

<https://aspe.hhs.gov/sites/default/files/documents/f81aafbb0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>

services that address SDOH bring value to health care clinics, facilitate effective medical treatment, and are beneficial to providers and patients.²⁰

Principal Illness Navigation (PIN) Services

- Patient navigation is an evidence-based practice that helps to reduce health disparities.²¹ With its start in oncology services, the contributions of patient navigators, social work navigators, and nurse navigators have been well-documented. Patient navigators are a key component of care teams that work closely with providers to facilitate medical care, reduce barriers to services, address psychosocial needs, and support patients throughout the cancer continuum.²² In recent years, promising navigation practices have expanded to other chronic illnesses.
- NASW anticipates that CMS support for PIN services for patients with a serious high-risk condition or illness will lead to better health outcomes, improved collaboration between patients and providers, increased patient satisfaction, and a reduction in health disparities that often are present in complex systems of care. NASW agrees that staff who provide PIN services must have appropriate competency-based training and preferably relevant certification or credentials before working with vulnerable patients and families. The National Navigation Roundtable Workforce Development Task Group, convened by the American Cancer Society, has identified competency domains that can be used to further standardize training competencies for patient navigators.²³
- NASW requests clarification regarding training and certification that CMS considers appropriate for staff to deliver PIN services. CMS notes that most states have professional certification programs for peer support specialists to provide services to patients with substance use or mental health conditions. However, the skill set of patient navigators is distinct, and as described in the proposed rule, PIN services relate to serious medical conditions and high-risk diseases. NASW hopes that CMS will provide additional guidance on training and certification standards that prepare personnel to deliver PIN services.

²⁰ Kung, et al.

²¹ Dixit, N., Rugo, H., Burke, N.J. (2021). Navigating a path to equity in cancer care: the role of patient navigation. *Am Soc Clin Oncol Educ Book*. 2021; 41: 1-8. doi:10.1200/EDBK_100026

²² Oncology Nursing Society; Association of Oncology Social Work; National Association of Social Workers. (2010). Oncology Nursing Society, the Association of Oncology Social Work, and the National Association of Social Workers joint position on the role of oncology nursing and oncology social work in patient navigation. *Oncol Nurs Forum*. 2010; 37: 251-252.

²³ Valverde, P.A., Burhansstipanov, L., Patierno, S., Gentry, S., Dwyer, A., Wysocki, K.L., Patterson, A.K., Krebs, L.U., Sellers, J., & Johnston, D. (2019) Findings from the National Navigation Roundtable: A call for competency-based patient navigation training. *Cancer*. 2019 Dec 15;125(24):4350-4359. doi: 10.1002/cncr.32470

- NASW hopes that CMS will consider expanding the range of visit types that can initiate PIN services beyond E/M visits exclusively, such as annual wellness visits and those conducted by mental and behavioral health providers like social workers. NASW agrees that PIN services can occur under general supervision and ongoing PIN services, as indicated by a corresponding treatment plan, can be delivered as needed. NASW encourages CMS to allow flexibility for PIN services to be delivered during in-person encounters, audio-video communication, and two-way audio to maximize accessibility and allow for remote PIN services that benefit patients in underserved areas. NASW is pleased to see that PIN services can be used by contracted third-parties or community organizations that have clinical integration with the billing practitioner.
- NASW also supports a mechanism for patients and families to consent to PIN services with an understanding of the following information:
 - how these services will support their medical treatment
 - how the services will appear in the Electronic Medical Record to providers
 - with whom and in what capacity their information may be shared

Advancing Access to Behavioral Health (Section II.J)

Implementation of Section 4123 of the CAA, 2023: Crisis Services

NASW welcomes CMS' proposal to increase payment for crisis care, substance use disorder treatment, and psychotherapy. The association also supports the need for separate coding and payment for interventions initiated or furnished in the emergency department (ED) or other crisis setting for patients with suicidality or at risk of suicide. Mental health services are often not reimbursed at the same rate as other medical services, leading to a shortage in mental health resources and a lack of prioritization for mental health crises. Separate coding and payment for interventions in the ED or other crisis setting could allow providers to better identify and address the needs of patients with suicidality or at risk of suicide, while also providing financial incentives for providers to provide care in those settings. This would help ensure that individuals with mental health issues are treated with the same seriousness and urgency as those with physical health problems.

Patients who enter the ED with the presenting problem of suicidality or at risk of suicide deserve to have a safety plan intervention especially if they are returning to their environment after discharge. Mental health services provided to patients who are at risk for suicide are comprehensive and not captured by coding in the ED. New coding to address this growing diagnosis would assist in correctly identifying the problem and provide structure for patients experiencing suicide. In cases of suicidal risk, it is best practice to perform a follow-up telephone call within 24 hours of discharge or earlier to help ensure the safety of the patient. Having a code to identify this follow-up service would also be helpful in tracking this service and improve the quality of care.

NASW agrees with the proposal to increase the valuation for timed behavioral health services under the Physician Fee Schedule (PFS) and believes this is an important step towards providing

more equitable payments for all providers of mental health services and increasing patient access to essential mental health services.

NASW supports the creation of new G-codes [HCPCS codes GPFC1 and GPFC2] describing psychotherapy for crisis services furnished in any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, and services can be provided through telecommunication technology as long as patients can be provided with services that maintain their privacy and confidentiality.

NASW recognizes the need to strengthen the workforce to address increasing mental and behavioral health needs of Medicare beneficiaries. More clarification is needed regarding the role of peer specialists and their provision of mental health services. Social workers, including clinical social workers, are invaluable members of crisis services teams. They are well versed in resources available in the community, which can help people facing a crisis find ways to cope. In addition, their expertise in the psychosocial, emotional, and behavioral aspects of crisis are essential to providing comprehensive, effective crisis services.

Health Behavior Assessment and Intervention (HBAI) Services

NASW is appreciative of CMS' proposal to allow clinical social workers to receive reimbursement for HBAI services beginning January 2024. Thank you for your recognition that clinical social workers are valuable providers of HBAI services. This change is warranted and long overdue, with NASW having advocated for many years in its support. Finalization of this proposal will have a profound impact through the provision of counseling, assessment, treatment, and management of physical health problems that will allow beneficiaries access to emotional and behavioral services by clinical social workers. This will empower them to make informed decisions about their health care.

Update to the Payment Rate for the PFS Substance Use Disorder (SUD) bundle (HCPCS codes G2086-G2088)

NASW supports the increase in the current SUD payment rate to reflect two individual psychotherapy sessions per month, from 30 minutes with patient to 45 minutes with patient.

Comment Solicitation on Expanding Access to Behavioral Health Services

Advance Care Planning (ACP) Services

Beneficiary engagement in ACP promotes self-determination, which is integral to mental and emotional well-being. ACP can also ease the uncertainties associated with a serious or advanced illness and enhance the ability of caregivers to support beneficiaries living with such illnesses. Moreover, ACP services are integral to person-centered care and treatment not only of physical health conditions, but also of mental health conditions.

NASW appreciates CMS' recognition that ACP services may be provided using a team-based approach and that such teams often include social workers. In our comments on the proposed PFS for CY 2016 (CMS-1631-P), we provided extensive information regarding the psychosocial expertise required for effective ACP service delivery and the research base supporting the social

work role in ACP services.²⁴ We noted that some payers had already begun reimbursing social workers for such services²⁵ and that the editorial board of one prominent newspaper had called for Medicare reimbursement for clinical social worker facilitation of advance care planning conversations.²⁶ CMS authorization of direct reimbursement to clinical social workers for ACP services would expand beneficiary access to those services, thereby enhancing behavioral health.

Care Management Services

NASW appreciates CMS' recognition that care management services are integral to effective behavioral health care. We have welcomed CMS' initiatives to implement and strengthen Medicare reimbursement for chronic care management services (CCM), principal care management services (PCM), transitional care management services (TCM), and chronic pain management and treatment services (CPM).

As prior final rules and associated educational materials issued by CMS have made clear, delivery of care management services is often an interdisciplinary effort. NASW appreciates CMS' recognition that clinical social workers are among the disciplines who provide care management services within their scope of practice under the general supervision of a physician, NP, PA, or CNS. We are concerned, however, that the current billing structure restricts beneficiary access to care management services. Although care management services for some beneficiaries may require direct implementation or general supervision by a physician, NP, PA, or CNS, in some circumstances a beneficiary's needs may align best with care management services provided by another clinical staff member, such as a clinical social worker. Accordingly, we encourage CMS to authorize clinical social workers to obtain independent reimbursement for care management services.

Resident Access to Mental Health Services Provided by Independent Clinical Social Workers under Medicare Part B

NASW has been working for years to remove the restriction that prohibits beneficiaries who receive SNF services under Medicare Part A from accessing mental health services provided by independent clinical social workers under Medicare Part B. We call to CMS' attention the following recommendation from the 2022 National Academies of Sciences, Engineering, and Medicine (NASEM) nursing home study:

²⁴ McClain, A. (2015). *NASW comments regarding payment policies under the physician fee schedule and other revisions to Part B for the CY 2016 NPRM (CMS-1631-P)*. National Association of Social Workers. <https://www.socialworkers.org/LinkClick.aspx?fileticket=sNrU8pmSw3g%3d&portalid=0>

²⁵ Belluck, P. (2014, August 30). Coverage for end-of-life talks gaining ground. *The New York Times*. https://www.nytimes.com/2014/08/31/health/end-of-life-talks-may-finally-overcome-politics.html?emc=edit_hh_20140902&nl=health&nid=59798532&r=1

²⁶ Boston Globe Editorial Board. (2015, July 20). Making the end of life part of health care. *The Boston Globe*. <https://www.bostonglobe.com/opinion/editorials/2015/07/19/making-end-life-part-health-care/1USjMcW8H2aFsh1BZWQ8K/story.html>

Recommendation 2D: To enhance the available expertise within a nursing home:

- Nursing home administrators, in consultation with their clinical staff, should establish consulting or employment relationships with *qualified licensed clinical social workers at the M.S.W. or Ph.D. level* [emphasis added], advanced practice registered nurses (APRNs), clinical psychologists, psychiatrists, pharmacists, and others for clinical consultation, staff training, and the improvement of care systems, as needed.
- The Centers for Medicare & Medicaid Services should create incentives for nursing homes to *hire qualified licensed clinical social workers at the M.S.W. or Ph.D. level as well as APRNs for clinical care* [emphasis added], including allowing Medicare billing and reimbursement for these services.²⁷

One of the most acute problems posed by the existing restriction is illustrated when a Medicare beneficiary is unable to continue mental health treatment with a clinical social worker when they are transferred to a skilled nursing facility from a nursing home. As you are aware, a beneficiary in a nursing home bed can be transferred unexpectedly to a skilled nursing bed within the same day, building, room, and bed. When the beneficiary is receiving mental health treatment from a clinical social worker, services must stop abruptly causing the Medicare beneficiary to suffer the loss of mental health services and their provider when continuous mental health treatment is needed. As a result, the beneficiary feels abandoned during a critical time of declining health and loss of mental health treatment.

In the June 28, 2002, Proposed Rule 67 FR 43845, CMS indicated it would address comments received on the October 29, 2000, Proposed Rule entitled, "Clinical Social Worker Services." In the final rule dated December 31, 2002 (65 62681) of the Federal Register, Vol. 67, No. 251, CMS announced that it would not add this issue to the final rule but would consider doing so in future rulemaking. The future rulemaking has not taken place and NASW encourages CMS to address this issue in the 2024 Physician Fee Schedule final rule. We appreciate CMS' consideration of this long-standing barrier to beneficiary mental health care and urge the agency to expand mental health services provided by clinical social workers to residents requiring mental health care in a skilled nursing facility.

With CMS having implemented regulations permitting marriage and family therapists and mental health counselors to provide independent mental health services to Medicare beneficiaries placed in skilled nursing facilities, NASW urges CMS to build on this step by permitting clinical social workers to do the same.

Reimbursement Rates

NASW supports CMS' proposal to increase psychotherapy reimbursement over a four-year period. The need for mental health services increased during and after the pandemic. Improving reimbursement rates would help recruit and retain clinical social workers, reduce mental health

²⁷ National Academies of Sciences, Engineering, and Medicine. (2022). *The national imperative to improve nursing home quality: Honoring our commitment to residents, families, and staff*. National Academies Press. <https://doi.org/10.17226/26526> [Quote is from p. 512]

shortages, and improve access to mental health care in the Medicare program. This reimbursement increase is particularly warranted in light of recent year cuts and NASW urges finalization; however, NASW highlights that the current 75% reimbursement rate applicable to clinical social worker services remains a tremendous barrier to participation in the Medicare program. NASW urges CMS to work with NASW to explore additional policy changes to increase Medicare reimbursement for clinical social workers and remove barriers to participation.

Request for Information on Digital Therapies, Such as, But Not Limited to, Digital Cognitive Behavioral Therapy

The use of digital therapies, such as digital Cognitive Behavioral Therapy (dCBT), may be an adjunct to traditional therapies under the guidance of a trained clinician such as a clinical social worker by providing patients with more tailored support, such as 24-hour access to mental health resources. However, there are several factors to consider when utilizing dCBT or other digital therapies as a primary or supplemental treatment for mental and behavioral health conditions. For instance, patient technology should not replace the therapeutic relationship between a provider and patient. It is also important to identify what types of patients are best suited for dCBT or other digital therapies and which ones require more in-person treatment. Additionally, some patients may not have access to the technology or equipment for digital therapy. Furthermore, it is important to understand the clinical and technical competencies needed to provide digital therapies safely and any relevant ethical and legal considerations associated with providing digital mental health services. Technology should be user-friendly to accommodate those with various ability levels, literacy, and language proficiency. Lastly, there is a potential for misuse of self-treating tools, which can lead to dangerous outcomes. NASW encourages the continued evaluation of these services to ensure their efficacy in patient care. The association commends CMS for its consideration of digital services in the workplace.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (Section III.B)

NASW was pleased to see CMS' proposal to extend payment for telehealth services furnished in RHCs and FQHCs and delay the in-person requirements under Medicare for mental health visits furnished in these settings. Extending payment for telehealth services provided in RHCs and FQHCs and delaying the in-person requirements under Medicare for mental health visits in these settings can help to ensure that vulnerable communities have continued access to essential health care services. Social workers, including clinical social workers, offer a unique and valuable set of skills when it comes to providing care in RHCs and FQHCs. Social workers are experienced professionals who specialize in psychosocial and emotional healthcare. They have the unique ability to help individuals, families, and communities understand and cope with complex social and emotional issues, which can have significant impacts on health outcomes. NASW encourages CMS to consider the complexity of the service, the skills and training of the personnel performing the service when determining requirements for the type of patient and provider supervision. The association recommends consideration of digital therapies for all modalities of treatment.

Medicare and Medicaid Provider and Supplier Enrollment (Section III.K)

NASW concurs with CMS regarding the importance of confirming that providers and suppliers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable federal and state requirements to do so. Thus, we support the following proposals:

- changing the language at existing § 424.535(a)(1) to clarify that providers and suppliers must adhere to all enrollment requirements, regardless of their placement in title 42, or risk revocation; we also support the corresponding proposed change to § 424.530(a)(1), which addresses reasons for denial of Medicare enrollment
- adding new §§ 424.535(a)(16)(i) and 424.535(a)(16)(ii) stipulating that CMS may revoke or deny enrollment if a provider or supplier, or any owner, managing employee or organization, officer, or director thereof, has been convicted (as that term is defined in 42 C.F.R. 1001.2) of a misdemeanor under federal or state law within the previous 10 years that CMS deems detrimental to the best interest of the Medicare program and beneficiaries; such offenses would include, but not be limited in scope or severity to, the following three crimes:
 - (1) fraud or other criminal misconduct involving the provider's or supplier's participation in a federal or state health care program or the delivery of services or items therein
 - (2) assault, battery, neglect, or abuse (including sexual abuse) of a person served
 - (3) any other misdemeanor that places the Medicare program or beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct
- adding text to § 424.535(a)(15) and creating a new § 424.530(a)(17) stipulating that CMS could revoke or deny the enrollment of a provider or supplier if the provider or supplier, or any owner, managing employee or organization, officer, or director thereof, has had a civil judgment under the False Claims Act (FCA, 31 U.S.C. 3729-3733) imposed against them within the previous 10 years
- adding to § 424.535(g)(2) the preceding requirements of § 424.535(a)(23) and the following additional situations warranting a retroactive effective date for revocation:
 - (1) revocations under proposed § 424.535(a)(16), regarding misdemeanor convictions
 - (2) revocations based on a state license surrender in lieu of further disciplinary action
 - (3) revocations based on termination from a federal health care program other than Medicare (such as Medicaid)
- adding text to the existing § 424.535(a)(23) and creating a new § 424.530(a)(18) to address revocation and denial would be retroactive in the following circumstances:
 - (1) If the standard or condition violation involved the suspension, revocation, or termination (or surrender in lieu of further disciplinary action) of the provider's or supplier's federal or state license, certification, accreditation, or MDPP recognition, wherein the revocation or denial effective date would be the date of the license, certification, accreditation, or MDPP suspension, revocation, termination, or surrender.

- (2) If the standard of condition violation involved a nonoperational practice location, the revocation or denial effective date would be the date the nonoperational status began.
 - (3) If the standard violation involved a felony conviction of an individual or entity described in § 424.67(b)(6)(i), the revocation or denial date would be the date of the felony conviction.
- expanding existing § 424.555(b) to reflect that providers and suppliers currently under a stay of enrollment may not receive payment for Medicare services and items furnished to a beneficiary; the current language includes deactivated, denied, or revoked providers and suppliers

We concur with CMS that these requirements would prevent payment for services rendered while providers or suppliers were noncompliant with enrollment requirements.

Additionally, NASW strongly supports CMS' proposal to define "indirect ownership interest" in § 424.502.

Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs) (Section III.F)

NASW supports CMS' proposal to continue to allow OTPs to furnish substance use counseling and individual and group therapy via audio-only telephone calls when audio and video communication technology is not available to the beneficiary through the end of CY 2024. This accommodation provides needed and continued care in various underserved communities and to individuals who are aging and have limited access to care. Allowing continued support through audio only promotes health equity and decreases disparities in access.

Hospice: Changes to the Hospice Conditions of Participation (Section III.O)

The Consolidated Appropriations Act (CAA) of 2023, extended the opportunity for Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) to serve on interdisciplinary hospice teams, and NASW is glad to see that hospice organizations have the flexibility to determine staffing based on the needs of their population. Social workers have a long history of working within interdisciplinary hospice teams as recommended in the widely adopted *National Consensus Project Clinical Practice Guidelines for Quality Palliative Care*.²⁸ In addition, the *NASW Standards for Palliative & End of Life Care*, and other standards recognize the unique role of social workers who have training in the person-in-environment and life course perspectives and understand complex health systems and community resource networks.²⁹

²⁸ The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition 2018. Available from <https://www.nationalcoalitionhpc.org/ncp/>.

²⁹ National Association for Social Workers Standards for Palliative & End of Life Care 2004. Available from

Social workers at all levels (Bachelors, Masters, and Clinical), serve as important providers in palliative and hospice care services.³⁰ Over the past twenty years, the social work profession has recognized hospice and palliative care as a specialty area of practice through expanded opportunities for clinical training and advanced certification. The growth of advanced practice credentials and certifications further highlight social work expertise in this area and mirror specialty certifications of nurses and physicians including the NASW Palliative Care Credential (AHP-SW) and Advanced Palliative Hospice Social Worker – Certified (APHSW-C).³¹ Social workers bring critical experience and expertise to interdisciplinary hospice care teams in hospitals and community settings.

A Social Determinants of Health Risk Assessment in the Annual Wellness Visit (Section III.S)

NASW strongly supports CMS’s proposal to add a new SDOH Risk Assessment to the annual wellness visit (AWV). We agree that the assessment must be standardized, evidence based, and furnished in a manner that all communication with the beneficiary be culturally and linguistically appropriate, including for the individual’s developmental, educational, and health literacy level.

NASW concurs that the assessment would be an additional element of the AWV, meriting an additional payment to practitioners. We also agree that beneficiary cost sharing would not apply to the SDOH Risk Assessment when conducted in the context of the AWV. However, we encourage CMS to enable elements of the AWV to be completed over multiple visits and days rather than in a single visit on a single day. This flexibility would enable primary care practices (including FQHCs and RHCs) to maximize the participation of social workers and other professionals in the AWV, thereby promoting integrated care.

Furthermore, we encourage CMS to consider making the SDOH Risk Assessment a mandatory element within the AWV and increasing reimbursement rates for the AWV accordingly. Social risk factors are common among Medicare beneficiaries and, as CMS has noted in the NPRM, around 50 percent of an individual’s health is directly related to SDOH.³² Routine incorporation

<https://www.socialworkers.org/Practice/NASW-Practice-Standards-Guidelines/Standards-for-Palliativeand-End-of-Life-Care>

³⁰ Glajchen, M., Berkman, C., Otis-Green, S., Stein, G.L., Sedgwick, T., Bern-Klug, M., Christ, G., Csikai, E., Downes, D., Gerbino, S., Head, B., Parker-Oliver, D., Waldrop, D., & Portenoy, R.K. (2018). Defining Core Competencies for Generalist-Level Palliative Social Work. *J Pain Symptom Manage.* 2018 Dec;56(6):886-892. doi: 10.1016/j.jpainsymman.2018.09.002. Epub 2018 Sep 7. PMID: 30201485.

³¹ Dahlin, C. (2023). Interprofessional Specialty Palliative Care Education and Training. *Curr Geri Rep* 12, 40–49 2023. <https://doi.org/10.1007/s13670-023-00381-9>

³² Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022). *Addressing social determinants of health: Examples of successful evidence-based strategies and current federal efforts* [Report] (HP-2022-12). <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>

of the SDOH Risk Assessment within the AWW would reduce barriers and expand access to health care, thereby promoting health equity and improving care for historically underserved populations.

As stated earlier in this comment letter, NASW urges CMS to add clinical social workers as one of the providers to perform SDOH Risk Assessments.

Proposals on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Specific Covered Services (Section II.K)

NASW applauds CMS for continuing to recognize the need to maximize its authority to cover medically necessary dental care in Medicare. Dental problems that are caused by a medical condition or treatment—or that could jeopardize a beneficiary’s medical condition or treatment—can have catastrophic consequences for beneficiaries. Moreover, Medicare’s lack of dental coverage makes oral health care unaffordable for millions of beneficiaries³³ and exacerbates underlying disparities related not only to disability,³⁴ but also to ethnicity and race.³⁵

Therefore, NASW strongly supports the proposal to clarify and codify CMS’ authority to cover “medically necessary” dental care related to cancer treatment in Medicare. More specifically, we support the proposals to permit Medicare Parts A and B payment for dental services offered in either inpatient or outpatient settings under the following conditions:

- before or during chemotherapy, CAR T-cell therapy, or antiresorptive therapy, regardless of whether chemotherapy is used in combination with other cancer therapies
- when one or more of the preceding therapies is used to treat any type of cancer, regardless of primary or metastatic cancer status or site of origin

We urge CMS to include dental services related to radiation treatment for cancer in the final rule.

NASW appreciates CMS’ request for information regarding Medicare coverage of additional dental services before or during treatment for additional diseases and conditions. We encourage CMS to consider autoimmune conditions, cardiovascular disease, diabetes, hemophilia, and sickle cell disease among the clinical scenarios for which medically necessary

³³ 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>

³⁴ 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>

³⁵ Christ, A., Burke, G., & Goldberg, J. (2019). *Adding a dental benefit to Medicare: Addressing racial disparities*. Justice in Aging. <https://www.justiceinaging.org/wp-content/uploads/2019/10/Addressing-Oral-Health-Equity-by-Adding-a-Dental-Benefit-to-Medicare.pdf>

dental care could be covered. We also encourage CMS to consider including dental services related to specific medical treatments that may apply under the medical necessity coverage standard, regardless of the associated diagnosis. For example, chemotherapy is used to treat certain blood disorders and autoimmune diseases in addition to cancer; consequently, dental services related to chemotherapy may make sense to cover when such services are inextricably to chemotherapy to treat noncancerous conditions.

NASW also appreciates CMS' request for information regarding implementation of payment for dental services inextricably linked to other specific covered services. We encourage CMS to engage in the following actions:

- Continue to educate providers about these clarifications to Medicare payment policy for dental and oral health services.
- Take steps to promote coordination of this benefit across providers and payers.
- Clarify that beneficiaries may access this dental and oral health coverage regardless of the site of care, including in FQHCs.

Continued clarification of Medicare-covered dental and oral health services would improve equitable access to dental services and lead to better health outcomes, consistent with the Administration's goals of increasing equitable access to affordable, high-quality health care.^{36,37} Moreover, it would help to build the infrastructure and provider participation that would support a full Medicare dental benefit, should such a benefit be enacted by Congress at some point.

Drugs and Biological Products Paid Under Medicare Part B (Section III.A)

NASW supports CMS' proposed conforming changes to regulatory text to reflect two provisions of the Inflation Reduction Act (Pub. L. 117–169):

- Section 11101, which requires that, as of April 1, 2023, beneficiary coinsurance for a Part B rebatable drug is to be based on the inflation-adjusted payment amount if the Medicare payment amount for a calendar quarter exceeds the inflation-adjusted payment amount; CMS has previously issued initial guidance implementing the provision.
- Section 11407, which provides that for insulin furnished through a durable medical equipment item on or after July 1, 2023, the deductible is waived and coinsurance is limited to \$35 for a month's supply; CMS has implemented this provision under program instruction for 2023

³⁶ Office of Minority Health. (2022). *CMS framework for health equity 2022–2032*. Centers for Medicare & Medicaid Services. <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>

³⁷ U.S. Dept. of Health and Human Services. (2022). *Strategic plan FY 2022–2026*. <https://www.hhs.gov/about/strategic-plan/2022-2026/index.html>

Medicare Shared Savings Program (Section III.G)

NASW supports CMS's proposal to require Spanish-language administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for Merit-Based Incentive Payment Systems (MIPS) (Section 2.g). We encourage CMS to consider the addition of other survey languages in future rulemaking.

Medicare Part B Payment for Preventive Vaccine Administration Services (Section III.H)

NASW appreciates CMS's study analyzing use of the billing code indicating that a COVID-19 vaccine was administered in the home. We agree that such in-home administration improves access to vaccines for underserved groups of Medicare beneficiaries, such as those who are dually eligible for Medicare and Medicaid and those who are 85 years or older. Accordingly, NASW supports the following proposals by CMS:

- Maintain the in-home additional payment for COVID-19 vaccine administration under the Part B preventive vaccine benefit.
- Extend the additional in-home payment to the administration of the other three preventive vaccines included in the Part B preventive vaccine benefit (hepatitis B, influenza, and pneumococcal vaccines).
- Limit the additional reimbursement to one payment per home visit, regardless of the number of vaccines administered.

Medicare Diabetes Prevention Program (Section III.I)

The Medicare Diabetes Prevention Program (MDPP) is an important health promotion tool for beneficiaries. NASW supports the following CMS proposals:

- extension of the flexibilities allowed under the COVID-19 public health emergency through December 31, 2027
- application of extended flexibilities only to MDPP suppliers that have and maintain CDC certification as Diabetes Prevention Recognition Program (DPRP)
- addition of definitions for distance learning and online delivery modalities in § 410.79(b) to clarify which virtual modalities can be used in the proposed extended flexibilities period (we are not, however, recommending which virtual modalities *should* be used)
- creation of a new HCPCS G-code specific to distance learning, which will enable CMS to track trends related to this service delivery modality
- enabling MDPP suppliers to deliver the program through both in-person and distance learning.

We agree with CMS that extending these flexibilities would increase equitable access to diabetes preventive services among rural and at-risk beneficiaries.

Expand Diabetes Screening and Diabetes Definitions (Section III.L)

In 2019, about 11 percent of the population of the United States, or 37.3 million people, had diabetes; of that number, 8.5 million were undiagnosed.³⁸ The condition (both diagnosed and undiagnosed) was even more prevalent—about 29 percent of the population, or 15.9 million people—among adults 65 years and older. Moreover, 96 million adults 18 years or older had prediabetes in 2019.

Given the prevalence of diabetes and prediabetes and the potentially severe consequences of diabetes, NASW supports the following CMS proposals:

- addition of the Hemoglobin A1C (HbA1c) test to the types of diabetes screening tests covered under § 410.18(c), consistent with the recommendations of the U.S. Preventive Services Task Force and input offered by the American Diabetes Association and other diabetes-focused organizations
- simplification of frequency limitations for diabetes screening by enabling a beneficiary who was previously diagnosed with prediabetes to obtain up to two diabetes screening tests within a 12-month period rather than within a calendar year

Quality Payment Program (QPP)

RFI seeking comment on potential approaches to, and considerations for, public reporting

Public Reporting: Telehealth Indicators

NASW supports CMS' proposed modification to existing public reporting policies regarding telehealth indicators which will provide patients with more accurate and timely information when making healthcare decisions. The most recent place of service and billing codes that are available at the time of information refresh will provide the most comprehensive insight about telehealth services that clinicians are furnishing. In addition, this policy modification will also provide greater flexibility to ensure that the telehealth indicator is reporting the appropriate telehealth services.

³⁸ American Diabetes Association. (2022). *Statistics about diabetes*. <https://diabetes.org/about-us/statistics/about-diabetes> [This reference supports the subsequent statistics in the paragraph]

Public Reporting: Utilization Data

NASW supports CMS' proposals to modify their policies about publicly reporting utilization procedures on clinician profile pages. This proposed change will provide patients with more accurate and meaningful information when selecting clinicians for their healthcare needs. The ability to select clinicians based on specific procedures performed, as well as including Medicare Advantage data in the counts, will enable patients to make more informed decisions about their health care providers. In addition, the proposed changes will also reduce redundancy to provide a more streamlined process for publicly reporting utilization data. We believe the proposed changes will greatly benefit patients and clinicians alike by providing more accurate and useful information.

Transparency should be a key element of any public reporting system. Appropriate mechanisms should be in place to ensure that the data reported is accurate and unbiased, and that healthcare providers are held to a high standard of disclosure and accuracy. CMS could also consider providing training and assistance to providers to ensure that they understand the public reporting requirements and how to properly submit data. This could help to reduce the burden on providers and ensure that the data is accurate when it is submitted.

RFI on how we might be able to change performance standards to encourage clinicians to continuously improve care, particularly clinicians with little room for improvement under MIPS

NASW appreciates CMS for continuing to allow clinical social workers to be automatically reweighed in the Merit-based Incentive Payment System (MIPS) Promoting Interoperability Performance category. The association also appreciates CMS' efforts to add to the clinical social work specialty skill set and agrees with the proposed measure. Such measures are needed to obtain meaningful data and promote quality care. NASW is concerned about the proposed increase for the performance threshold from 75 to 82 points for the 2024 MIPS performance period/2026 MIPS payment year. The association understands this is a statutory requirement increase but is concerned that an increase this significant could make program participation more challenging as participants will have to achieve a score of 82 in order to avoid a negative payment adjustment. NASW appreciates CMS including automatic reweighting opportunities for providers and notes the inclusion of complex patient bonus for subgroups. Such efforts are helpful to participants. The association asks CMS to consider re-evaluating the scoring structure to ensure providers can successfully participate in the QPP while delivering quality patient care.

RFI on the future of QPP, specifically the future of MVPs, the alignment across QPP and the Medicare Shared Savings Program

NASW commends CMS' efforts to improve MIPS Value Pathways (MVPs) need to better meet the needs of clinicians and the patients they serve. NASW would like to commend CMS for their commitment to the QPP and for their ongoing efforts to include more measures in the clinical social work measure set related to behavioral health and substance use. The future of MVPs in the QPP is an important step forward to ensure alignment in quality measurement across the program. In addition, NASW appreciates CMS' commitment to improving the Shared Savings Program and its goals of creating a sustainable system that addresses the needs of both providers and beneficiaries. The association is encouraged that CMS is continuing to prioritize

the importance of addressing Social Determinants of Health in the Quality Payment Program. Adding additional social work measures to the QPP is an important step forward. NASW believes these measures can assist clinicians in providing comprehensive, quality care for their patients and will ultimately help to improve our healthcare system.

We agree that these proposals will expand access to quality care and improve health outcomes for beneficiaries.

Thank you for the opportunity to provide comments on this proposed rule. If you have any questions, please do not hesitate to contact me at bbedney.nasw@socialworkers.org

Sincerely,

Barbara Bedney, PhD, MSW

Barbara Bedney, PhD, MSW
Chief of Programs