COUNCIL ON SOCIAL WORK EDUCATION
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January 26, 2016

The Honorable Orrin Hatch
Chairman, Senate Committee on Finance
104 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Senate Committee on Fin
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senator
131 Russell Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senator
475 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

On behalf of the Council on Social Work Education (CSWE), thank you for the opportunity to comment on the Bipartisan Chronic Care Working Group Policy Options Document. I value the opportunity to provide comments to the Working Group of behalf of CSWE.

Social workers are not only important to patients with chronic conditions, who often require complex care and services, but also to their families and/or caregivers. Social workers help address the holistic care of patients, ensuring that the full needs of each individual are met. Furthermore, social workers are important and effective members of care coordination teams helping improve the wellbeing and health outcomes of individuals with chronic conditions.

To the aforementioned point, CSWE would like to respond to the request for input relating to ***Improving Care Management Services for Individuals with Multiple Chronic Conditions***, specifically the types of providers who should be eligible to bill with the new high severity chronic care code. As outlined in the Policy Options Document, the Working Group is considering a new code to reimburse clinicians for coordinating care outside of a face-to-face encounter for beneficiaries living with multiple chronic conditions. The Working Group notes that managing multiple chronic conditions requires increased levels of patient and provider interaction beyond the typical in person visit that often includes practice team members such as social workers, dieticians, nurses, and behavioral health specialists. CSWE concurs with this point and stresses the importance in including social workers in the types of providers who should be eligible for the new billing code.

In this time of healthcare transformation, coordinated interprofessional team-based care is vital for improving health and health outcomes; however, reimbursement that does not recognize the providers critical to coordinating care for patients creates barriers to successful care and treatment. CSWE encourages the Working Group to include social workers in this code because of their vital roles in providing care and coordinating healthcare and services. For example, social workers provide care and services such as health assessments, counseling, helping beneficiaries plan and manage their healthcare, assisting beneficiaries to adhere to their medical and medication plan, serving as a vital link between

beneficiaries and vital social services, and addressing social determinants that impact their health and healthcare.

In addition to these comments, I would like to direct you to the attachment, which provides recommendations to the Working Group on this document from the National Association of Social Workers (NASW). CSWE is pleased to endorse these comments and hopes you will give serious consideration to including these comments in new policies for chronic care. CSWE is a nonprofit national association representing more than 2,500 individual members, as well as graduate and undergraduate programs of professional social work education. "The National Association of Social Workers (NASW) is the largest membership organization of professional social workers in the world, with 132,000 members. NASW works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies." While a separate organization, CSWE appreciates their thoughtful comments on this issue, which would enhance the environment in which future social workers would provide care and services to individuals who receive care for chronic conditions.

Thank you again for this opportunity to provide comments. Please do not hesitate to reach out to me if you have questions and would like further information.

Sincerely,

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NASW comments to the Senate Committee on Finance Bipartisan Chronic Care Working Group
Submitted January 28, 2016

NASW appreciates the opportunity to submit comments regarding the policy options document posted by the Senate Committee on Finance Bipartisan Chronic Care Working Group on December 18, 2015. As the largest membership organization of professional social workers in the world, NASW works to enhance the professional growth and development of its 132,000 members, to create and maintain professional standards, and to advance sound social policies.

Social workers are core members of interdisciplinary care teams across health care settings and, consequently, play integral roles in improving health outcomes for Medicare beneficiaries. NASW offers the following feedback on select policy options proposed by the working group.

Expanding the Independence at Home model of care (p. 6)
NASW has long maintained that coordinated, team-based care can improve health outcomes for older adults. As the working group considers expanding the Independence at Home (IAH) demonstration into a permanent, nationwide program, NASW urges the working group to modify the program to incorporate social workers as core members of the IAH team.

Social workers are the only health care professionals devoted exclusively to addressing the psychosocial needs of Medicare beneficiaries and family caregivers—needs that are increasingly understood to influence health outcomes. In its 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" (IOM, 2007, p. 9).

Social workers perform multiple roles within interdisciplinary primary care teams, including case management and care coordination, medically related social services, education of beneficiaries and families, discharge and transition planning, advance care planning, and community outreach and engagement. A recent systematic review examining the impact of social work interventions in aging, as documented in 42 studies published between 2004 and 2012, found that 71 percent of the studies reported significant outcomes in improving quality of life. Of the 21 studies that addressed cost outcomes, 15 (71.4 percent) documented significant cost savings; of that subset, 12 studies (80 percent) addressed health-related social work interventions, such as care coordination and end-of-life/palliative care (Rizzo & Rowe, 2014).

The following primary care models illustrate successful interdisciplinary efforts that incorporate social workers.

GERIATRIC RESOURCES FOR ASSESSMENT AND CARE OF ELDERS (GRACE). The GRACE model of primary care includes a nurse practitioner–social worker care coordination team, which works closely with primary care physicians and a geriatrician (American Hospital Association, 2012). The program, which is being replicated nationally (Counsell,

2011b), has been featured in both the Agency for Healthcare Research and Quality's (AHRQ's) Health Care Innovations Exchange ("Team-developed care," 2009) and the American Hospital Association's report *Caring for Vulnerable Populations* (2011). A randomized controlled trial of GRACE demonstrated decreased use of the emergency department, lower hospitalization rates, and enhanced quality of life among older adults participating in the program, as compared with those in control groups (Counsell et al., 2007). Moreover, the program yielded cost savings in the third year of the three-year clinical trial, preceded by two years of cost neutrality (Counsell, Callahan, Tu, Stump, & Arling, 2009). The integration of medical and social care is cited as one of the keys to GRACE's success (Counsell, 2011).

HOME BASED PRIMARY CARE (HBPC). HBPC, created by the Department of Veterans Affairs (VA), provides comprehensive primary care to veterans in their homes. Social workers are part of the HBPC interdisciplinary team. Outcomes of the program include improved veteran functional status and satisfaction, reduction in costs to the VA, and reduction in days spent in both hospital and nursing home (Beales & Edes, 2009; see also Edes, 2011, and Egan, 2012).

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE). Social workers also play integral roles in the PACE model, which provides primary care and other services to help individuals 55 years and older maintain independence in their homes and communities. Program outcomes include effective and efficient processes for complex primary care, high participant and family caregiver satisfaction, improved participant health status and mortality rates, reduction in preventable hospitalizations, and cost savings to Medicare and Medicaid (National Pace Association, 2016).

At this time, social work participation in IAH programs varies and data about such participation is limited. NASW urges (1) incorporation of professional social workers—defined as individuals with a bachelor's or master's degree in social work from a program accredited by the Council on Social Work Education (NASW, 2005, 2010, 2013)—in all future IAH demonstration sites and (2) integration of professional social work in any permanent program providing home-based primary care to older adults.

Providing Medicare Advantage enrollees with hospice benefits (p. 8)

NASW concurs with the working group that access to high-quality hospice care is essential for all Medicare beneficiaries. However, the association is concerned that the working group's proposal to "carve in" hospice to Medicare Advantage (MA) could have negative repercussions for MA beneficiaries.

- Limited MA networks would limit beneficiary choice of provider, which is especially important in end-of-life care. For example, an MA plan might exclude religiously affiliated hospices or small community-based providers, which could be the very programs with which some beneficiaries feel most comfortable.

- The integrity of hospice benefit could be diluted, thereby decreasing MA beneficiaries' access to the full scope of services available to beneficiaries in traditional fee-for-service (FFS) Medicare. For example, home health programs that participate in MA have already faced restrictions on the number of visits and additional preauthorization (beyond the current "face-to-face" requirement). Such limitations disrupt the continuity of care and the ability of both the beneficiary and the interdisciplinary team to plan for the beneficiary's future care needs. Furthermore, MA plans might attempt to contract with hospice providers at rates below those paid by traditional Medicare, thereby limiting providers' ability to provide the full array of services. (Such practices are already in effect with commercial insurers and Medicaid managed

care organizations, which sometimes offer a reduced FFS rate for hospices to provide a subset of services.) NASW is concerned that in such circumstances, the psychosocial and spiritual support services so integral to beneficiaries and families at the end of life could become a low priority.

- The balance of care related to the beneficiary's terminal diagnosis (covered by the hospice) and care unrelated to the terminal diagnosis could be disrupted if financial incentives prompt MA plans to shift responsibility for unrelated services to contracted hospice programs. On a day-to-day level, beneficiaries could be caught in the middle and unable to access the care they need in a timely manner. On a broader level, programs could face threats to their financial viability. Moreover, although the Medicare Payment Advisory Commission (MedPAC) has asserted that the cost to Medicare of a carve-in would be negligible (MedPAC, 2014), a study by Avalere Health estimated that the carve-in would cost the Medicare program more than $1.3 billion over a 10-year period (Avalere Health, 2014).

Thus, NASW is concerned that the proposal to eliminate the hospice carve-out would actually decrease access to high-quality hospice care—not only for MA beneficiaries but also, ultimately, for beneficiaries in traditional Medicare.

Improving care management services for individuals with multiple chronic conditions (p. 11)
NASW strongly supports the establishment of a new Current Procedural Terminology (CPT) code for high-severity chronic care management (CCM). The association concurs with the working group that CCM often involves multiple members of the interdisciplinary team, including social workers. With their person-in-environment, strengths-based perspective, social workers play an integral role in assessment and care coordination with older adults and families. The *NASW Standards for Social Work Case Management* (2013) and the *NASW Standards for Social Work Practice with Family Caregivers of Older Adults* (2010) elaborate on the aforementioned concepts, as do NASW's comments on the IAH model within this document. Thus, NASW advocates strongly for inclusion of social workers among the disciplines eligible to use the new high-severity CCM code. Furthermore, NASW supports allowing practitioners to bill using the CCM code more than one time per month per beneficiary; as the working group has noted, a once-per-month limit on Medicare reimbursement for high-severity CCM services may be insufficient to meet the needs of some beneficiaries.

At the same time, beneficiary uptake of high-severity CCM services is essential if the new code is to have value. Therefore, NASW urges the working group to adopt the following strategies to promote use of the new code:

- Educate beneficiaries about the new service and its value.
- Waive beneficiary cost sharing for the service.

Addressing the need for behavioral health among chronically ill beneficiaries (p. 12)
NASW concurs with the working group that the lack of integration between primary care and mental and behavioral health (MH/BH) care poses a significant concern for Medicare beneficiaries. Nearly one in five older adults in the United States has at least one mental health or substance use condition (IOM, 2012). Moreover, the growing shift toward integrated care is congruent with the finding that most older adults prefer to receive care for behavioral and mental health conditions within their primary care provider's office (Escobedo, 2012). Many younger beneficiaries would also benefit from integrated care, though they may prefer to access primary health care in the context of MH/BH settings.

NASW supports the working group's proposal to request a study by the Government Accountability Office (GAO) on the status of primary care and MH/BH care among Accountable Care Organizations (ACOs) and medical homes/health homes in the public and private sectors, as well as among ACOs participating in the Medicare Shared Savings Program (MSSP). NASW also encourages the working group to consider the following resources as it considers policy proposals to foster health–MH/BH care integration:

- AHRQ report: *Integration of Mental Health/Substance Abuse and Primary Care* (Butler et al., 2008)
- SAMHSA-HRSA Center for Integrated Solutions (http://www.integration.samhsa.gov/)
- *American Journal of Psychiatry* article: Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: Systematic review and meta-analysis (Woltmann et al., 2012).

Furthermore, NASW urges the working group to support passage of the Improving Access to Mental Health Act of 2015 (S. 2173), which enhances Medicare beneficiaries' access to mental health services provided by clinical social workers. Clinical social workers have a master's or doctoral degree in social work, at least two years of post-degree supervised experience in a clinical setting, and a clinical social work license, certification, or registration issued by the state or jurisdiction in which services are performed. The Health Resources and Services Administration (HRSA) recognizes social work as one of five core mental health professions (Heisler & Bagalman, 2015). As noted in the recent IOM reports *Retooling for an Aging America: Building the Health Care Workforce* (2008) and *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?* (2012), the workforce is not large enough to meet older adults' health and MH/BH needs. Limited beneficiary access to clinical social workers exacerbates this shortage and poses barriers to beneficiaries' optimal health and MH/BH. The Improving Access to Mental Health Act of 2015 enhances beneficiary access to mental health services provided by clinical social workers in three ways.

- S. 2173 increases the Medicare reimbursement rate for clinical social workers to 85 percent of the Physician Fee Schedule (PFS) rate, equal to the current rate to nonphysician practitioners such as occupational therapists, physical therapists, and physician assistants. Medicare now reimburses clinical social workers at only 75 percent of the rate; in contrast, psychiatrists and psychologists receive 100 percent of the PFS rate. The increased reimbursement rate will encourage even more clinical social workers to participate in Medicare, thereby increasing the supply of qualified mental health professionals available to serve beneficiaries with co-occurring health and MH/BH conditions.

- S. 2173 amends the definition of "clinical social worker services" to permit Medicare to reimburse clinical social workers for all services they are legally authorized to perform under state law or under the mechanism provided by state law. Such services may include, specifically, services reflected in the Health and Behavior and Assessment and Intervention (HBAI) CPT codes. HBAI services help Medicare beneficiaries to cope with the emotional and social concerns related to a medical condition (such as a diagnosis of cancer or Alzheimer's disease)—concerns that are unrelated to a mental health condition. NASW helped to develop the HBAI codes, which are psychologists and psychiatrists already use. Yet, because of an overly narrow definition of "clinical social worker services" in Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2) (as amended by the Omnibus Budget Reconciliation Act of 1989), clinical social workers are unable to bill Medicare Part B for services reflected in the HBAI codes. Expansion of the definition of "clinical social worker services" within the Social Security Act will enable

Medicare beneficiaries with co-occurring health and MH/BH conditions to access a more robust set of services rendered by clinical social workers.

- S. 2173 amends Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) (as amended by the Balanced Budget Act of 1997) to include clinical social workers among the providers who are exempted from skilled nursing facility (SNF) consolidated billing. This change will enable beneficiaries who are receiving SNF services under Medicare Part A to receive clinical social worker services under Medicare Part B (privileges currently available to psychiatrists and psychologists), thereby enhancing access to mental health services for beneficiaries in SNFs who have co-occurring health and MH/BH conditions. Please refer to NASW's recent comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule Medicare and Medicaid Program; Reform of Requirements for Long-Term Care Facilities (2015), for additional background on this issue (McClain, 2015, pp. 14–15). (NASW also encourages the working group to review pages 18 to 24 of the aforementioned comments, which urge CMS to require professional social workers in nursing homes and to improve the ratio of social workers to residents.)

These policy changes will improve health outcomes for Medicare beneficiaries living with multiple chronic conditions. Thus, NASW urges the working group to include S. 2173, the Improving Access to Mental Health Act, as an essential component of its Chronic Care Initiative.

Finally, NASW refers the working group to its other recommendations on integrated care as submitted to the 2015 White House Conference on Aging (NASW, 2015, p. 3).

Maintaining ACO flexibility to provide supplemental services (p. 18)
NASW supports clarification that ACOs participating in the MSSP may furnish a social service or transportation service for which payment is not made under FFS Medicare. Such services can be helpful in improving health outcomes for beneficiaries. At the same time, NASW encourages monitoring to ensure that ACOs and the community-based organizations with which they collaborate (such as Area Agencies on Aging) have the infrastructure and resources to provide such supplemental services. A demonstration could help to achieve this goal. NASW also encourages consideration of similar flexibility within traditional Medicare.

Providing flexibility for beneficiaries to be part of an accountable care organization (p. 21)
NASW supports the working group's proposal to enable Medicare FFS beneficiaries to elect voluntary alignment with the ACO in which their main provider participates. Should this change be implemented, assigned beneficiaries should retain access to any Medicare provider, even those outside the ACO; such flexibility is a central feature of the traditional Medicare program. Moreover, NASW encourages the committee to support the following actions related to voluntary alignment:

- guidance on how ACOs and participating providers may educate beneficiaries regarding ACO alignment
- safeguards to ensure transparency about provider incentives and to prevent discriminatory practices that result in risk avoidance by ACOs
- CMS-initiated education to beneficiaries about ACOs (potential benefits, participating providers, and beneficiary rights)

- increased resources to State Health Insurance Assistance Programs (SHIPs), which frequently field beneficiary inquiries about ACOs
- clear delineation of opt-out processes and education to beneficiaries regarding the same.

Developing quality measures for chronic conditions (p. 22)
NASW concurs with the working group that CMS should include, within its quality measures plan, the development of measures that focus on health care outcomes for individuals with chronic disease. The association supports the topic areas outlined by the working group. Furthermore, NASW encourages the working group and CMS to consider lessons learned from three National Quality Forum (NQF) projects:

- Measure Applications Partnership Dual Eligible Beneficiaries Workgroup (NQF, 2016a);
- Measuring HCBS [Home and Community-Based Services] Quality (NQF, 2016b);
- Person- and Family-Centered Care Measures (NQF, 2016c).

For example, the NQF workgroup on persons dually eligible for Medicare and Medicaid has identified multiple high-priority measurement gaps, such as beneficiary sense of autonomy; psychosocial needs; community integration and participation; and optimal functioning (NQF, 2015).

NASW also urges inclusion of measures addressing the health care workforce, without which beneficiary needs cannot be met. Generally speaking, such measures include (1) education and training in geriatrics, gerontology, and eldercare, (2) recruitment and retention practices, and (3) data on staffing levels. Specifically, NASW encourages tracking of the availability of professional social workers, as defined in the association's preceding comments on IAH, across health care settings. Such staffing is essential to meet the complex psychosocial needs of beneficiaries with chronic conditions.

Encouraging beneficiary use of chronic care management services (p. 23)
NASW supports the working group's proposal to waive beneficiary cost sharing for services billed using the existing CCM code. Enhanced beneficiary education regarding the code is needed to encourage use of the service and to allay beneficiary concerns about the appearance of CCM services on summary of benefit notices.

Establishing a one-time visit code post initial diagnosis of Alzheimer's/dementia or other serious or life-threatening illness (p. 24)
NASW supports the development of a CPT code for a one-time planning visit following diagnosis of Alzheimer's disease and other dementias. Such a code is consistent with the association's support for the Health Outcomes, Planning, and Education (HOPE) for Alzheimer's Act (S. 857) (Alzheimer's Association, 2015). This code could also be valuable for people with other types of serious illnesses, including (but not limited to) cancer, cardiovascular diseases, chronic obstructive pulmonary disease, HIV, and multiple sclerosis.

Expanding access to digital coaching (p. 27)
The National Institutes of Health (NIH) (https://www.nlm.nih.gov/medlineplus/) and AHRQ (http://www.ahrq.gov/patients-consumers/index.html) already offer excellent consumer information on a variety of health conditions and self-management. NASW believes that adding such information to Medicare.gov is an unnecessary duplication of effort and resources. Instead, the association recommends that CMS add links to AHRQ and NIH consumer information on both Medicare.gov and Medicaid.gov.

Increasing transparency at the Center for Medicare & Medicaid Innovation (p. 28)
Beneficiaries with multiple chronic conditions already face significant financial, medical, and psychosocial challenges. Therefore, changes to Medicare must be approached with caution. NASW recommends that the working group test potential changes to both the MA and traditional Medicare programs through the Center for Medicare & Medicaid Innovation. Such demonstrations enable policymakers to design, evaluate, and refine innovations carefully. Transparency and stakeholder input are integral to the success of the Innovation Center.

NASW notes the working group's strong focus on MA and appreciates the working group's desire to enhance chronic care through MA innovations. At the same time, innovations to strengthen both MA and traditional (FFS) Medicare are essential. Although MA works well for some beneficiaries, traditional Medicare is a better option for others. In fact, the majority of beneficiaries continue to receive coverage through traditional Medicare (Jacobson, Damico, Neuman, & Gold, 2015). Any innovations within traditional Medicare should preserve the integrity of program benefits and avoid shifting additional costs to beneficiaries. Medicaid expansion will continue to play a central role in improving chronic care for dually eligible beneficiaries.

In closing, NASW wishes to commend the Senate Finance Committee for creating an open process to explore policy solutions to improve care for Medicare beneficiaries with chronic conditions. We appreciate your consideration of NASW's concerns and priorities.

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