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National Association of Social Workers
Office of the Executive Director
Elizabeth J. Clark, PhD, ACSW, MPH
Executive Director

September 27, 2011

Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9989–P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Notice of Proposed Rule Making (NPRM) on Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; CMS–1345–P

Dear Dr. Berwick:

On behalf of the 145,000 members of the National Association of Social Workers (NASW), I am pleased to submit our comments on the proposed rule for the establishment of the new affordable insurance exchanges, mandated by the Patient Protection and Affordable Care Act of 2010.

NASW is a strong supporter of the Affordable Care Act and we eagerly await the full implementation of the state-level insurance Exchanges, which will facilitate expanded access to health insurance coverage for millions of individuals and employees of small businesses. We are especially supportive of the protections for low and moderate-income individuals and families, who will receive premium and cost-sharing subsidies to make health coverage more affordable.

We offer, for your consideration, the following recommendations to strengthen the proposed Health Exchange regulations.

A. Commentary regarding Part 155 – Exchange Establishment Standards

Entities eligible to carry out Exchange functions; Governing Board Structure (§155.110)

NASW recommends that the majority of Exchange board members should be "consumer representatives." The preamble of the NPRM states that "*Exchanges are intended to support consumers, including small businesses, and as such, the majority of the voting members of [Exchange] governing boards should be individuals who represent their interests.*" The actual text of the proposed rule states only that a majority of the board should NOT have a conflict of interest. NASW recommends that states must ensure that Exchange governing boards are comprised of a majority of "consumer representatives." The final rule also should provide a clear definition of "consumer representative." NASW recommends that the definition include

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Exchange beneficiaries, as well as organizations that represent medically underserved communities and individuals with certain diseases or conditions.

Required Consumer Assistance Tools and Programs of An Exchange (§155.205)

Community-based outreach and application assistance will be essential in reaching and enrolling all eligible individuals into the Exchanges. As such, **NASW recommends that all consumer assistance tools, including notices, should be designed and coordinated to meet the needs of a diverse range of consumers, including adults and children with cognitive and/or physical disabilities; populations that experience health disparities; families with mixed immigration status; and individuals with limited English proficiency.** States should be required to conduct a consumer needs assessment to inform the design, operation and evaluation of the state's proposed consumer assistance tools, including its call center, website, navigator program and outreach initiatives.

NASW appreciates that the NPRM requires Exchanges to maintain up-to-date websites that incorporate information to help consumers make initial comparisons between qualified health plans (QHPs). We would also recommend that HHS require the same information to be available in written format for consumers without internet access. With regard to the information available to consumers, we recommend that the Exchanges offer information on chronic disease management programs offered by QHPs, and also maintain up-to-date information about specific providers, including clinical social workers, who participate in QHP provider networks.

Single Streamlined Application (§155.405)

NASW believes that one of the most important features of the Affordable Care Act is the requirement that states create a "no wrong door" system for individuals and families seeking coverage through the Exchanges. For instance, the law explicitly requires that the enrollment and renewal processes for Exchange subsidies be fully integrated with the Medicaid and CHIP programs. **A critical aspect is ensuring that Exchanges have the ability to conduct Medicaid/CHIP enrollment, rather than simply referring people coming through the Exchange door to Medicaid/CHIP**. This will require extensive collaboration between the Exchanges and Medicaid/CHIP.

The single streamlined application is critical to ensuring that state Exchanges create a seamless system for eligibility determinations, enrollment, retention, and renewal, and to guarantee that individuals and families get and keep their health care coverage and do not slip between the cracks of Medicaid, CHIP and the exchanges plans, particularly as beneficiaries move among programs and plans, as their individual circumstances change.

Requiring both paper-based and web-based enrollment applications, and permitting online, telephone, mail, or in-person applications, will help facilitate the enrollment of underserved populations, including individuals with low literacy, limited English proficiency, or those who reside in low income communities with limited computer and internet access.

B. Commentary regarding Part 156 – Health Insurance Issuer Standards

Inclusion of professional social workers in QHPs offered through the Exchanges

NASW strongly recommends that professional social workers be included as providers in all QHPs offered through the Exchanges. Social workers play key roles in interdisciplinary care teams across the full continuum of health care settings. Social workers are also the only health care professionals devoted exclusively to addressing the psychosocial needs of Exchange beneficiaries and their family caregivers. In its 2008 report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*, the Institute of Medicine (IOM) defined psychosocial health services as "psychological and social services and interventions that enable patients, their families, and health care providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of illness and its consequences, so as to promote better health" (IOM, 2008).

Roles and qualifications of professional social workers participating in QHPs

Professional social workers fulfill distinct but complementary roles in health care. ***Clinical social workers*** work in behavioral, mental health and addiction treatment settings, and as independent practitioners. ***Medical social workers*** work in hospitals; FQHCs and other primary care settings; long-term care and rehabilitation agencies; and hospice and palliative care programs.

CLINICAL SOCIAL WORKERS: As the largest group of clinically trained mental health providers in the United States, social workers are recognized for their expertise in providing service to children and adults experiencing emotional, behavioral, psychological, and social problems. There are more than 240,000 clinical social workers in the United States. A *clinical social worker* is an individual who possesses a master's or doctoral degree in social work; has performed at least two years of supervised clinical social work; and is either licensed or certified as a clinical social worker by the State in which the services are performed; or, in the case of an individual in a State that does not provide for licensure or certification, has completed at least two years or 3,000 hours of post master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic (CMS, 2009). (Since 2009, all states license social workers at the clinical level.)

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

should be licensed at the advanced practice level and be able to provide supervision for licensure (NASW, 2005).

Network adequacy standards (§156.230)

NASW recommends that the final rule require network adequacy standards that ensure consumers have access to professional social workers within a reasonable geographic proximity to their home or workplace. NASW also supports requirements that QHPs regularly update an electronic directory of participating providers, which includes participating social workers, so that consumers can search by name to see which plans include the desired social worker in their network and ascertain whether that provider is accepting new patients for a particular QHP.

Essential community providers (§156.235)

With their expertise in serving low-income, medically underserved, and hard-to-reach populations, NASW strongly recommends that professional social workers be included as essential community providers in all QHPs operating within the Exchanges.

The NPRM defines "essential community provider" as those organizations specified in Section 340(b) of the Public Health Service Act. Many social workers are currently employed by or under contract to these organizations, including FQHCs, HIV clinics, family planning clinics, critical access hospitals and children's hospitals. However, social workers in other settings, as well as those operating as independent practitioners, serve similar populations of vulnerable, underinsured, uninsured or publically insured adults and children. NASW's study of licensed social workers found that over 80 percent of medical social workers' clients receive health coverage through publicly funded programs (Whitaker, Weismiller, Clark & Wilson, 2006). Clinical social workers in addiction treatment and behavioral health settings also have significant caseloads of publically insured and uninsured patients (Center for Health Workforce Studies & NASW Center for Workforce Studies, 2006).

The preamble to the NPRM states:

"We continue to look at other types of providers that may be considered essential community providers to ensure that we are not overlooking providers that are critical to the care of the population that is intended to be covered by this provision. We solicit comment on the extent to which the definition should include other similar types of providers that service predominantly low-income, medically underserved populations and furnish the same services as the providers referenced in Section 340(b)(a)(4) of the PHS Act."

It is arbitrary to narrowly define essential community provider as only those practicing within 340(b) organizations. **We respectfully request that for the purposes of the Exchanges, the definition of "essential community provider" be expanded to include all professional social workers.**

Thank you for your consideration of our comments. NASW looks forward to collaborating with you to make the new health insurance Exchanges successful in expanding coverage to more Americans.

Sincerely,

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Executive Director

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