750 First Street NE, Suite 800, Washington, DC 20002-4241
202.408.8600 » SocialWorkers.org

NASW
National Association of Social Workers

March 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–0057–P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically via https://www.regulations.gov/commenton/CMS-2022-0190-0002

Re: Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes for Medicare Advantage Organizations, Medicaid Managed Care Plans, State Medicaid Agencies, Children's Health Insurance Program (CHIP) Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-Facilitated Exchanges, Merit-Based Incentive Payment System (MIPS) Eligible Clinicians, and Eligible Hospitals and Critical Access Hospitals in the Medicare Promoting Interoperability Program (CMS–0057–P, published December 13, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments regarding CMS–0057–P.

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. We work to enhance the professional growth and development of our members, to create and maintain professional standards, and to advance sound social policies.

NASW's comments address four sections of the proposed rule:

- improving prior authorization processes, particularly in Medicare Advantage (MA)
- request for information (RFI) on accelerating the adoption of standards related to social risk factor data
- RFI on the electronic exchange of behavioral health information
- RFI on improving the electronic exchange of information in the Medicare fee-for-service (FFS) program.

Improving Prior Authorization Processes (Section II.D)

NASW concurs with the Centers for Medicare & Medicaid Services (CMS) that prior authorization processes can delay health care delivery and worsen health outcomes. Therefore, we applaud CMS's efforts to align prior authorization decision time frames across federal payers. We support CMS's proposal to require MA plans and applicable integrated plans to transfer automatically to the standard time frame any expedited organization determination request if the plan denies a request for an expedited organization determination. Such action would reduce burden on providers and plan enrollees, who would otherwise need to initiate a request for a standard organization determination.

NASW encourages CMS to strengthen its proposals regarding notification time frames in the following manner:

- Beginning January 1, 2026, require MA organizations and applicable integrated plans to notify providers of prior authorization decisions on standard requests as expeditiously as a patient's health condition requires, but no later than five (rather than seven) calendar days for standard requests.
- Beginning January 1, 2026, require MA organizations and applicable integrated plans to notify enrollees of prior authorization decisions on standard requests as expeditiously as the enrollee's health condition requires, but no later than five (rather than seven) calendar days after the organization receives the request for a standard preservice organization determination for a medical item or service.

Additionally, NASW supports CMS's proposal to allow MA plans to implement ''gold-carding'' or similar programs that relax or reduce prior authorization requirements for providers who have demonstrated a consistent pattern of compliance. At the same time, we urge CMS to identify providers who struggle to obtain prior authorization and provide technical assistance to mitigate this pattern. Such proactive action is essential to reducing disparities in health care access and outcomes.

NASW is concerned that CMS has not proposed to require that MA plans and applicable integrated plans approve requests for prior authorization when the plans do not meet the required standard or expedited decision time frame (deemed approval). We do not believe that providers and enrollees should be required to follow up with a payer if the payer fails to respond to a prior authorization request within the time frame for standard (14 calendar days, decreasing to seven calendar days in 2026) and expedited (72 hours, decreasing to 24 hours in 2026) requests, respectively. This policy leaves providers and, more importantly, enrollees in a potentially interminable cycle of pursuing plans for determinations. Rather, we urge CMS to require plans to deem approval for any prior authorization request to which a payer does not respond within the specified time frame. If this strategy is not determined by CMS to be feasible, we urge CMS to require that any failure by an MA plan or applicable integrated plan to provide notice of an organization determination within the same time frame (and without having requested an extension) shall constitute a deemed denial; in other words, an adverse decision that may be appealed. Such a deemed denial should trigger an automatic appeal to the next stage in the appeals process (Level 2) in which the beneficiary or health care provider may request a reconsideration determination by an Independent Review Entity—as is the case when an MA plan upholds its initial denial at the reconsideration stage (Level 1) or fails to issue a decision in a timely manner.

Moreover, NASW urges CMS to strengthen its proposed language regarding the rationale MA plans and applicable integrated plans must provide to providers. We believe that CMS's language requiring MA plans and applicable integrated organizations to provide "specific reasons" for denials of prior authorization requests does not promote plan accountability and transparency. Consequently, we encourage CMS to incorporate in the final rule language such as, "The reason for denial must articulate the specific standard for medical necessity that the payer applied to the request and the source of the standard; why the particular facts of the enrollee's condition and the evidence submitted in the prior authorization failed to meet that standard; and what evidence would be needed to reverse the decision." Such language would reduce the frequency of vague rationale such as "failure to meet medical necessity" and the use of secret proprietary guidelines. Furthermore, NASW recommends that MA plans and applicable integrated plans provide the same detailed information regarding prior authorization denials as providers do.

NASW also urges CMS to incorporate in the final rule provisions addressing the following denial-related topics:

- Streamline appeals processes for providers and enrollees.
- Forbid MA plans and applicable integrated plans from engaging in loops in which prior authorization is denied, appealed, and overturned. If a plan denies an item or service and the denial is overturned, the plan should not be allowed to restart that process.
- Audit and sanction MA plans and applicable integrated plans with high levels of denials that are overturned.

On a broader level, we urge CMS to forbid MA plans and applicable integrated plans from using secret rules in prior authorization determinations. If a factor affects an enrollee's access to care, it should be public not only to people who are enrolled in the plan and providers, but also to individuals who might be considering enrolling.

NASW commends CMS for requiring MA plans to report, publicly, metrics about prior authorization by posting them directly on the payer's website or via a publicly accessible hyperlink on an annual basis. We strongly support the proposal to include in such metrics a list of all items and services that require prior authorization. We urge CMS to strengthen its other public reporting requirements for MA plans by requiring public reporting of prior authorization metrics at the plan level, not the organizational level. As CMS noted, many MA organizations have multiple plans. When a Medicare beneficiary considers MA as their coverage source, they must choose a specific plan, not an MA organization. Likewise, when a provider requests prior authorization for an item or service, they seek such approval from a particular MA plan. Therefore, data will only be meaningful to beneficiaries and providers if it is specific to a given MA plan, not to the entire MA organization.

We also encourage CMS to remove the disaggregation modifier from the following proposed metrics for MA plans:

- percentages of standard prior authorization requests that were approved, denied, and approved after appeal, respectively
- percentages of prior authorization requests that were approved following an extension of the time frame for review
- percentages of expedited prior authorization requests that were approved and denied, respectively

- for standard and expedited prior authorizations, respectively, the average and median times that elapsed between the submission of a request and a decision by the payer, plan, or issuer

In other words, for each metric in this list, MA plans should publicly report data regarding the applicability to individual items and services. For example, the public should be able to find the percentage of standard prior authorization requests for a pelvic ultrasound that were approved after appeal or the median time that elapsed between the submission of an expedited prior authorization request for magnetic resonance imaging of the brain and a decision by the MA plan. Such information about particular items and services is essential to informed decision making by beneficiaries and providers.

Furthermore, NASW urges CMS to require MA plans to incorporate the following metrics in their publicly reported prior authorization data: age, ethnicity, race, gender, gender identity, sexual orientation, and geographic area. CMS should also enable disaggregation of such data so that enrollees, potential enrollees, providers, and other stakeholders may determine, for example, the extent to which a plan denies prior authorization requests for power wheelchairs for older Black women who live in rural areas.

To promote the accessibility of publicly reported data on prior authorization, we recommend that CMS require MA plans to meet the following requirements:

- Write publicly reported data at the sixth-grade reading level.
- Conduct consumer focus testing on data readability.
- Provide translations in multiple languages.

Lastly, we encourage CMS to apply the preceding public reporting requirements to applicable integrated plans.

Accelerating the Adoption of Standards Related to Social Risk Factor Data (Section III.A)

Research has demonstrated that the social determinants of health and social needs are critical factors that inform patient health, health care services utilization, and health outcomes at the individual, community, and population level.[1] NASW supports CMS efforts to enhance data collection of social risk factors to better understand patient needs and promote health equity.

Health care institutions and practices must thoughtfully consider protocols to conduct social needs screening. Interprofessional teams must include staff who specialize in assessing and addressing social needs, such as social workers. Social workers have expertise in working with individuals with complex mental health, medical, and social needs and connecting individuals to community resources.[2] Institutions have a responsibility to respond to the identified needs of patients through organizational resources or community partnerships. CMS can support education regarding social needs by

[1] Magnan, S. 2021. Social Determinants of Health 201 for Health Care: Plan, Do, Study, Act. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202106c

[2] 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.

encouraging training at all levels of health care systems, from front-line staff to organizational leadership, highlighting the link between social needs and health equity.

As more systems implement social risk screening and document social needs, patients must be informed about screening processes and the way in which data appears in the Electronic Health Record (EHR). Patients should be offered a choice to opt-out of screening. NASW urges health care systems to encourage consistent use of Z codes to document social needs across departments in clinical encounters, so that patients have the option of disclosing sensitive information to any providers. NASW recommends periodic review and reassessment so that the information in the EHR is current and relevant to medical services. Health systems must consider ways to engage patients in providing and managing this data to avoid unintended negative consequences.

NASW supports efforts to facilitate the exchange of social needs data between health care and community providers. Health practices should develop relationships with local community organizations, with an understanding that community organizations are often under-funded and may have limited capacity to exchange data. Local organizations are often trusted entities that have longstanding relationships with community members and knowledge of social needs. CMS should advocate for infrastructure investments to support nonprofits and community organizations to enhance capacity and advance interoperability of social needs data.

Electronic Exchange of Behavioral Health Information (Section III.B)

NASW appreciates CMS' requesting stakeholder feedback on the electronic exchange of Behavioral Health Information. The CARES Act is an example that has promoted data sharing among treatment providers. However, precautions must of course be taken to protect patient health information. NASW requests CMS to consider the challenges related to confidentiality in the treatment of substance use disorders as outlined in 42 CFR Part 2. Care coordination and collaboration efforts are extremely important to providing care. This is especially true when treating co-occurring disorders, but differences in consent mandates related to 42 CFR Part 2 substance use disorder treatment records and the Health Insurance Portability and Accountability ACT (HIPAA) can create barriers to care across providers which affect continuity of care.

Clinical social workers (CSWs) are often faced with navigating these challenges as they provide treatment to patients with co-occurring mental health and substance use disorders. In order to maintain compliance, health information technology would need to segment protected substance use disorder treatment information from the rest of a patient's health record[3]. Data segmentation capabilities are needed for behavioral health electronic health records (EHRs) as patients may request restrictions on the use of their treatment information under 42 CFR Part 2. Disclosure or redisclosure protections for other sensitive information (i.e. domestic violence, HIV/AIDS) may also be subject to stricter state or federal laws. Thus, information technology standards that promote segmentation for access, security labeling, and consent management is essential for behavioral health settings[4].

[3] McCarty, D., Rieckmann, T., Baker, R. L., & McConnell, K. J. (2017, March 1). *The perceived impact of 42 CFR part 2 on coordination and integration of care: A qualitative analysis*. Psychiatric services (Washington, D.C.). Retrieved March 6, 2023, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5441679/

[4] (OCR), O. for C. R. (2021, September 22). *2088-does HIPAA provide extra protections for mental health information compared with other health*

Cost is another factor that should be considered to facilitate greater collaboration and exchange of information among providers and suppliers. Most CSWs in small solo or group practices do not have the financial resources to afford industry-wide standards-based application programing interface (API) technology. Financial assistance and training would be needed to fully acclimate practices to new APIs. This can also take time away from providing valuable clinical services, which can be detrimental in areas with limited resources. NASW believes an exemption would be appropriate for a small practice similar to that of Medicare's Quality Payment Program.

The association supports recommendations from the Office of the National Coordinator for Health Information Technology's (ONC) *2020-2025 Federal Health IT Strategic Plan* as it outline concrete steps federal partners can take to improve health through health IT. The goals, objectives, and strategies within this Plan highlight the importance not only of electronic health information, but also of the capabilities enabled by health IT, including public health surveillance, telehealth, and remote monitoring.

NASW also asks CMS to consider the Medicaid and CHIP Payment and Access Commission's (MACPAC) recommendations as outlined in their *Report to Congress*. Delivery systems in healthcare are often fragmented constituting to high costs and impeding access to care. NASW supports MACPAC's recommendations to encourage health information technology adaption in behavioral health which include:[5]

- The Secretary of the U.S. Department of Health and Human Services directing CMS, Substance Abuse and Mental Health Services Administration (SAMSHA) and ONC to provide guidance on how states can use federal resources to promote interoperability and the adaption of behavioral health information technology.
- The Secretary of the U.S. Department of Health and Human Services directing ONC and SAMSHA to develop a voluntary behavioral health information technology certification.

Mitigating clinician burnout should be considered to facilitate greater collaboration and exchange of information among providers and suppliers. A study in 2021 noted factors linking burnout to the use of EHRs. Some of which include poor EHR design, charting and documentation burden, workload, and alert fatigue[6]. NASW advocates for continued improvements in usability features that provide shortcuts to assist with documentation. The American Medical Informatics Association (AMIA) makes the following recommendations:[7]

- Establish principles for adding documentation to EHRs, integrate notes across disciplines and improve clinicians training on effectiveness of documentation.
- Simplify views within EHRs to assist in accessing information and dispense best training practices.

---

information? HHS.gov. Retrieved March 6, 2023, from https://www.hhs.gov/hipaa/for-professionals/faq/2088/does-hipaa-provide-extra-protections-mental-health-information-compared-other-health.html

[5] *Chapter 4: Encouraging Health Information Technology adoption in Behavioral Health. The Medicaid and CHIP Payment and Access Commission (MACPAC)* (n.d.). Retrieved March 6, 2023, from https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-4-Encouraging-Health-Information-Technology-Adoption-in-Behavioral-Health.pdf

[6] Person. (2023, February 22). *Technology's role in clinician burnout*. Health Data Management. Retrieved March 2, 2023, from https://www.healthdatamanagement.com/articles/technologys-role-in-clinician-burnout

[7] *Amia 25x5*. AMIA. (n.d.). Retrieved March 2, 2023, from https://amia.org/about-amia/amia-25x5

- Develop technology that standardizes ways to create and manage reimbursement data and fund research that captures billing code information without interfering with clinician time.

Improving the Electronic Exchange of Information in Medicare Fee-for-Service (Section III.C)

NASW thanks CMS for soliciting information about how to improve the electronic exchange in Medicare FFS. We encourage CMS and all Medicare Administrative Contractors to make prior authorization standards clear and searchable for providers and beneficiaries.

Thank you for your consideration of NASW's comments. If you have any questions, please do not hesitate to contact me at BBedney.nasw@socialworkers.org

Sincerely,

Barbara Bedney

Barbara Bedney, PhD, MSW
Chief of Programs