

November 15, 2021

The Honorable Ron Wyden  
Chairman  
U.S. Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mike Crapo  
Ranking Member  
U.S. Senate Committee on Finance  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

The National Association of Social Workers (NASW) applauds your leadership in working to reform our behavioral healthcare system and to enhance the quality and delivery of these vital services. NASW appreciates the opportunity to provide input in response to the September 21<sup>st</sup> Request for Information on recommendations to strengthen the behavioral health workforce; increase integration, coordination, and access to care; ensuring parity between behavioral and physical health care; furthering the use of telehealth; and improving access to behavioral health care for children and young people.

Founded in 1955, NASW is the largest membership organization of professional social workers in the world. NASW has 110,000 members and works to enhance the professional growth and development of social workers, to create and maintain professional standards, and to advance sound social policies. The nation's 700,000+ social workers are an essential workforce that provide critically needed services to millions of Americans every day, in a broad range of settings including health and behavioral health care facilities, schools, child welfare, community agencies, correctional institutions, and private practice. Social workers are licensed and credentialed at the bachelor's, master's, and doctoral levels. Approximately 250,000 social workers are licensed clinical social workers (CSWs), who are required to have a master's degree in order to practice independently.

As the largest provider of mental health services in the U.S., the value of social work has been especially visible during the COVID-19 pandemic. As an essential workforce, social workers continue to serve on the frontlines helping communities directly affected by the pandemic, delivering behavioral health services to individuals and families in crisis, and in many cases risking their own lives to ensure that care remains accessible for those in need of assistance.

### ***Overview of the Current State of Social Work Workforce***

According to the Bureau of Labor Statistics, the need for social work workforce is projected to grow by 12% by 2030.<sup>1</sup> The majority of the social work workforce serves high-need populations regardless of their setting of practice.<sup>2</sup> This projection will be further fueled by the exponential rise in mental health concerns resultant from the COVID-19 pandemic with 4 in 10 adults in the U.S. reporting symptoms of anxiety and/or depression.<sup>3</sup> Additionally, 6 in 10 parents report that their child has experienced mental health challenges within the past month within the context of the pandemic<sup>4</sup>. A significant numbers of older adults, too, live with mental health conditions and substance use disorders, and rates of suicide attempts and completion among older adults are increasing. Recent overdose rate data reveals that overdose deaths increased in almost every state during the first eight months of 2020.<sup>5</sup> Added to this, rates of substance abuse, intimate partner violence, housing instability, economic distress, and exacerbation of chronic diseases continue to increase. In short, the combination of these individual and contextual stressors in conjunction with chronic exposure to the health threats posed by COVID-19 are collectively compromising mental health and well-being.

The disparate mental health and health impact of the pandemic is especially felt by racial and ethnic minorities who historically experience higher rates of chronic medical conditions which in turn further exacerbate their baseline risk factors for severe illness from COVID-19.<sup>6</sup> Furthermore, the pandemic has served to disrupt key social programs that provide essential forms<sup>7</sup> of complementary support to vulnerable populations and communities (i.e. home

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<sup>1</sup> Bureau of Lab. Stat., U.S. Dep't of Lab., Occupational Outlook Handbook - Social Workers, <https://www.bls.gov/ooh/community-and-social-service/social-workers.htm> (last visited Sept. 21, 2021) ("BLS").

<sup>2</sup> Fitzhugh Mullan Institute for Health Workforce Equity, The Social Work Profession: Findings from Three Years of Surveys of New Social Workers (2020) at 12, <https://www.cswe.org/CSWE/media/Workforce-Study/The-Social-Work-Profession-Findings-from-Three-Years-of-Surveys-of-New-Social-Workers-Dec-2020.pdf>

<sup>3</sup> Panchal, N., Kamal, R., Cox, C., & Garfield, R. (2021). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

<sup>4</sup> Panchal, N., Kamal, R., Cox, C., & Garfield, R., Chidambaram, P. (2021). Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>

<sup>5</sup> Jesse C. Baumgartner and David C. Radley. (2021). The Spike in Drug Overdose Deaths During the COVID-19 Pandemic and Policy Options to Move Forward. To the Point (blog), Commonwealth Fund, Mar. 25, <https://doi.org/10.26099/gyf5-3z49>

<sup>6</sup> "Addressing Racial Health Disparities In The COVID-19 Pandemic: Immediate And Long-Term Policy Solutions," Health Affairs Blog, July 20, 2020. DOI: 10.1377/hblog20200716.620294

<sup>7</sup> Panchal, N., Kamal, R., Cox, C., & Garfield, R., Chidambaram, P. (2021). Mental Health and Substance Use Considerations Among Children During the COVID-19 Pandemic. Kaiser Family Foundation. <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>

visitation services, chronic disease management programs, social support programs etc.).<sup>8</sup> Thus, the retraction of supportive services has doubly harmed populations that were already experiencing the harmful effects of social isolation, marginalization, and economic vulnerability. Given the growing need for comprehensive behavioral health services, communities of color are at increased risk for receiving disparate and biased care due to paucity of providers trained to provide culturally competent care.<sup>9</sup>

While the professional and academic training of social workers positions this workforce to meet these complex social and mental health needs of affected populations, workforce challenges exist. These include the structure of care related to current reimbursement models that pose a myriad of barriers to rendering essential mental health and supportive care and limit social workers' ability to utilize the full extent of their education, training, and expertise as a licensed professional. In addition, the need to grow the behavioral health workforce will require meaningful policy reform that dually supports current social work providers of behavioral health care and incentivizes future entry into and retention in the social work workforce.

### ***Strengthening the Workforce***

Despite the broad scope of work performed by social workers, and significant volume of direct clinical services provided to Medicare and Medicaid beneficiaries, annual salaries and insurance-based reimbursement remain consistently lower than professional peer groups. Despite possessing extensive education, training, and using the same billing codes as Psychologists, CSWs are reimbursed at only 75 percent of the Physician Fee Schedule – a percentage rate that has not been reevaluated since clinical social workers were first added as Medicare providers in 1989.<sup>10</sup> Furthermore, lack of enforcement of mental health parity for the rendering of behavioral health services further compounds the disparate patterns evidenced in reimbursement. These marked disparities in both pay and reimbursement are especially felt in this racially and economically diverse workforce and create economic disincentives for entry into the social work profession.

Effectively responding to the nation's growing and complex mental health and behavioral health needs will require meaningful and strategic investment in the social work profession, given that our workforce is the primary provider of these essential services.

NASW recommends that the Senate Finance Committee:

1. Support and advance the [Improving Access to Mental Health Act \(S. 870\)](#), led by Senators Debbie Stabenow (D-MI) and John Barrasso (R-WY), which will increase access to clinical social worker services in Medicare and increase the reimbursement rate of clinical social

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<sup>8</sup> "Addressing Racial Health Disparities In The COVID-19 Pandemic: Immediate And Long-Term Policy Solutions," Health Affairs Blog, July 20, 2020.

DOI: 10.1377/hblog20200716.620294

<sup>9</sup> American Society of Addiction Medicine (2021). Public Policy Statement on Advancing Racial Justice in Addiction Medicine. Retrieved from: [asam-policy-statement-on-racial-justiced7a33a9472bc604ca5b7ff000030b21a.pdf](#)

<sup>10</sup> NASW submits comments to CMS on the Calendar Year 2022 Physician Fee Schedule:  
<https://www.socialworkers.org/LinkClick.aspx?fileticket=iU-x6-BcthI%3d&portalid=0>

workers (CSW) from 75% of the Physician Fee Schedule (PFS) to 85% of the PFS. CSWs are providing nearly the same services and billing the same codes and are reimbursed at only 75% of the fee that psychologists and psychiatrists are reimbursed.

- a. *For additional information, review the: [Issue Brief](#) and [FAQ document](#).*
2. **Increase workforce investments** such as, but not limited to:
  - a. Provide funding for scholarships, service opportunities, fellowships, Pell grants and other forms of financial support to social work students, practitioners and other mental health professionals who work in public child welfare, schools, healthcare, mental health, substance use care and other settings.
  - b. Provide funding for social workers who work in crisis response (such as mobile crisis, domestic violence and rape/ sexual violence social workers).
  - c. Strengthen the workforce investments by the Children's Bureau through Title IV-E and Title IV-B and other funding sources to enhance partnerships between schools of social work and child welfare agencies to increase the number of professional social workers in child welfare, in strengthen the ability of child welfare staff to assess and treat behavioral health needs and promote the use of evidence-based prevention and treatment interventions.
  - d. Fund social workers and other health care providers in schools and promote the expansion of mental health programs in K-12 and higher educational settings.<sup>11</sup>

### ***Increasing Integration, Coordination, and Access to Care***

Social workers have and continue to serve in a variety of healthcare roles (i.e. hospital-based social work, medical social work, behavioral health, care coordination etc.) and are highly skilled in conducting outreach to socially vulnerable patient populations, conducting preventive social needs screenings, coordinating linkages to services, and addressing co-occurring behavioral health and social care needs.<sup>12</sup>

Integration of interprofessional teams in healthcare settings to include primary care is critical in enhancing care coordination efforts as well as enabling access to care. Research has shown that lower rates of patient-provider discussion about social demographic circumstances were found to be associated with significant risk of adverse outcomes.<sup>13</sup> Improved capture of patient-level contextual data can, on the other hand enable proactive identification of barriers to care and opportunities for enhanced care coordination efforts.<sup>14</sup>

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<sup>11</sup> NASW 2021 Blueprint of Federal Social Policy Priorities:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=KPdZgqY60t4%3d&portalid=0>

<sup>12</sup> National Academies of Sciences, E. and M., Health and Medicine Division, Board on Health Care Services, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating Social Care Into the Delivery of Health Care : Moving Upstream to Improve the Nation's Health. National Academies Press.

<sup>13</sup> National Academies of Sciences, E. and M., Health and Medicine Division, Board on Health Care Services, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health. (2019). Integrating Social Care Into the Delivery of Health Care : Moving Upstream to Improve the Nation's Health. National Academies Press.

<sup>14</sup> National Academies of Sciences, E. and M., Health and Medicine Division, Board on Health Care Services, & Committee on Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health.

The consequences of lack of access to essential social care and behavioral health care are evidenced in the increased rates of patients accessing emergency care due to untreated/undertreated behavioral health conditions and most profoundly in the increased rates of patient suicides despite their linkage to an established primary care provider.<sup>15</sup> In rural areas especially, lack of access to care is also driven in part by provider shortages. These shortages are further exacerbated among specialty populations to include veterans who are higher risk for suicide, substance abuse, and service-related mental health conditions (i.e. PTSD). Thus, it is critical that individuals in acute crisis be able to access timely stabilizing care as well as comprehensive follow-up (i.e. specialty care, therapeutic counseling, peer support etc.) to mitigate the risks of self-harm, overdose, suicide etc.

NASW recommends that the Senate Finance Committee:

1. Expand and sustain Integrated Behavioral Health Care Models. Provide funding for integrated care models, such as the Collaborative Care Model, and Primary Care Behavioral Health Model, in primary care settings<sup>16</sup> as these models expand and improve access to evidence-based mental health and substance use care. These models also reduce stigma and allow for early intervention and prevention in the treatment of behavioral and mental health and health issues. Specifically, we urge you to incorporate proposals like the [Collaborate in an Orderly and Cohesive Manner Act \(H.R. 5218\)](#) which aims to expand and improve access to evidence-based mental health and substance use care by supporting and investing in the implementation of integrated care in primary care offices.
2. Expand and sustain Suicide Prevention Programs as well as Crisis Services. Provide funding to expand access to crisis services across community settings as these models of care enable access to timely and evidence-based services reduce the risk of suicide, violence, and self-harm. Specifically we urge you to incorporate proposals like the [Behavioral Health Crisis Services Expansion Act \(S. 1902\)](#) which aims to expand crisis response centers, mobile crisis response teams, crisis stabilization centers, short-term crisis residential services, behavioral health urgent care centers etc.
3. Support and advance the [Community-Based Response Act of 2021 \(S. 2046\)](#) led by Senator Chris Van Hollen (D-MD) which would establish a program to assist communities with implementing alternative emergency response models in vulnerable populations to resolve crisis situations that may not require a law enforcement response or situations where a law enforcement response may increase the risk of harm.
4. Support and advance the [Sgt. Ketchum Rural Veterans Mental Health Act of 2021 \(S. 1468\)](#) led by Senators Jon Tester (D-MT) and Jerry Moran (R-IA), which would establish

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(2019). Integrating Social Care Into the Delivery of Health Care : Moving Upstream to Improve the Nation's Health. National Academies Press.

<sup>15</sup> "Understanding Suicide Risk And Prevention, "Health Affairs Health Policy Brief, January 29, 2021.

DOI: 10.1377/hpb20201228.198475

<sup>16</sup> H.R.5218 - Collaborate in an Orderly and Cohesive Manner Act: <https://www.congress.gov/bill/117th-congress/house-bill/5218>

and maintain three new centers of the Rural Access Network for Growth Enhancement (RANGE) Program in areas in need of mental health services for rural veterans. This bill not only expands access to specialized mental health care for veterans but also resources areas with marked provider shortages.

### ***Ensuring Parity Between Behavioral and Physical Health Care***

As mentioned previously, the COVID-19 pandemic has exponentially increased population-wide rates of mental health concerns. Consequently, there is an even greater need to ensure that there is parity between behavioral and physical health. The Affordable Care Act expanded on the Mental Health Parity and Addiction Equity Act of 2008, requiring all health plans in the Health Insurance Marketplace to cover mental health and substance abuse disorders, but coverage for mental health care varies depending on the state where the patient lives and it remains unacceptably difficult for many individuals and families to find mental and behavioral health care that is accessible, affordable, and covered by insurance.<sup>17</sup> Research continues to demonstrate parity-related disparities related to network adequacy, out of network service use, reimbursement rates, substance use disorder, and total spending on behavioral health services.<sup>18</sup>

Medicare's discriminatory coverage provisions are especially problematic in limiting access to timely and comprehensive essential behavioral health care, thereby disenfranchising many people with disabilities and older adults. Examples of coverage deficiencies embedded within Medicare include:

- Not Subject to the Federal Parity Act. Discriminatory coverage for MH/SUD treatment within Medicare is legal, including for Medicare Advantage plans.
- 190-Day Lifetime Limit on Inpatient Psychiatric Hospital Services. No other medical condition has this limitation, which arbitrarily cuts off necessary treatment for individuals with serious mental illness.
- Lacks Coverage of Intensive, Evidence-Based Interventions. Medicare does not cover evidence-based, multi-disciplinary team interventions for people with the most severe MH/SUDs. This includes Coordinated Specialty Care for early psychosis, Assertive Community Treatment (ACT) teams, and medical nutrition therapy for eating disorders.
- Limited Coverage of Levels of Behavioral Health Care. Medicare does not cover residential care or intensive outpatient services for MH/SUD. It also inadequately covers services within each of the American Society of Addiction Medicine (ASAM) Criteria's five broad levels of substance use disorder care
- No Coverage for Freestanding Community-Based SUD Treatment Facilities. Medicare does not authorize payment for treatment in these facilities, which needlessly limits the availability of SUD treatment.

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<sup>17</sup> NASW 2021 Blueprint of Federal Social Policy Priorities:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=KPdZqqY60t4%3d&portalid=0>

<sup>18</sup> Melek, S., Davenport, S., & Gray, T. (2019). Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement. Milliman Research Report. Retrieved from: [Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement \(milliman.com\)](https://www.milliman.com/research/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-provider-reimbursement)

- Restrictions on Telehealth. Medicare's coverage of telehealth services is very limited, though some temporary flexibilities have been granted during the COVID-19 pandemic.

Medicare payment policy is routinely looked to as a standard that guides both commercial and Medicaid payers as it relates to quality dimensions as well as reimbursement standards. Thus, the disparate practices embedded within the Medicare system are mimicked across payer systems thus exacerbating disparities in behavioral health care access and outcomes. For instance, gaps in Medicare are copied in TRICARE, and most commercial insurance plans rely on Medicare procedure codes, which do not exist for some mental health and substance use disorder services. Medicare fails to cover mental health crisis services, which commercial coverage mirrors, thus inhibiting the expansion of the nationwide 988 mental health crisis system that Congress has taken pains to set up through the National Suicide Hotline Designation Act of 2020. Additionally, Medicare sets provider reimbursement trends across the U.S. health care system, so disparities in its rate-setting process, which tend to undervalue mental health and substance use disorder services, are replicated elsewhere.

The undervaluation of substance abuse treatment is especially apparent given the widespread disparities in covered and reimbursable services as well in the discontinuity of care that patients routinely experience. While more people are seeking treatment for Substance Use Disorders (SUDs), these services have become less available due to a population-wide demand for services coupled with inadequate reimbursement for all [American Society of Addiction Medicine \(ASAM\) Levels of Care](#). Addressing long-standing parity-related issues also necessitates resourcing the development of a robust continuum of care for populations in need of substance abuse treatment.

NASW recommends that the Senate Finance Committee:

1. Extend mental health and substance use treatment parity – required for most of the commercial market and to Medicaid plans to some extent under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 -- to Medicare, Medicaid, and TRICARE. More than 60 million older adults and individuals with disabilities enrolled in Medicare have limited coverage for mental health and substance use disorder services, as do 20 million enrollees in traditional Medicaid and 10 million enrollees in TRICARE. Congress has not yet extended parity protections for Americans in health coverage administered directly by states and the federal government. Accordingly, we recommend extending the full rights and benefits of the federal Parity Act to Medicare, Medicaid, and TRICARE, including extending MHPAEA requirements to Medicare Advantage plans.
2. Include the *Parity Implementation Assistance Act (S. 1962/H.R. 3753)*. Under the Consolidated Appropriations Act, 2021, health insurers are required to perform comparative analyses demonstrating that they are complying with the federal Parity Act. Recognizing that these analyses can be time consuming and labor intensive for state regulators, the *Parity Implementation Assistance Act* authorizes \$25 million in annual

grant funding to states for five years. We also recommend extending these parity analysis and documentation requirements to Medicaid managed care plans.

3. Support and advance the [PEERS Act of 2021 \(S. 2144\)](#) led by Senators Catherine Cortez Masto (D-NV) and Bill Cassidy (R-LA), which would require Medicare to cover certified peer support specialists in integrated settings to promote recovery for individuals with mental health and substance use conditions and to provide evidence-based services recognized by SAMHSA and covered by Medicaid. Social workers routinely work alongside and supervise peer support providers in integrated settings. Peer providers are a valued member of the interdisciplinary team and bring lived experience around often stigmatized psycho-social concerns.

### ***Furthering the Use of Telehealth***

The expansion of telehealth and related flexibilities (i.e. audio-only behavioral health services in Medicare) during the COVID-19 pandemic has been critical in increasing access to mental health care. The ability to render audio-only services has been especially helpful to individuals and households that lack Wi-Fi and broadband access. The removal of geographic restrictions has enabled more individuals and families to receive care and treatment in their homes without the undue burdens that come from addressing transportation barriers, coordination of children and eldercare services etc. These flexibilities have created viable solutions that expand access to mental health care while removing barriers to care that are resultant from poverty, disability, geography etc.

During the COVID-19 pandemic, thousands of social workers and other mental health providers quickly transitioned to deliver vital mental health and behavioral health services using technology, including video conferencing, smartphones and audio-only telehealth. Telehealth has been a lifeline for many clients, allowing access to services, while ensuring safety from COVID-19.

Moving forward, we advocate that service modality be predicated on the needs and preference of the client and the judgement of their provider.

### **NASW recommends that the Senate Finance Committee:**

1. Support and advance the [Telemental Health Care Access Act](#) (S. 2061) led by Senators. Smith (D-MN), Cassidy (R-LA), Cardin (D-MD), and Thune (R-SD). The Telemental Health Care Access Act would provide continuity in behavioral health care access by removing the statutory requirement that Medicare beneficiaries be seen in person within six months of being treated for a mental health service via telehealth.
2. Remove the in-person requirement for mental and behavioral health services provided via telehealth in Medicare. Even under the relaxed timeline of 12 months included in CMS' Final Rule this in-person restriction on access to telehealth for mental health services is not required for telehealth substance use treatment services. We believe that access to care for older adults, individuals with disabilities and others with transportation, mobility

and geographic challenges will be significantly compromised if this in-person requirement is retained.

3. Expand telehealth services, whether they are provided through video-enabled telehealth or audio-only, beyond just the diagnosis, management, and treatment of mental health conditions to include health behavior services.
4. Reimburse telehealth for mental and behavioral health services, including audio-only telehealth services, at the same rate as in-person services. For mental and behavioral health providers, whose patients rely heavily on telehealth services, it would be a costly reduction if payment for these services returns to pre-pandemic reimbursement levels. Given the significant investments required of providers to offer and maintain telehealth services, this change could discourage many providers from continuing to offer telehealth services and thereby jeopardize access to mental and behavioral health services for many beneficiaries. It is also important to ensure that the commercial insurance market maintains telehealth coverage for mental and behavioral health conditions.
5. Consider codifying telehealth as a valid treatment modality for mental and behavioral health services within commercial plans under the Committee's jurisdiction. At a minimum, we urge the Committee to request the HHS Secretary to report on how essential health benefits will be modified to address any such gaps in access or changes in the evidence as notated in 4 (G) (iii) of 42 U.S.C.A. § 18022. This report would document how the expansion of telehealth has increased access to care for individuals with mental and behavioral health diagnoses and further inform how these plans can better serve enrollees.

### ***Improving Access to Behavioral Health Care for Children and Young People***

Access to essential behavioral health care for children and young people has been historically complicated by provider shortages. Addressing such profound provider shortages, which have only been further worsened by the pandemic, will require meaningful investment in the behavioral health workforce as well as investment in mental health care for adolescents in complementary settings such as schools and child welfare and juvenile justice services. Social workers in school settings as an example provide counseling to students and help communities address systemic issues such as school dropout, adolescent pregnancy, child abuse, homelessness, and juvenile crime, as well as emotional and behavioral problems such as substance use and suicide.<sup>19</sup>

NASW recommends that the Senate Finance Committee:

1. Support and advance the [Child Suicide Prevention and Lethal Means Safety Act \(S. 2982\)](#) led by Senator Brian Schatz (D-HI). This bill would allow the Secretary of Health and Human Services to award grants to establish or expand programs to implement evidence-aligned practices in health care settings for the purpose of reducing the suicide rates of children.

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<sup>19</sup> NASW 2021 Blueprint of Federal Social Policy Priorities:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=KPdZqgY60t4%3d&portalid=0>

2. Support and advance the [Counseling Not Criminalization in Schools Act \(S. 2125\)](#) led by Senator Christopher Murphy (D-CT), which would prohibit the use of federal funds for law enforcement officers in schools and would instead establish a grant program to replace law enforcement officers in schools with personnel and services that support mental health and trauma-informed services.
3. Support bills like the [Child Welfare Workforce Support Act \(S.1496\)](#) led by Senator Tim Kaine (D-VA) which would establish a demonstration grant program for state or local agencies, tribes, tribal organizations, and other entities that administer certain child welfare programs to support workforce recruitment, retention, and advancement.
4. Support programs like SAMHSA's [Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances](#) which aims to improve the mental health outcomes for children and youth, birth through age 21, with SED, and their families. This program supports the implementation, expansion, and integration of the Systems of Care (SOC) approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program, and through the provision of evidence-based technical assistance to providers and families.

#### **Resources:**

**To further inform your important work on this issue, NASW offers the following resources for your review and benefit:**

- [The Grand Challenges for Social Work](#)
  - Initiated by the American Academy of Social Work and Social Welfare, the 13 Grand Challenges for Social Work is a groundbreaking initiative to champion social progress powered by science.
- [Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health](#)
  - Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health was released in September 2019, before the World Health Organization declared COVID-19 a global pandemic in March 2020. Improving social conditions remains critical to improving health outcomes, and integrating social care into health care delivery is more relevant than ever in the context of the pandemic and increased strains placed on the U.S. health care system. The report and its related products ultimately aim to help improve health and health equity, during COVID-19 and beyond.
- [NASW Blueprint of Federal Social Policy Priorities](#)
  - NASW's 2021 Blueprint articulates meaningful actions the Biden-Harris Administration and Congress can take to address the COVID-19 crisis, promote mental and behavioral health, eliminate systemic racism and ensure civil and human rights for all.
- [Modernize Medicare to Treat Substance Use Disorders: A Roadmap for Reform](#)

- A significant number of Medicare beneficiaries need SUD treatment, but Medicare does not cover essential SUD benefits or services. This roadmap provides a comprehensive summary of policy-related recommendations to modernize Medicare to more effectively treat substance use disorders.

Thank you again for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me at [amangum.nasw@socialworkers.org](mailto:amangum.nasw@socialworkers.org).

Sincerely,

A handwritten signature in cursive script that reads "Anna Mangum". The signature is written in a dark ink and is positioned above the typed name and title.

Anna Mangum, MSW, MPH  
Deputy Director, Programs