



Leaders in Aging Well at Home

Date: August 31, 2022  
To: Centers for Medicare and Medicaid Services, HHS  
From: Sandy Markwood, CEO, USAgings  
Re: **Response to CMS/HHS RFI on Medicare Program (Docket No. CMS-4203-NC)**

Submitted via <https://www.regulations.gov>

USAgings appreciates the opportunity to respond to CMS's request for information on aspects of the Medicare Advantage (MA) program.

This letter represents our comments, which are primarily focused on addressing the social determinants of health (SDOH) through partnerships between health care, such as MA plans, and community-based organizations (CBOs), such as AAAs, in order to improve the health of older adults and people with disabilities. This includes but is not limited to the Special Supplemental Benefits for the Chronically Ill (SSBCI) program.

### **Background on Area Agencies on Aging Role in Addressing SDOH**

USAgings is the national association representing and supporting the network of Area Agencies on Aging (AAAs) and advocating for the Title VI Native American Aging Programs. Our members are the local leaders that develop, coordinate and deliver a wide range of home and community-based services, including information and referral/assistance, case management, home-delivered and congregate meals, in-home services, caregiver supports, transportation, evidence-based health and wellness programs and more.

AAAs are long-standing, trusted community resources on healthy aging, addressing the social determinants of health, and home and community-based services. AAAs are experts at providing supportive services and care that is person-centered and addresses complex care needs, chronic disease management and wellness for both clients and caregivers. In addition, embedded in their nearly 50-year-old designated role under the Older Americans Act, AAAs also target those most in need of services based on economic or social need, so they have experience working through an equity lens.

AAAs use multiple funding sources to provide these programs and services, including Medicaid, and are interested in and increasingly contracting with Medicare Advantage plans to address the social determinants of health. Our responses below

focus in on those benefits and relationships, although it should be noted that AAAs are frequently also the key local resource for understanding Medicare benefits and enrollment assistance, given that two-thirds of AAAs operate as the local State Health Insurance Assistance Program (SHIP) and nearly all AAAs provide some degree of Medicare education.

### **USAging Responses to Select RFI Questions**

***Question 3: What are effective approaches in MA for screening, documenting, and furnishing health care informed by social determinants of health (SDOH)? Where are there gaps in health outcomes, quality, or access to providers and health care services due partially or fully to SDOH, and how might they be addressed? How could CMS, within the scope of applicable law, drive innovation and accountability to enable health care that is informed by SDOH?***

Research has shown that non-medical risk factors in the physical environment and individual behaviors account for 80 percent of the factors that influence overall health.<sup>1</sup> **To be able to successfully adapt the health care system in general and MA in particular, to support the social determinants of health, it is essential that community-based experts in social care are part of the comprehensive system of care and funded for their work.** Addressing the social determinants is no less complicated or difficult than solving for an acute health problem—but the good news is experts are available in every community to support addressing the whole person in the provision of health care and social care.

Access to social services and other home and community-based services (HCBS) that keep older adults healthy and independent has traditionally been significantly underfunded despite the growing need for these services as the aging population grows at historic rates. There is ample opportunity to bridge the gap between the social care networks and acute medical systems, but to do so, **it is imperative that these partnerships are promoted, strengthened and funded.**

Specifically, CMS should invest in the Aging Network's ability to make even greater contributions to SDOH-informed health care in MA (and ideally in Traditional Medicare in the future). AAAs have a unique strength in their ability to reach older adults, particularly hard-to-reach populations such as older adults with low-incomes, those from historically marginalized populations or vulnerable older adults. AAAs are social care specialists with a nearly 50-year history of assessing and addressing SDOH/social care and other HCBS needs. AAAs have staff who are extensively trained to support older adults and caregivers; employ case managers who specialize in person-centered and complex care; and lead networks of

community-based providers to deliver the other social care services their clients require.

Health plans are taking note: 50 percent of AAAs that currently contract with health care partners are providing SDOH assessments<sup>ii</sup> under contract and we expect that number to rise. Eighteen percent of responding AAAs have contracts *specifically with MA plans*<sup>iii</sup> to deliver assessment or other SDOH-related services, a number that doubled in a few short years.

**In addition to encouraging these contracting relationships, CMS can improve access to social services through the following ideas.**

- Building in opportunities in MA and throughout Medicare (as possible at this time) to screen beneficiaries for social needs, perhaps through the Welcome to Medicare and the Medicare Annual Wellness visits. The key to this being feasible and appropriate for health care professionals to deploy is to refer beneficiaries with needs identified on the short screening to AAAs or other social care experts for a more comprehensive assessment, and once referred, to be reimbursed for services.
- Another way to increase access to social services is to avoid over-medicalizing the provision of services. Why use medical personnel, almost always paid at a higher rate, to do social work? It just makes more sense to tap the talents of the social care industry, but in doing so, there are certain translation issues that come up. In considering the health care services workforce, it is imperative to recognize that applying licensure requirements for social services can be restrictive and cost prohibitive for plans to implement. A majority of SDOH services are not clinical in nature and MA plans should embrace the opportunity to leverage an alternative workforce that supports older adults and people with disabilities in their home and community, especially as we seek to improve programs by applying a health equity lens. For example, AgeSpan, a AAA in northeastern Massachusetts, reports improved outcomes for its programs with underserved populations with the use of bilingual, bicultural workers including community health workers. Requiring clinicians/licensing for the delivery of services addressing social determinants of health impedes the ability to engage such staff, who often come from historically excluded and underserved communities.
- CMS should consider physician-related incentives to improve health care delivery and outcomes through social services engagement. One suggestion is to include Graduate Medical Education training recognizing SDOH needs of older adults and people with disabilities as well as the social service systems infrastructure. Another suggestion is to consider possible incentives for more

clinicians to document SDOH needs through the Z Codes. Currently Z Codes are an underutilized resource that could provide supplementary SDOH data, but there is no financial or other incentive to compensate for the additional administrative burden.

**On a cautionary note, CMS should remain cognizant of the limitations of technology deployed to support health care referrals to social care.** While technological tools can be a significant benefit and ease use for all parties, it's important to understand that technology platforms cannot do what social care leaders and networks can, which is to provide hands-on, in-home, assessment and support. USAging members have reported concerning examples of tech companies overstating their purpose and/or exploiting existing resources in the community for their own profit.

Specifically, social health access referral platforms (SHARPs) which are often paid by health care payers to make referrals on behalf of their members to AAAs and other CBOs, rarely pay the AAA or CBO for the needed service. While technology can be an important tool in connecting the health care and social sectors, it is imperative that the core values of assessing and providing person-centered care (which often needs to be conducted in person) are not lost, and that AAAs and CBOs are adequately compensated for the SDOH-related services that they provide to MA plan members.

The nearly 50-year-old Aging Network infrastructure that Congress has charged to actually make referrals, conduct thorough and often in-person assessments, coordinate care and provide direct services to older adults with complex care needs should not be overridden, wasted or exploited by erroneously unloading patients on underfunded social services systems. Moving forward, CMS must ensure that all of the systems—health care, social care and the technology vendors who want to assist communication between the two (i.e., SHARPs)—be in sync regarding process design and implementation and adequately compensated.

***Question 6: For MA plans and providers that partner with local community-based organizations (for example, food banks, housing agencies, community action agencies, Area Agencies on Aging, Centers for Independent Living, other social service organizations) and/or support services workers (for example, community health workers or certified peer recovery specialists) to meet SDOH of their enrollees and/or patients, how have the compensation arrangements been structured? In the case of community-based organizations, do MA plans and providers tend to contract with individual organizations or networks of multiple***

***organizations? Please provide examples of how MA plans and providers have leveraged particular MA supplemental benefits for or within such arrangements as well as any outcomes from these partnerships.***

Thank you for including this important question in this RFI. As long-standing, trusted community resources on healthy aging, the social determinants of health and HCBS, AAAs are experts at providing services and care that is person-centered and addresses complex care needs, chronic disease management and wellness for both clients and caregivers. There is a long history of community partnerships between AAAs and health care entities, but these relationships have and continue to evolve to more formal contracting relationships that allow for AAAs to be paid for their role in achieving better health outcomes.

To address the question, while some AAAs have secured direct contracts with a health plan to address beneficiaries' SDOH needs, the more common model is AAAs working together across a region or state (often in partnership with other CBOs) to better meet the geographic reach of the prospective payer. Since AAAs are experts at forming and sustaining networks—they already lead local networks of providers as part of their congressional designation as AAAs—this has emerged as an effective way to meet the MA plans' service needs with one contract.

Aging and disability CBOs have dramatically increased their involvement with Medicare Advantage in a short period of time and opportunities to partner continue to grow. In a study conducted by USAging's Aging and Disability Business Institute, the percent of responding CBOs listing MA plans as a contracting partner doubled between 2018 and 2020, from 10 percent to 20 percent, and held relatively steady during the ongoing pandemic.<sup>iv</sup> Furthermore, the survey found that 18 percent of AAAs contracting with health care reported doing so with MA plans.<sup>v</sup>

According to USAging's recent survey, the top services that aging and disability CBOs were delivering under contract with MA plans were:<sup>vi</sup>

- Ongoing case management/care coordination/service coordination; transitions from hospital to home, including discharge planning and hospital readmission prevention programs;
- Evidence-based programs (e.g., fall prevention programs, Chronic Disease Self-Management, medication reconciliation program). Evidence-based programs focusing on disease prevention, physical and behavioral health management, and falls management complement the health promotion and wellness benefits many MA plans already offer; [\[Read this example of a Massachusetts AAA with a contract to provide evidence-based program for an MA plan.\]](#)
- Assessments for long-term services and supports eligibility; and

- Assessments or screenings for SDOH needs.

To broaden beyond MA for a moment to identify the potential to grow this type of work to address SDOH within MA: just as innovation and policy development around SDOH continues to occur, so, too, has the expansion of the AAA (and other CBOs') involvement in such efforts with health care entities. As per the USAging's Aging and Disability Business Institute 2021 [Request for Information Survey on CBO-Health Care Contracting](#), more than three-quarters of contracting aging and disability CBOs (78 percent) reported that they had one or more contracts paid on a fee-for-service (FFS) basis, including as FFS tiered rate, per service unit or per service unit plus administration fee. Other payment models such as per member/per month and pay for performance/performance-based contracts were less common but grew noticeably between 2020 and 2021. For example, in 2020, only 7 percent reported a capitated payment model for any of their contracts; in 2021, that percentage had grown to 30 percent.

As noted above, a growing percentage of AAAs report contracting with health plans and other health care payers and providers through networks of CBOs. In 2017, 22 percent of contracting AAAs reported contracting through networks. By 2021 that had risen to 44 percent. MA contracting opportunities, which tend to be larger in geographic scope, will continue to promote that growth.

**This overall growth in AAA and health care contracting is critical to the ultimate success of SDOH-addressing services in MA** because, unlike Medicaid LTSS health plans, MA plans have not historically maintained networks of non-medical service providers. In the process of deciding on which SSBCI benefit to offer, MA plans must ensure there are service providers in the markets in which the benefits are being offered, and that they can provide those benefits with the scale necessary to serve the MA plan's entire service area—which provides an opportunity to invest in critical partnerships with AAAs and aging and disability CBOs.<sup>vii</sup> In addition to contracting with MA plans to provide SSBCI, AAAs can also help MA plans determine whether an individual meets the eligibility requirements for SSBCI. A key benefit of MA plans partnering with AAAs is the fact that our network (and the disability network) has more experience identifying functional limitations, which contribute to higher medical costs than chronic conditions alone.

**We urge CMS to weigh all available options to encourage wider development of SSBCI**, including but not limited to:

- ensuring that referral solutions reflect the strengths of existing social care networks and their need for payment to provide services;
- funding of SSBCI beyond the plans' rebate dollars, such as having actual payment codes and Medicare coverage for SDOH interventions; and

- ensuring that MA plans are not simply using the SSBCI as merely a marketing tool. USAging members report that too often plans put a greater emphasis on marketing these supplemental benefits than thoughtfully developing and deploying the benefits themselves.

We will also note that USAging has long been on record as supporting SDOH-related services within all of Medicare and hope a robust adoption of SSBCI in MA will ultimately serve as the proving ground for future expansion and additional data on the benefits of addressing SDOH to improve health outcomes.

***Question 7: What food- or nutrition-related supplemental benefits do MA plans provide today? How and at what rate do enrollees use these benefits, for example, for food insecurity and managing chronic conditions? How do these benefits improve enrollees' health? How are MA Special Needs Plans (SNPs) targeting enrollees who are in most need of these benefits? What food- or nutrition-related policy changes within the scope of applicable law could lead to improved health for MA enrollees? Please include information on clinical benefits, like nutrition counseling and medically tailored meals, and benefits informed by social needs, such as produce prescriptions and subsidized/free food boxes.***

Older adults are at increased risk of malnutrition for many reasons, including those related to disease, functionality, social and mental health, and hunger and food insecurity. Malnutrition in older adults was exacerbated by the COVID-19 pandemic in part due to intensified disparities, inequities, social isolation, and increased rates of food insecurity.<sup>viii</sup>

USAging's members develop, coordinate and deliver local aging programs to help millions of older Americans and their caregivers get the support they need to age successfully at home and in their communities, and these programs and services are often targeted toward the most economically and medically vulnerable older adults in the country. Nutrition programs are a major component of these aging services, both home-delivered meals and meals served in congregate settings; AAAs also offer nutrition education and counseling, and with the added flexibility under COVID-19-relief funding from the federal government, have innovated to support "grab and go" meals when socially gathering for a meal is unsafe as well as grocery delivery services. Some AAAs offer these services directly, but for the most part, they contract with community-based providers to host the meal site, to offer home-delivery and to operate the day-to-day programs.

For the older adults that USAging members serve, access to nutrition benefits is a critical link to maintaining health and independence. Research indicates that food-insecure older Americans have less nutritious diets and have worse, and often more

costly, health outcomes than food-secure seniors. Compared to other age groups, older adults are particularly vulnerable to the health consequences of food insecurity. Access to nutrition benefits help to alleviate these adverse conditions and can mean the difference between older adults having to choose between paying for food and other necessities such as medicine, housing, transportation and utilities.

We suggest the following improvements to the MA plans' ability to offer nutrition-focused supplemental benefits.

- In addition to meals, nutrition assessment should be paid for.
- Low reimbursement rates are a barrier for supplying person-centered meals, forcing providers to choose between medically tailored and culturally responsive meal delivery. MA reimbursement rates should better reflect the diversity of an exponentially growing aging demographic and the complexity of medically tailored diets.
- Dietician access, coverage and reimbursement are critical issues. Low reimbursement rates are prohibitive to qualifying dietitians causing access issues for individuals in need of this critical benefit. In addition, for many conditions, dietitian access is not covered at all.

***Question 8: What physical activity-related supplemental benefits do MA plans provide today? At what rate do enrollees use these benefits? How do these benefits improve enrollees' health? What physical activity-related policy changes within the scope of applicable law could lead to improved health for MA enrollees?***

We know that health happens at home, extending opportunities for health prevention and chronic-disease self-management outside the clinical environment. However, programs that enable independence, self-sufficiency and successfully address disease prevention/management should be adequately vetted and in turn, compensated. This is another service that AAAs can offer to MA beneficiaries!

All AAAs are required to use their Older Americans Act Title III D Disease Prevention and Health Promotion funding to provide **evidence-based health and wellness programs**, which are then approved by the U.S. Administration for Community Living. These offerings align with CMS's intent to improve physical activity and disease prevention programs for MA beneficiaries.

For example, of the evidence-based programs offered by AAAs, fall prevention programs are the most common, offered by 89 percent of AAAs. Reducing falls is a priority, as falls are the leading cause of fatal and non-fatal injury in older adults



and are associated with high health care costs.<sup>ix</sup> Other evidence-based programs by AAAs include Tai Chi for Arthritis, Diabetes Self-Management and more. These programs have rigorous evidence to support their investment.

The funding for OAA Title III D evidence-based programs is extremely limited, it should be noted, so AAAs and other CBOs offering these services would need to be paid by MA plans to offer this programming to their members. While this can be done now, we urge CMS to encourage MA plans to expand their contracting with aging and disability CBOs into this arena—there's huge potential here in building on existing programs and reaching more older adults who could benefit from these proven programs. As previously cited, our Aging and Disability Business Institute recently profiled an existing example of a health plan contracting with a AAA to provide fall prevention and other evidence-based programming to MA members in three New England states:

<https://www.aginganddisabilitybusinessinstitute.org/partnering-with-medicare-advantage-plans-on-evidence-based-approaches-to-improve-health-outcomes/> .

Thank you for the opportunity to comment via this RFI process. This correspondence does not comprehensively address all of USAging members' possible policy input on Medicare Advantage but as mentioned, we have focused here on our network's role in the provision of social care through MA and SSBCI in particular.

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<sup>i</sup> Sanne Magnan, Social Determinants of Health 1010 for Health Care: Five Plus Five, National Academy of Medicine, <https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/>.

<sup>ii</sup> USAging, Aging and Disability Business Institute, 2022, <https://2yjszzobx7o304u1b45x6bsd-wpengine.netdna-ssl.com/wp-content/uploads/2022/07/Survey-Spotlight-AAAs-508.pdf>.

<sup>iii</sup> USAging, Aging and Disability Business Institute, 2022, <https://2yjszzobx7o304u1b45x6bsd-wpengine.netdna-ssl.com/wp-content/uploads/2022/07/Survey-Spotlight-AAAs-508.pdf>.

<sup>iv</sup> Suzanne R. Kunkel, Advancing Partnerships: Contracting Between Community-Based Organizations and Health Care Entities, Scripps Gerontology Center, <https://2yjszzobx7o304u1b45x6bsd-wpengine.netdna-ssl.com/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf>

<sup>v</sup> USAging, Aging and Disability Business Institute, 2022, <https://2yjszzobx7o304u1b45x6bsd-wpengine.netdna-ssl.com/wp-content/uploads/2022/07/Survey-Spotlight-AAAs-508.pdf>.

<sup>vi</sup> USAging, Aging and Disability Business Institute, 2022, <https://2yjszzobx7o304u1b45x6bsd-wpengine.netdna-ssl.com/wp-content/uploads/2022/07/Survey-Spotlight-CBOs-508.pdf>.

<sup>vii</sup> USAging, Aging and Disability Business Institute, <https://www.aginganddisabilitybusinessinstitute.org/2020-final-call-letter-offers-guidance-and-structure-for-medicare-advantage-supplemental-benefits/>.

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<sup>viii</sup> Arensberg MB, Saal-Ridpath K, Kerr K, Phillips W., Opportunities to Improve Quality Outcomes: Integrating Nutrition Care Into Medicare Advantage to Address Malnutrition and Support Social Determinants of Health, *Inquiry*, 2022 Jan-Dec;59:469580221081431. doi: 10.1177/00469580221081431. PMID: 35255728; PMCID: PMC8908402.

<sup>ix</sup> USAging, 2020 AAA National Survey Report: Meeting the Needs of Today's Older Adults, <https://www.usaging.org/Files/AAA-Survey-Report-new-identity-508.pdf>