



September 11, 2023

Chiquita Brooks-LaSure, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave. SW  
Washington, DC 20201

**RE: CMS-1784-P: CY 2024 Physician Fee Schedule Proposed Rule**

Dear Administrator Brooks-LaSure:

USAgings applauds the Centers for Medicare & Medicaid Services for its efforts to better serve older adults and address their health-related social needs in the CY 2024 Physician Fee Schedule and appreciates the opportunity to provide comments.

USAgings is the national association representing and supporting the network of Area Agencies on Aging (AAAs) and advocating for Title VI Native American Aging Programs (Title VI programs) that help older adults and people with disabilities live with optimal health, well-being, independence and dignity in their homes and communities. 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, case management, long term care ombudsman programs and more to millions of Americans each year.

We applaud CMS for taking the expansive step to recognize the impact of Health-Related Social Needs (HRSNs) on health outcomes and total cost of care, especially for the Medicare population. The proposed creation of new Healthcare Common Procedure Coding System (HCPCS) codes for community health integration, social determinants of health risk assessment, and principal illness navigation services aim to create a new pathway for

providers to collaborate with community-based organizations such as AAAs to address these critical HRSNs.

Furthermore, we believe the Community Integration Services and Paid Caregiver Training components of the proposed rule have potential to transform the relationship between social care and health care if implemented in a way that reflects both sector's realities. The following are our comments and recommendations regarding the policies included in the CY 2024 Physician Fee Schedule proposed rule.

## **Community Health Integration (CHI) Services**

### ***Role of Area Agencies on Aging (AAAs) in Addressing Health-Related Social Needs (HRSNs)***

USAging applauds the specific reference to and inclusion of AAAs as an example of a well-equipped type of social care provider able to deliver CHI services. AAAs were formally established in the 1973 Older Americans Act (OAA) as the "on-the-ground" organizations charged with helping vulnerable older adults live with independence and dignity in their homes and communities. For 50 years, AAAs have served as the local leaders on aging by planning, developing, funding and implementing local systems of coordinated aging and other home and community-based services for consumers.

Building on their congressionally mandated roles under the OAA, AAAs tap other funding streams and take on other roles to further meet their missions and to serve more older adults and caregivers, as well as people of all ages living with disabilities. A foundational role of AAAs is to create local Information and Referral/Assistance (I&R/A) hotlines to help consumers find aging and other home and community-based services. AAAs help clients match services and solutions to their individual needs, enabling consumers to age in place with increased health, safety and independence.

As long-standing, trusted community resources, AAAs are experts at providing programs and care that address social needs that affect health outcomes, such as access to nutritious food, housing, transportation and social support. Furthermore, their deep-in-community standing and

connections, thorough assessments, and expertise in care coordination/case management is what sets them apart from referral systems that merely hand the client off to AAAs and CBOs without proper assessment or transfer of resources to ensure a social care service is able to be delivered.

AAAs increasingly contract with health care entities such as medical providers, health plans and health systems to address HRSNs to drive better health outcomes. Top contracted services include assessment for HRSNs and long-term services and supports, care transitions, home care, care coordination/case management, nutrition, evidence-based health promotion/disease prevention programs and transportation. The U.S. Administration for Community Living (ACL) has championed and supported the Aging Network's ability to be excellent partners with health care for more than a decade. Thanks in part to ACL's funding and encouragement, as well as USAging's Aging and Disability Business Institute's extensive contracting and business acumen resources, the Network has successfully expanded into the contracting arena: 47 percent of AAAs reported at least one health care contract in the 2021 USAging Request for Information survey on CBO–health care contracting, and that number is continuously growing. Forty-four percent of contracting AAAs do so as part of a network of AAAs/CBOs, which can allow them to respond to larger scale contracting opportunities with health plans, ACOs, etc.

These health care partnerships with AAAs and AAA/CBO networks are one clear solution to addressing HRSNs and CMS should strongly encourage replication and expansion given its goals on addressing HRSNs. **To address HRSNs in the best and most effective way, it is better to contract with social care entities than to build a new system within health care to provide social care and support.**

Safety net providers and physician practices that serve high volumes of vulnerable populations are often undercapitalized and may lack the infrastructure to hire additional personnel to deliver and supervise CHI services. Even in a well-resourced practice or system, it makes economic and practical sense to tap existing expertise and resources in the social care arena—instead of acute health entities medicalizing the social care work. As social care clinicians, AAAs are already experts at working with older adults, including those who have multiple chronic conditions, cognitive impairments,

low incomes or are frail or vulnerable, as well as other health and social challenges.

**USAgings urges CMS to ensure the final rule provides AAAs and other social care CBOs with a clear and leading role in assessing and addressing health-related social needs through contracts and partnerships with Medicare providers.**

Not only does this ensure that beneficiaries in need of social care are interacting with long-standing experts in the field, optimizing the highest possible level of health status improvement, but it also spares health care clinicians from yet another duty that pulls them away from their primary role. The benefits of partnering with CBOs to address HRSNs have not only been noted by the social care networks and researchers, but public health and health care organizations have been collecting data for years to prove this.

Adding additional HRSN assessment requirements for health care providers would exacerbate the type of added and burdensome responsibilities that are creating physician shortages and burnout. According to the American Medical Association, physician burnout is an epidemic in the U.S. health care system. Nearly 63 percent of physicians are reporting signs of burnout such as emotional exhaustion and depersonalization at least once a week.<sup>i</sup> Putting the responsibility of providing social care on physicians will increase the burden currently experienced by many physicians across the country. Limitations like lack of trust from patients and the community and limited screenings often result in low-quality referrals or referrals that do not address a patient's most pressing need.

A 2022 survey conducted by the Physicians Foundation found 89 percent of physician respondents said a limited amount of time during the patient visit was somewhat or very impactful to discussing SDOH. This was followed by a lack of workforce to direct patients to community resources (84 percent); community resources being unavailable, inadequate or difficult to access (77 percent); and a lack of adequate information on community resources (also 77 percent). In the same survey, 83 percent said the challenges of addressing patient SDOH moderately or significantly contributed to burnout

and only 19 percent said they had adequate resources in their practice to address patient HRSNs.<sup>ii</sup>

This data clearly shows the need for a new model that allows health care to continue to play to its strengths and taps social care clinicians to support the beneficiary in addressing their HRSNs. Like cardiology, radiology, oncology and other clinical specialties, social care is its own specialty. Social care work is not top of license for health care providers and most do not understand the intricacies of the players, eligibility for programs and supports and the overall landscape of social care. AAAs and other CBOs are experts in providing and navigating social care and can be a strong resource and partner for health care providers in addressing HRSNs ensuring better overall outcomes for patients.

A foundational role of AAAs is to create local Information and Referral/Assistance (I&R/A) hotlines to help consumers find aging and other home and community-based services. All AAAs offer core services including supportive (in-home, transportation, etc.) services, meals, caregiver services, health and wellness, and elder rights. The average AAA offers more than a dozen additional services beyond the core offerings, including nutrition counseling, case management, benefits/health insurance counseling, assessment for care planning, and assessment for long-term care service eligibility. AAAs are experts in working with people to address HRSNs and are well-tied into other systems (housing, health care, legal, etc.) and not just their own. Solid partnerships between physicians and AAAs will help tremendously in improving health outcomes for beneficiaries across the country and will empower appropriate, coordinated care provision among the various clinicians (health to post-acute to social care). See below for a model that showcases the ideal relationship for shared care by health care and social care clinicians.

## Shared Care by Healthcare and Socialcare Clinicians in support of an individual's Health Related Social Needs



*Work-in-progress by the Direct Trust Information Exchange for Human Services (IX4HS) Consensus Body subgroup Socialcare Work Group—a working document.*

### **Improving and Incentivizing Collaboration between ACOs and AAAs**

USAgging supports the addition of the Connection to Community Service Provider quality measure to the MIPS program which can also be used as an incentive for collaboration between ACOs and AAAs or other CBOs. This measure would allow for appropriate interventions to address HRSNs that go beyond the initial screening. Many physicians and beneficiaries have noted lack of trust as it relates to sharing information about HRSNs in a clinical setting due to potential bias, misuse or discrimination. AAAs and other CBOs can help to bridge the gap between physicians and beneficiaries sharing their HRSNs and ultimately improve health outcomes. If beneficiaries are asked to disclose information regarding HRSNs, it is imperative that following this information, services are offered to provide support and solutions. Ensuring appropriate follow-through and access to services does, however, require formal contracts or other partnerships between health care providers and social care specialists, so that the latter can actually provide the service.

An example of how AAA and ACO collaborations can deliver for patients is the partnership between AgeSpan (a AAA) and MassHealth/Medicaid ACOs in Massachusetts. In 2019, AgeSpan and its disability-focused partner, the

Northeast Independent Living Program (NILP), became the network lead entity for a newly certified Community Partner, The Merrimack Valley Community Partner (MVCP). AgeSpan and NILP teamed up to lead a network of CBOs that is now contracting with 11 ACOs and MCOs to offer housing-related services, such as pre-tenancy support, tenancy preservation and home modifications. One of these ACOs, My Care Family, consists of 16 primary care provider practices that serve more than 40,000 members. Members are culturally diverse, collectively speaking more than 20 languages and 70 percent identifying as Hispanic. Once an ACO member is added to the program, an MVCP care coordinator or navigator is assigned to work with the member and the health care partner to create a care plan to support the member's goals. To best ensure the work of the My Care Family ACO and MVCP partnership advances the goals of improved health outcomes, the team identified specific quality measures along with targeted improvement rates for each measure. These measures include: childhood immunization status, immunization for adolescents, asthma medication ratio, comprehensive diabetes care, metabolic monitoring for children and adolescents, initiation of alcohol or other drug of abuse or dependence treatment, and engagement of alcohol or other drug of abuse or dependence treatment.<sup>iii</sup>

Through partnerships with ACOs like the one previously described, AAAs have successfully conducted outreach to, screened, and assessed Medicaid populations and referred them to a wide range of existing community-based resources to address HRSNs. These successes have resulted in the expansion of contracts to provide services to address social needs, including those related to housing and nutrition. While this example focuses on the Medicaid population, the same approach can be applied to the Medicare population.

### ***Initiating Visit***

The proposed rule limits the initiating visit, for CHI, to an eligible Medicare provider evaluation and management (E/M) visit. We believe that providers should subsequently conduct HRSN screening during the Annual Wellness Visit (AWV) and urge CMS to include the AWV in the list of qualifying medical encounters for CHI services.

When a provider creates a wellness plan during an AWW visit, it is important to determine if there are HRSNs that will negatively impact the implementation of the wellness plan. For example, it is imperative for a provider to identify if a beneficiary is experiencing transportation challenges or housing insecurity when developing the wellness plan and note this in the plan itself. HRSNs can directly impact the ability of the beneficiary to complete the plan requirements and therefore should be included in the AWW as an eligible initiating visit for CHI services. As mentioned in the above section, we strongly advocate for AAAs and other CBOs to provide the necessary social care assessment services and supports following the identification of a HRSN by a physician. **We are not suggesting that the physician do a thorough social care assessment themselves during the AWW—just as we don't believe that is their role in the CHI services—merely that they do a high-level identification of if there are HRSNs that should be addressed via CHI or other method, in concert with social care specialists.**

### **Principal Illness Navigation (PIN) Services**

CMS has requested comment to confirm the understanding of where and how PIN services would be typically provided and whether navigators are typically local to the patient. We would like to emphasize again the role of AAAs in providing care coordination and care transition support. Discharge from any care setting is a critical and vulnerable time for Medicare beneficiaries, as our current health systems do not adequately provide care for patients moving between care settings, causing serious concerns for patient safety, quality of care and health outcomes.

Many Medicare beneficiaries experience difficulties during transition for a variety of reasons. For example, patients in a hospital typically defer to their medical providers but upon discharge, many of these same patients are expected to assume a self-management role in recovery with little support or preparation. Also, health care providers and families may not realize the level of support a patient may need, especially if the patient has not returned to his or her original level of physical or cognitive health.

Unfortunately, this confusion and lack of adequate preparation can have serious consequences ranging from medication errors to an overall decline in



health of an older adult that could result in hospital readmission. Nearly one in six Medicare patients discharged from a hospital—approximately 2.6 million individuals—is readmitted within 30 days, at a cost of over \$26 billion every year. Of those additional expenditures, an estimated \$12 billion was spent on readmissions that could have been prevented. Through the launching of CMS' Community-based Care Transitions Program (CCTP) in 2011, AAAs proved their value in addressing HRSNs for Medicare beneficiaries. Most of the 101 CBOs in this program were AAAs or Aging and Disability Resource Centers (ADRCs) with extensive experience connecting older adults to community support services. Participants from all 101 sites exhibited lower readmission rates and Medicare Part A and Part B expenditures relative to comparisons and strong CBO and hospital partnerships were key to making steady progress towards this outcome. When the demonstration concluded, some AAAs continued working with hospitals on care transitions and further strengthened their partnerships to address health and social care needs.<sup>iv</sup>

AAAs have long recognized the seriousness of this issue and have been on the forefront of developing effective strategies to make smooth transitions more commonplace. The most frequently used care transitions strategies AAAs employ are: working directly with the older adult's family to improve planning; providing additional services including transportation, in-home care services and case management; and providing or paying for home modification. Some AAAs have also leveraged cutting-edge, mobile technologies to significantly reduce hospital readmissions, such as a tablet-based care coordination platform. Taken together, these services provide a well-rounded person-centered approach that ensures that people transition throughout the continuum of care as smoothly as possible.

CMS is proposing that a billing practitioner may arrange to have PIN services provided by auxiliary personnel who are external to, and under contract with, the practitioner or their practice, such as through a CBO, if all of the "incident to" and other requirements and conditions for payment of PIN services are met. USAging strongly agrees that this reference to auxiliary personnel is essential given our previous remarks about social care specialists. However, we urge CMS to not solely identify Community Health Workers (CHWs) but acknowledge the *functions* that the social care

specialist would perform in such a relationship, rather than limit which type of specialist would be best suited for these duties.

### **Payment for Caregiver Training Services (CTS)**

USAgings commends CMS for including support for caregivers in the CY 2024 Physician Fee Schedule proposed rule. However, **we urge CMS to consider the role AAAs and others play in providing caregiver training services—and create an appropriate pathway for such caregiving experts to contribute to the value of this new program.** Through the OAA's Title III E National Family Caregiver Support Program (NFCSP), AAAs play a major role for those who care for friends or family members as they age by providing and coordinating caregiver support through training, respite, support groups and other programs. The NFCSP funds local AAAs to assist older caregivers and family members caring for older loved ones by offering a range of in-demand supports to family caregivers in every community. AAAs also play a crucial role in Information and Referral, connecting families with local aging services providers who can help them create a caregiving plan, address specific challenges, or identify support services.

In the proposed rule, it is stated that a physician or nonphysician practitioner (NPP) would provide training to caregivers. While we believe this may be necessary for caregivers who may have a more clinically focused role (changing dressings, incision care, blood pressure monitoring, etc.), for caregivers providing support for activities of daily living (ADLs), AAAs or other caregiver-supporting organizations should be the entities providing this type of caregiver training, not medical personnel. Codes 96202 and 96203 for multiple-family group behavior management/modification training for parents/guardians/caregivers of patients with a physical or mental health diagnosis should be designated for a physician or NPP. However, codes 9X015, 9X016 and 9X017 for ADLs should be designated for AAAs or CBOs that specialize in this type of training and could contract with physicians to provide it. We strongly urge CMS to make clear that physicians can contract with such caregiver services providers for caregiver training services—and are encouraged to do so.

We also encourage CMS to permit CTS in more than one single session or more than once per year and allow alternative methods of CTS delivery, including via telehealth; clarify and confirm that CTS will not serve as a substitute or replacement for Medicare-covered home health aide benefits under the law, but rather as additional services to increase a willing and able caregiver's knowledge.

### **Caregiver Definition**

USAging generally supports the definition of caregiver CMS has included in the proposed rule, and notes it aligns with ACL's definition in its proposed rule for the OAA in terms of including caregivers who are not related or otherwise legally connected to the beneficiary, which is important to ensure equity. However, we have one suggested edit (in red) to the CMS description of a caregiver's duties to reflect the social care realities of caregivers.

*(1) Definition of a Caregiver: In our ongoing education and outreach work on the use of caregivers in assisting patients, we have broadly defined a caregiver as a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition. Further, in the context of our proposals for CTS services, we believe a caregiver is an individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long-term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care, assistive technology and ADL activities at home; and helping to navigate the patient's transitions between care settings.*

### **Medicare Part B Payment for Services Involving Community Health Workers (CHWs)**

USAging applauds CMS for their efforts in better understanding and recognizing, through coding and payment policies, how social care specialists can be integrated into the care of Medicare beneficiaries.

In the proposed rule, CMS specifically mentions the contributions of CHWs. While CHWs are one type of community-based social care and health-related professional, and one in five AAAs employ CHWs, we must caution against

inadvertent limitation of the wide range of social care specialists by only providing one model either as a standard or as the sole example. **We strongly encourage CMS to broaden the descriptors of the codes to ensure other professionals, many of whom would be more qualified than CHWs to handle the complexity of some cases, are not overlooked.** For example, in the proposed rule, the below descriptor was included for a potential code for services provided by CHWs and other certified or trained auxiliary personnel.

*GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit.*

USAgings recommends the following language change to eliminate the potential to unduly limit the impact of these services by focusing in on one type of provider, and instead focus on the qualifications and expertise (broadly) that are needed to play this critical role.

*GXXX1 Community health integration services performed by certified or trained auxiliary personnel **with expertise in HRSN and social care provision to address HRSNs** under the direction of a physician or other practitioner; ...*

## **Conclusion**

We believe it is important to raise one last point about the value that our members can offer to Medicare beneficiaries, as it cuts across all codes, demos or programs: **AAAs have a long track record of working with diverse populations and advancing equity and access in social care.** The common distrust between marginalized communities and health care providers has resulted in HRSNs going unaddressed, ultimately leading to worsened health outcomes. AAAs and other social care clinicians are trusted resources and hear first-hand the real stories, challenges and concerns of older adults, people with disabilities and caregivers in communities across the country. To effectively and appropriately address HRSNs, AAAs use an approach that centers cultural awareness, health literacy levels and other

sensitivities. This approach is key for proper screenings, navigation of complex care and cultivating strong working relationships with caregivers. AAAs are the community leaders MCOs, ACOs, physicians and other health care providers should rely on to provide HRSN support and drive better health and social outcomes for Medicare beneficiaries.

We commend CMS for recognizing the need for caregiver support and addressing HRSNs for the Medicare population. Establishing new codes for screening and addressing health-related social needs and navigation services is a monumental advancement for the alignment of health care and social care and, done in concert with social care clinicians such as AAAs, we believe will deliver significant results. We strongly advocate for the Community Health Integration services to be included in the CY 2024 Physician Fee Schedule final rule with USAging's recommendations.

We welcome future conversations and collaboration to advance our goals of ensuring Medicare beneficiaries have access to the services they need to live and age well. If you or your staff have any questions about our comments, please feel free to contact Amy Gotwals, Chief of Public Policy and External Affairs, at [agotwals@usaging.org](mailto:agotwals@usaging.org) and Olivia Umoren, Director of Public Policy and Advocacy, at [oumoren@usaging.org](mailto:oumoren@usaging.org).

Sincerely,



Sandy Markwood  
Chief Executive Officer

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<sup>i</sup>American Medical Association, *What is Physician Burnout?*, 2023, <https://www.ama-assn.org/practice-management/physician-health/what-physician-burnout>.

<sup>ii</sup> Physicians Foundation, *2022 Survey of America's Physicians*, 2022, <https://physiciansfoundation.org/wp-content/uploads/SDOH-Survey-Report.pdf>.

<sup>iii</sup> USAging, Aging and Disability Business Institute, *Elder Services of the Merrimack Valley and North Shore and My Care Family Accountable Care Organization*, 2022, [https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/01/ESMV-Partnership-Profile\\_10-16-1.pdf](https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/01/ESMV-Partnership-Profile_10-16-1.pdf).

<sup>iv</sup> Econometrica, Inc., *Final Evaluation Report: Evaluation of the Community-based Care Transitions Program*, 2017, <https://downloads.cms.gov/files/cmmt/cctf-final-eval-rpt.pdf>.