USAging
Leaders in Aging Well at Home

September 9, 2024

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-1807-P: CY 2025 Physician Fee Schedule Proposed Rule

Dear Administrator Brooks-LaSure:

USAging applauds the Centers for Medicare & Medicaid Services for its efforts to better serve older adults by addressing their health-related social needs through the CY 2025 Physician Fee Schedule and appreciates the opportunity to provide comments.

USAging 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. Through the Older Americans Act (OAA), the cornerstone of the nation's non-Medicaid home and community-based services (HCBS), our members provide nearly 11 million older Americans annually with the critical support services they need. Our members are the local leaders that develop, coordinate and deliver a wide range of HCBS, including information and referral/assistance, case management, home-delivered and congregate meals, in-home services, caregiver supports, long-term care ombudsman programs and more to millions of Americans each year. **In addition to their OAA foundational programs and services, 45 percent of AAAs also provide HCBS through contracts with health care, such as Medicaid managed care organizations, Medicare Advantage plans and others.**

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USAging is also the home of the Aging and Disability Business Institute, which has been a leader in the building of business capacity for health care contracting of AAAs, Centers for Independent Living, Community Care Hubs (CCHs) and other aging and disability community-based organizations (CBOs). Funded by the Administration for Community Living (ACL) and CDC, USAging also houses the Center of Excellence to Align Health and Social Care, which funds and provides technical assistance to Community Care Hubs and the networks of CBOs that they lead which screen, assess and address health-related social needs (HRSNs) for older adults, people with disabilities, caregivers and other complex care populations.

USAging applauds CMS for recognizing the importance of the direct care workforce by proposing to establish new coding and payment for caregiver training for direct care services and supports. We also thank CMS for the continued efforts in understanding the relationships between CBOs and billing practitioners as it relates to providing Community Health Integration (CHI) and Principal Illness Navigation (PIN) services. Our members' experience and expertise inform our comments and recommendations regarding the CY 2025 Physician Fee Schedule proposed rule that follow. Our comments will provide feedback on the critical role of social care providers in supporting Medicare beneficiaries, Caregiver Training Services, and implementing community health integration (CHI) and principal illness navigation (PIN) services, as well as improving relationships between CBOs and Medicare billing practitioners.

The Critical Importance of Social Care Experts in Supporting Medicare Beneficiaries

USAging appreciates CMS' efforts to address beneficiaries' HRSNs, especially among the older adult population. However, this rule and subsequent policies must reflect and respect the way the social care sector actually works if we are to be successful and positively impact the health, and health care expenditures, of beneficiaries.

Overreliance on CHWs

Specifically, USAging is concerned about the distinct and oversimplified emphasis on Community Health Workers (CHWs) by CMS in the past several

years. While CHWs can be key players in health care navigation for beneficiaries, their abilities and scope are naturally more limited than we believe the proposed rule suggests. CHWs are one type of community-based social care and health-related professional, and while 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 for bridging health care and social care worlds. CHWs hold lower levels of training than the many other types of social care workers such as social workers (licensed or otherwise designated by their state), case managers at a social service agency such as a AAA and other, more highly trained and connected social care experts. We do not believe CHWs alone are the bridge between the health and social care worlds because if they are not employed by a social service agency with a range of information, services and programs (such as AAAs), they cannot fully assist in addressing the HRSNs of beneficiaries.

In focusing too much on CHWs alone, we are concerned CMS is riskily overlooking the existing and long experienced social care networks and their professionals in favor of the latest trend in reaching consumers, without ensuring actual service provision or comprehensive social care that CHWs cannot—and should not—provide on their own. This overemphasis on one type of provider over the more comprehensive range of social care services and professions risks leaving beneficiaries without the person-centered, comprehensive assessment and level of care they need and deserve.

When a Social Worker is More Appropriate than a Physician

We commend CMS' efforts in the past several years to recognize the critical role social care plays in supporting Medicare beneficiaries and their caregivers. However, to be successful in addressing HRSNs and not just identifying them, CMS must more strongly recognize the role of social care experts and not rely solely on health care clinicians to assess needs and deliver services. For one, it's not their expertise.

Secondly, while we understand that these new pathways must be built into and onto existing medical pathways such as Medicare billing codes, and thus must involve physicians and other clinical medical providers, there also

needs to be new pathways for outsourcing social care assessments and services to actual social care experts in the best position to ensure success.

One potential barrier to care as an example: the lengthy wait times for physician appointments and limited time with the physician during the appointment itself that may prevent Medicare beneficiaries from receiving the services needed to address their HRSNs in a timely way.

Wait times for physician appointments have increased over the past 20 years and currently, it can take anywhere from one week to three months to get an appointment.[i] Given this timing barrier to receiving clinical care, CMS should not require an initiating visit with a health care provider prior to screening for HRSNs. We are concerned that waiting for clinical appointments will further delay Medicare beneficiaries from receiving the needed food, housing, transportation and other HRSNs critical to their well-being. **It would be preferrable to allow clinicians to refer to social care partners even in advance of their patient's medical visit.** If an initiating visit is required, then it should be held with a social care worker present or include a visit with a social care worker as an initiating visit and not just with a physician. This would increase beneficiaries' access to needed HRSN services in a timely fashion, while still allowing for clinical oversight of the social care expert.

Additionally, while we are pleased that CMS has addressed the role of social care workers in the proposed rule, it is important to note that not all social workers have the same access to information and resources in a community. Social care workers based in a AAA, for example, hold potentially broader or deeper knowledge about different HRSN-related programs than those working directly for a medical office. This disconnect from the broader social care sector, even when staffed by social care professionals, can ultimately have the largest negative impact on complex clients and diverse populations, as they are most in need of person-centered, comprehensive access to HRSN-related services and supports.

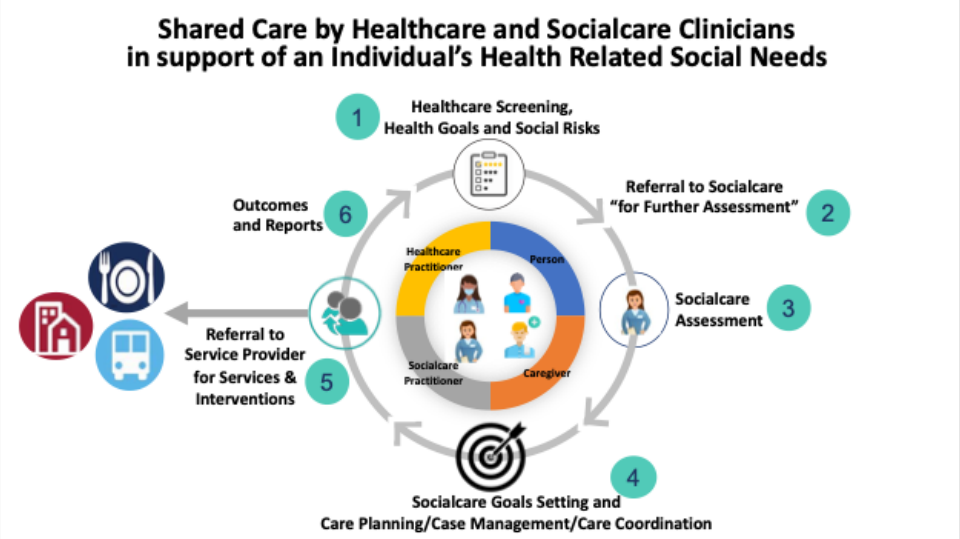
As long-standing, trusted community resources, AAAs are experts at providing programs and care that address a range of social needs that affect health outcomes, such as access to nutritious food, housing, transportation and social support. Furthermore, their deep-in-community standing and

connections, thorough assessments and expertise in care coordination/case management is what sets them apart from solo social workers, CHWs or medical personnel, who merely hand the client off to AAAs and CBOs sometimes without proper assessment and often without any transfer of resources for the AAA to provide the service.

USAging urges CMS to ensure the final rule provides AAAs and other community-based and integrated social care providers with a clear and leading role in assessing and addressing health-related social needs through contracts 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 social care networks and researchers, but also by public health and health care organizations.

See below for a model that showcases the ideal relationship for shared care by health care and social care experts. In this model, health clinicians identify that a risk exists using a brief screening tool (such as the HRSN screen or the PREPARE screen), and then refer to social care experts for "further assessment" and person-centered coordinated and delivered care. In this ideal relationship, information is shared on a bi-directional basis, so the sharing of care is complete.



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

Caregiver Training Services (CTS)

USAging applauds CMS for proposing to establish a new coding pathway for CTS focused on preparing caregivers to provide direct care supports, such as preparing meals, managing medication, housekeeping, etc. However, despite the much-needed recognition of direct care supports, the rule's restriction on eligible CTS providers to only include "clinically based" professionals (Physicians and Non-Physician Practitioners) is unfortunate and would limit the number of caregivers who can access these vital services. Both the original CTS benefit and the proposed Direct CTS are difficult to implement due to structural barriers in the policy, which do not allow for the use of appropriately trained auxiliary personnel to provide CTS under general supervision as an incident to service. The current benefit requires a provider to squeeze in caregiver training services into clinical settings that were based on Evaluation and Management (E/M) encounters, such as physicians holding fixed 10-15-minute appointments in small exam rooms, which is not conducive to the completion of the extensive training needed by caregivers from both physical space and time perspectives.

Instead of medical professionals and practices conducting the training in-house, CTS should be outsourced to existing experts in the social care

sector. There is already a national network of organizations that provide essential caregiver training services. AAAs provide critical services to family caregivers of older adults, as well as older adults who are caregivers themselves, and those services include training. In fact, 31 percent of contracting CBOs deliver caregiver support and training services under contract with health care providers and payers.[i]

Through the OAA's Title III E National Family Caregiver Support Program (NFCSP), these family caregivers receive 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. Increasingly, evidence-based* or evidence-informed caregiver training program providers such as those run by AAAs and other Aging Network partners, are working with health care providers across the country to deliver services and training.

*Examples include:
• Powerful Tools for Caregivers (https://www.powerfultoolsforcaregivers.org)
• Savvy Caregiver® (https://savvycaregiver.com)

Currently, caregiver training programs are often provided under general supervision of a qualified health care provider but are not reimbursable because of the restriction on billing for CTS using auxiliary personnel as an incident to service provided under general supervision. The adoption of essential CTS would be vastly expanded if CTS were permitted to be provided as an incident to service that can be provided by trained auxiliary personnel operating under general supervision. Allowing CTS to be delivered by auxiliary personnel would also benefit minority and geographically isolated populations that have a long history of medical mistrust.

We urge CMS to change the Caregiver Training Services benefit and the proposed Direct Caregiver Training Services benefit to allow a qualified health care provider to bill for all CTS when rendered by trained auxiliary personnel as an incident to benefit, under general supervision. Additionally, as AAAs across the country already provide caregiver education and resources, they should be included as an eligible CTS provider.

Insights into Relationships Between CBOs and Billing Practitioners

USAging commends CMS for taking the necessary steps to better understand the relationships between community-based organizations (CBOs) and billing practitioners. There are many nuances and barriers to these relationships that CMS should be aware of, some of which we will address below.

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. AAAs, CCHs and other CBOs are continuing to increase their contracting with health care entities and as of 2023, 45 percent of AAAs report having at least one health care contract.[ii] Additionally, the percentage of contracting AAAs working with Medicare Advantage plans has increased from 4 percent in 2017 to 24 percent in 2023. Of the 45 percent of AAAs with health care contracting relationships, 64 percent of AAAs with contracts provide case management/care coordination or service coordination through contracts with health care entities. Other commonly contracted services include caregiver support, training, and engagement; assessment for long-term services and supports (LTSS) eligibility; assessment or screening for HRSNs; and transitions from hospital to home, including discharge planning and hospital readmission prevention program.

Growing numbers of AAAs are also leading networks as CCHs and contracting through those networks. CCHs streamline the contracting process for health care partners, help to attain a broader geographic reach and provide administrative and operational support for CBO member organizations. The most significant benefits AAAs noted as a result of contracting are: positioned their organization or network as a valuable health care partner, expanded visibility of their organization or network in the community, increased number of people served, and expanded or enhanced the types of services offered.

However, AAAs also experience significant challenges in contracting with health care entities with the seven most significant challenges AAAs face in contracting being:[ii]

- Negotiation of price or contract terms

- Lack of awareness by health care entities of CBO programs and services
- Time it takes to establish a contract
- Staff turnover in the health care entity
- Common understanding of proposed programs or services
- Referrals and volume
- Staff turnover or shortages in an organization

Barriers Faced by AAAs when Contracting with Billing Practitioners

Despite the increases seen in health care contracting among AAAs, many of our members report challenges and barriers when faced with pursuing these contracts or serving the older adults referred to them from health care entities. Additionally, in many instances, AAAs are being left to provide services to older adults sent to them from non-contracted health care entities, **without pay.** Our members note a significant increase in referrals from 2023 to 2024 and are experiencing significant administrative and financial burdens supporting Medicare beneficiaries who are referred to them without the necessary financial investment. With COVID-relief funding expiring last year and increased demand from older adults for assistance, AAAs need to be funded for any additional services they are asked to provide to support older adults across the nation.

We encourage CMS to provide guidance, technical assistance and resources to incentivize adoption of CHI/PIN services. CMS-branded implementation support materials would increase awareness of and interest in provider implementation of critical services to address HRSNs.

For example, when CMS approved the Chronic Care Management (CCM) benefit, the agency also launched an outreach and education campaign to ensure that providers and beneficiaries were aware of the benefit. Additionally, CMS created a website, Connected Care, featuring a series of CCM implementation support materials. Creating agency-branded materials about CHI/PIN/PIN-PS codes that target providers and beneficiaries will increase adoption of this essential benefit. The CMS Connected Care website establishes a precedence for the deployment of targeted CMS-branded resources to support provider adoption of CHI/PIN services.

AAAs also face common barriers when leading CCHs. When CCHs enter a defined market of health care payers and providers, they become the central resource to provide auxiliary personnel to address HRSNs for hospitals and providers in their region. The current initiating visit requirement creates a barrier to deployment of the CCH model to implement CHI/PIN services when CCHs partner with multiple providers in a defined market. The initiating visit rule applied to a CCH in a defined market requires the CCH to secure contracts with every small and large practice in the region resulting in increased cost and complexity. Unfortunately, this barrier impedes the adoption of CHI/PIN by CCHs.

Some CCHs are overcoming this barrier by hiring a physician or non-physician practitioner and creating a group practice to bill for the initiating visit and subsequent CHI/PIN. This approach requires the CCH to create a legal entity that is eligible to enroll in Medicare as a group practice. While some CCHs have implemented a group practice model, it is implausible to expect that all CCHs develop internal capacity to establish a group practice to complete the initiating visit and supervise CHI/PIN. Additional flexibilities regarding the initiating visit would support the adoption and deployment of CCHs as a federally recognized and recommended method to scale models that effectively and efficiently address HRSNs in a defined community.

Therefore, we urge CMS to consider additional flexibilities for the initiating visit requirement to support the adoption and implementation of the CCH model to ensure that regional hubs can deploy HRSN interventions, which will serve as a resource available to multiple hospitals and physicians in a defined market.

Another barrier our members have reported when pursuing a contract, or making the first step towards one, is confusion and lack of clarity as it relates to the requirements needed for working with Medicare billing practitioners. **USAging urges the Center for Medicare to collaborate with ACL and Aging Network organizations** to provide key updates, announcements, partnerships or webinars dedicated to providing information and technical assistance to eligible and interested CBOs in pursuing contracts with Medicare billing practitioners.

Conclusion

Of final note, we raise one last point about the value that our members can offer to Medicare beneficiaries, as it cuts across all codes, demonstrations or programs: AAAs have a long track record of working with diverse populations and advancing equity in and access to social care. The common distrust between marginalized communities and health care providers has resulted in HRSNs going unaddressed, ultimately leading to poorer health outcomes. AAAs and other social care experts are longstanding, trusted resources in their communities and hear first-hand the real stories, challenges and concerns of older adults, people with disabilities and caregivers in communities across the country.

We commend CMS for recognizing the need for caregiver support and addressing HRSNs for the Medicare population. We strongly advocate for the new CTS codes and payment to be included in the CY 2025 Physician Fee Schedule final rule but urge CMS to encourage a clearer role for social care experts' provision of these benefits, in keeping with our noted recommendations.

We welcome future conversations and collaboration to advance our shared goal of ensuring Medicare beneficiaries have access to the high-quality 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, Public Policy and External Affairs, at agotwals@usaging.org and Olivia Umoren, Director, Public Policy and Advocacy, at oumoren@usaging.org.

Sincerely,

Sandy Markwood
Chief Executive Officer

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[i] AMN Healthcare/Merritt Hawkins, *2022 Survey of Physician Appointment Wait Times and Medicare and Medicaid Acceptance Rates, 2022*, https://www.wsha.org/wp-content/uploads/mha2022waittimesurveyfinal.pdf.

[ii] USAging, Aging and Disability Business Institute, *AAAs at the Nexus of Social Care: Contracting with Health Care Entities, 2024*, https://www.usaging.org/Files/7-5-AAA%20at%20the%20Nexus.pdf.