Medicare Advantage Plans & Evidence-Based Prevention Program Uptake

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Executive Summary

Since 1987, Title III-D of the Older Americans Act has authorized state grants that support health promotion programs for older adults (aged 60 and older), with a 2012 amendment requiring that all health promotion programs delivered using this funding be evidence-based. The Administration for Community Living (ACL) awards Title III-D funds to states and oversees the evidence-based program (EBP) review process, using an established definition and corresponding criteria for identifying EBPs. Area Agencies on Aging and other aging network organizations use this funding to implement EBPs that support health promotion among local older adults. These programs include rigorously evaluated approaches to build skills in areas like falls prevention, nutrition, physical activity, mental health promotion, and management of chronic conditions. There is strong federal interest, particularly within the current administration, to identify ways of increasing EBP delivery nationwide to reach a growing older adult population.

Medicare Advantage (MA) plans represent one potential avenue for EBP expansion, as plan growth has been rapid, with most older adults projected to be enrolled in MA plans within the next decade. MA plans can partner with community-based organizations (CBOs) within the aging network to deliver EBPs, but very few research studies have explored MA plans' EBP delivery to date. Consequently, little is known about these types of MA plan-CBO partnerships to deliver EBPs. This Assistant Secretary for Planning and Evaluation and ACL study tasked RTI International with exploring these partnerships and learning more about how MA plans provide EBPs. Through an environmental scan and interviews with MA plan leaders, aging network stakeholders, and federal MA plan and EBP experts within the U.S. Department of Health and Human Services, RTI gleaned a high-level understanding of how MA plans are using EBPs to support health promotion for older adults.

Key Findings included the following:

- MA plans offer supplemental benefits, including EBPs, for a variety of reasons, including to meet the health promotion needs of members, differentiate themselves from the competition, and improve their Centers for Medicare & Medicaid Services quality ratings.
- Because there is no requirement for MA plans to ensure that supplemental benefits are evidence-based, actual use of health promotion EBPs varies widely, as do definitions of what it means to be "evidence-based." Publicly available details are limited regarding what benefits are offered or why an MA plan might select a given benefit.
- Partnerships between MA plans and aging network CBOs offer multiple advantages: increasing quality ratings for plans, providing a sustained source of funding for CBOs, and supporting the health and wellness of beneficiaries. However, challenges to establishing these partnerships are widespread, including operational differences and difficulties sharing data.
- Community care hubs (CCHs) represent one opportunity to link MA plans to CBOs that deliver EBPs, providing needed coordination and communication between both entities.

- Establishing clear guidelines for both EBP implementation and more flexible evidence-informed programming would ensure that MA plans are prioritizing delivery of high-quality programs to support health promotion among older adults.
- Federal guidelines around EBP delivery, including potential ties to quality measurement, would encourage increased health promotion EBP uptake by MA plans.

Although more MA plans are offering supplemental benefits, such as EBPs, structural factors still restrict their adoption and implementation. Options for encouraging potential growth in EBP uptake include the following: identifying a shared definition of what evidence-based means; understanding appropriate implementation flexibilities while still maintaining core evidence-based components of a program; communicating how specific EBPs can meet MA plan member population needs; leveraging CCHs to enhance partnerships with aging network CBOs; and focusing on the benefits of EBP delivery for enhancing care quality and reducing health care costs. With additional federal guidance for MA plans and potential incentives (e.g., MA plan quality measures tied to EBPs), delivery of evidence-based designs will likely increase. Additional research could help facilitate a greater understanding of the types of guidance needed, including more engagement from MA plan leaders and testing to determine how EBPs could best fit into existing quality measurement practices.

Introduction

Since 1987, Title III-D of the Older Americans Act (OAA) has authorized state grants that support health promotion programs for older adults (aged 60 and over). In Fiscal Year (FY) 2012, an additional congressional appropriations law amended Title III-D, requiring all health promotion programs delivered using this funding to be evidence-based. This requirement for evidence ensures that programs meet the Administration for Community Living (ACL)-established criteria for evidence-based health promotion, verifying that these programs have been proven to improve the health and well-being of older adults or minimize disease or injury (ACL, 2025).

For over a decade, ACL has overseen a process for vetting evidence-based programs (EBPs) for health promotion and disease prevention for older adults. Examples include programming to support balance and reduce the incidence of falls (e.g., A Matter of Balance), chronic disease management (e.g., CDC Diabetes Prevention Program), and other health and wellness supports (e.g., Fit and Strong!). Programs that achieve EBP designation are added to a publicly available EBP registry so that state, community, and tribal entities can implement them to meet the needs of local older adults (National Council on Aging [NCOA], n.d.). Currently, many of these programs are delivered within aging network organizations, such as Area Agencies on Aging (AAAs) or other community-based organizations (CBOs) that can bridge health and social service delivery for older adults.

In 2024, a report from the U.S. Preventive Services Task Force indicated that some EBPs, specifically falls prevention programs, may benefit from additional research to help identify best practices for increasing EBP availability and accessibility (U.S. Preventive Services Task Force, 2024). The report showed some evidence of positive EBP impact, although it focused on understanding multifactorial impacts and comparison groups specific only to falls prevention programs. Still, there has been strong federal interest, particularly within the Trump administration, to identify ways of increasing uptake of EBPs to better support older adults (Centers for Medicare & Medicaid Services [CMS], 2025c, 2025d).

Medicare Advantage (MA) plans represent one potential avenue for EBP expansion, given that more than half (54%) of all Medicare-eligible older adults participate in MA plans (Freed, Biniek, & Neuman, 2024). MA plan enrollment has nearly doubled in the past decade and is projected to continue increasing. Nearly two in three older adults are expected to be MA plan participants by 2033 (Freed et al., 2024). Following the CHRONIC Care Act of 2018 and associated Special Supplemental Benefits for the Chronically Ill (SSBCI) provision in 2020, MA plans are increasingly providing an array of both health-related (e.g., caregiver supports) and nonmedical supplemental benefits (e.g., home modifications) that may result in better health outcomes (Hammond & Mejia, 2024). The combination of increased supplemental benefits and a growing participant volume makes MA plans an attractive vehicle for supporting and potentially expanding EBP delivery.

To date, few research efforts have explored how MA plans implement EBPs. Among those MA plans known to provide EBPs, most partner with CBOs or work with the aging network to facilitate service delivery (CHCS Resource Center, 2025). Accordingly, a team from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), in partnership with ACL, tasked RTI to explore MA plan EBP delivery and CBO partnerships. Through an environmental scan and interviews with MA plan leaders, aging network stakeholders, and federal MA plan and EBP experts within the U.S. Department of Health and Human Services (HHS), RTI gleaned a high-level understanding of how MA plans are using EBPs to support health promotion for older adults.

Methodology

The RTI team (**"**team**"**) worked with ASPE and ACL to identify key research questions for this effort as shown in Table 1. We also discussed the meaning of **"**evidence-based**"** with ASPE and ACL, relying on the ACL definition (ACL, 2025):

- *The* program *must either have been designated as an EBP by another HHS office, or*
- *It must do all the following:*
  - *Demonstrate through evaluation that it is effective for improving the health and well-being of or reducing disease, disability, or injury among older adults;*
  - *Prove effective with an older adult population, using an experimental or quasi-experimental study design;*
  - *Have research results published in a peer-review journal;*
  - *Be fully translated in one or more community sites, and*
  - *Include dissemination products available to the public.*

Throughout this report, we note that aging network organizations and MA plans also implement evidence-informed programs, which have not met the full requirements for EBP designation. These evidence-informed programs may take the form of supplemental benefits or health-focused programs that are grounded in research but have not yet met all EBP criteria. For example, an evidence-informed program may have demonstrated benefits in a small population, without having yet been tested in a large-enough community to show sufficient statistical power.

Table 1. Research Questions Guiding the Study

Research Questions
1. What MA plans are using EBPs? a. How do they determine which EBPs to cover? b. Are there issues not addressed through ACL's existing EBP clearinghouse that could help MA plans make better decisions about covering these programs?
2. Do MA plans partner with the aging network? a. If so, how do they partner? Does the partnership include EBPs?

Research Questions
b. If not, what might help MA plans work more cohesively with aging network partners (e.g., AAAs, CCHs, or other community-based aging service organizations) to implement EBPs?
3. Are there evidence frameworks or thresholds for evidence that MA plans use or could use for EBP coverage determination? a. If so, how do MA plans select EBPs for consideration (e.g., drawing from clinical practice standards, scientific literature, federal guidelines, and other relevant national or local determinations)? b. In what way, if any, does EBP selection factor into MA plan business development goals (e.g., improving star quality ratings, providing a competitive edge)?

To address these research questions, RTI first completed an environmental scan to assess the landscape of peer-reviewed and grey literature that described which MA plans offer EBPs, how MA plans implement EBPs, how MA plans partner with CBOs and the aging network for EBP delivery, and what role EBPs may play in the overall matrix of services that MA plans offer. Second, we interviewed an array of aging network stakeholders, federal experts, and MA plan representatives to understand their knowledge of and experiences with MA plan EBP implementation.

Environmental Scan Methodology

We developed a list of search terms related to MA plans and EBPs and searched English-language, U.S.-based literature, websites, and resources developed since 2010. Initial search terms included the following:

- Medicare Advantage, MA plan
- Evidence-based program/practice/intervention
- Falls prevention, falls risk, falls screening, health promotion
- Area Agencies on Aging/AAAs, Community Care Hubs, aging services, aging network
- Partnership, uptake, implementation
- Supplemental benefits, Special Needs Plans/SNPs

We searched several databases of peer-reviewed articles, including PubMed, Web of Science, CINAHL, AgeLine, and APA PsychInfo. Following our initial search, we identified 58 potentially relevant peer-reviewed sources. We logged all results in our customized literature review tracking spreadsheet, detailing the author, publication date, title, journal/organization, web link, and citation for each. Then, we screened the results for appropriate fit to this study. We excluded 45 article abstracts based on relevance, year, language, population type, or population outside the scope of the scan (e.g., focusing on EBPs for children, rather than older adults). We then reviewed the full texts of the remaining 13 articles, determining that 3 were relevant for inclusion.

For the grey literature, we conducted Google-based searches using the same, above-listed search terms. Finding few resources, we then pivoted to include the proper names of several ACL-approved EBPs listed on the National Council on Aging (NCOA) website (NCOA, n.d.).

That search, combined with our original grey literature search, yielded 80 potentially relevant sources. We excluded 51 for relevance and determined that 29 were appropriate for inclusion. **Table 2** summarizes the identified peer-reviewed and grey sources.

Table 2. Environmental Scan Sources

	Peer-reviewed Literature		Grey Literature	
Search Terms	**# Identified**	**# Included**	**# Identified**	**# Included**
Medicare Advantage, MA plan - Evidence-based program/practice/intervention - Falls prevention, falls risk, falls screening, health promotion - Area Agencies on Aging/AAAs, Community Care Hubs, aging services, aging network - Partnership, uptake, implementation - Supplemental benefits, Special Needs Plans/SNPs	**58**	**3**	**80**	**29**

Note: Total counts within this table include only citations specific to the study research questions.

Interview Methodology

The RTI team conducted 10 interviews to learn about the current landscape of EBP uptake by MA plans. Interviewees represented three groups: aging network leaders (6 interviews), MA plan representatives (2 interviews), and federal staff (2 interviews). We developed three interview guides, one for each group. Although each guide included organization-specific topics, they also all included a few common discussion topics, including considerations in offering EBP services, barriers and advantages to MA plan and aging network partnerships, and thoughts on how policymakers might facilitate expansion of EBP delivery.

We conducted all interviews via Zoom, with the recording and transcription features enabled. Each conversation included up to two RTI team members, with an interviewer and a note-taker. Our 10 interviews included a total of 17 people, as some interviews included multiple participants from the same organization.

Following each interview, we analyzed our notes by key theme and used the transcripts to highlight any key details missed in the notes. To analyze these data, four members of the team who participated in the interviews employed a team-based approach to thematic analysis, discussing key findings and common themes (Braun & Clark, 2006). We developed a priori themes based on the research questions and a posteriori themes derived from cross-interview findings. We then developed a spreadsheet to organize content across themes and interviewee types; the resultant thematic findings became the basis of this report.

Recruitment

Prior to outreach, we developed recruitment language detailing the nature of the project and its federal affiliation, highlighting the confidentiality of interviewee responses, and including a link for prospective participants to book an interview time. We used Microsoft Bookings to schedule

interviews, which allowed participants to click the embedded link and choose from an array of available business day times when RTI team members were available to conduct interviews.

We selected prospective interviewees based on their affiliations with each of the three target interview groups, including potential MA plan contacts engaging in falls prevention and health promotions activities and aging network and federal staff contacts. We identified additional MA plan contacts via sources mentioned in grey literature, general web searches, and the Center for Medicare and Medicaid Innovation (CMMI) MA plan directory, which lists MA plans and points of contact (CMS, 2025b). Additionally, we conducted LinkedIn searches for representatives of MA plans.

A snowball sampling approach was also applied, wherein we asked interviewees to provide other relevant contacts who might be interested in completing interviews for this project. Eight of the interviewees offered contacts, but most of these did not result in additional interviews. Only two of our completed interviews were the result of snowball sampling. In total, the team reached out to 44 prospective interviewees between May and July 2025. **Table 3** depicts the results of our recruitment efforts.

Table 3. RTI Interview Outreach

Interviewee Type	# of Individual Contacts Emailed*	# Individuals Responded but Not Interviewed**	# of Completed Interviews***	# of Individual Non-respondents
MA Plan	34	2	2	30
Aging Network	7	0	6	1
Federal Staff	3	0	2	1****
TOTAL	44	2	10	32

Notes: *Two RTI staff reached out to prospective interviewees by email, with two follow-up emails to each nonrespondent.
**Reasons for not interviewing after responding to initial outreach included lack of availability to interview in 2025 and a request to confirm the legitimacy of the study, which the ASPE Contracting Officer's Representative provided, but the prospective interviewee still declined to participate.
***We conducted a total of 10 interviews, but these included 17 people, as several interviews (mostly within the aging network) featured more than one staff member from the same organization.
****This prospective interviewee was no longer working as a federal employee.

Findings

The following sections provide summary findings from the environmental scan and interviews. All findings are arranged by methodology and key themes.

Environmental Scan Findings

Across the environmental scan searches, the team found limited prior research, particularly in the peer-reviewed literature. The following sections describe the overarching themes we identified from relevant peer-reviewed and grey literature sources, including MA plans offering EBPs as supplemental benefits, the importance of MA plan partnerships with CBOs in the aging network, and examples of MA plan EBP implementation.

MA Plans Offering EBPs as Supplemental Benefits

For several decades, MA plans have used supplemental benefits to provide flexible coverage for nonmedical services and supports that promote beneficiary member health, such as vision or hearing aid coverage (Gondi & Gebremedhin, 2021; Roberts, Burke & Haddad, 2024). The introduction of the CHRONIC Care Act expanded the types of benefits MA plans could offer to include services with the potential to "ameliorate the functional/psychological impact of injuries or health conditions or reduce avoidable emergency and healthcare utilization" (CMS, 2018). These expanded health-related benefits, including services related to diagnosing and treating conditions, can help to reduce costly emergency visits and hospital stays (Smith et al., 2023). Other qualified offerings under this expansion included transportation, nutrition, and a variety of home and community-based services (e.g., caregiver supports and adult day care services), which prior research has shown can improve health outcomes (Aging and Disability Business Institute, 2018).

Created by the CHRONIC Care Act, MA plans began offering SSBCI in 2020, which further expanded the list of potential supplemental offerings. Newly added nonmedical benefits (e.g., home modifications) had "a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee" (Aging and Disability Business Institute, 2018). Expanding coverage to include these services is important; for many older adults and their caregivers, access to these types of supports has the potential to help them remain healthy at home and continue to live independently (Markwood, Gotwals, & Billger, 2022; USAging, 2019).

MA plans have broadly expanded their supplemental benefits in recent years. From 2019 to 2023, for example, the number of MA plans offering caregiver supports increased 320%, and the number of MA plans offering social needs benefits, like access to companion care or programs to address member isolation, increased 1215% (ATI Advisory, 2023). Prior research including interviews with MA plan representatives, revealed three key reasons MA plan leaders choose to offer these benefits (Crook et al., 2019; Knowles et al., 2022;Thomas et al., 2019):

- To more effectively target the nonmedical, health-related needs of their members,
- To differentiate themselves from their competitors, and
- To improve their CMS quality ratings (e.g., Star Ratings) or other quality ratings.

As one source notes, "MA plans are using this [supplemental benefit] flexibility to evaluate which new benefits can move the needle in terms of reducing cost and improving health for MA enrollees" (Ipakchi et al., 2021).

Although more MA plans have offered supplemental benefits in recent years, few sources described plan efforts to implement specific programs, like those on ACL's list of approved EBPs. For some time, there was no federal requirement for MA plan supplemental benefits to be evidence-based.[1] However, in calendar year 2025, CMS began requiring programs offered as SSBCI to "meet the legal threshold of having a reasonable expectation of improving the health or overall function of chronically ill enrollees" (CMS, 2025c). Accordingly, MA plans must establish and maintain a bibliography of research studies "or other data" showing the effectiveness of each SSBCI they plan to offer (CMS, 2025c).

Our review of the literature indicates that at least some MA plans provide evidence-based health promotion programs as part of their covered supplemental benefit offerings (see **Table 4**). These programs include falls risk, chronic disease self-management, physical fitness, caregiver education, and care transitions (National Council on Aging, n.d.). Although there are reports describing evidence-based health promotion programs offered by MA plans (e.g., Aging and Disability Institute, 2022b; NORC at the University of Chicago, 2022), it is unclear how many MA plans offer evidence-based programs (vs. non–evidence-based or evidence-informed programs). The existing literature also offers few details about MA plans' decision-making around offering specific programs.

MA Plan Partnerships to Deliver EBPs

The literature indicates that when MA plans choose to offer supplemental benefits, including EBPs, they sometimes contract with CBOs within the aging network that have specific expertise in supporting older adults. A recent guide to support CBO partnerships suggests that MA plans may have a growing interest in these kinds of aging network relationships (HCPLAN, n.d.). A 2024 resource also highlights the potential of MA plans to provide social benefits, which seems directly aligned to supplemental benefits like EBPs (HCPLAN, 2024). A survey of nearly 600 CBOs, including AAAs, found that 38% of CBOs have a contract with an MA plan or other health care entity (Aging and Disability Business Institute, 2018). Although some MA plans partner with for-profit companies (ATI Advisory & Long-Term Quality Alliance, 2023) or deliver their own supplemental benefits (Knowles et al., 2022), opportunities for CBO partnerships are on the rise (Aging and Disability Business Institute, 2018). Findings from a CBO-Health Care Contracting survey indicated that 21% of CBOs contracted with MA plans in 2023, compared to 16% in 2021 (Kunkel & Lackmeyer, 2024).

When considering partnerships, MA plans likely focus on the potential benefits the partner can add to the plan (Ipakchi et al., 2021). Because EBPs undergo rigorous validity testing prior to earning the evidence-based designation, they are designed to yield quality improvement (Pferr, 2023). When MA plans deliver quality programming, they are poised to attain better scores on coveted CMS quality measures, such as Star Ratings. Higher quality ratings, in turn, drive enrollment increases, which help fund supplemental benefits (NCOA, 2022). As an example, the

[1] Although there is no federal requirement for EBP use, MA plan leaders seek programs with proven success and the potential for strong return on investment (ROI), meaning they need data metrics to demonstrate potential program value. EBPs, although not intended to demonstrate ROI or financial benefit, offer validated results that show proven effectiveness, which may appeal to MA plans.

Better Medicare Alliance (2016, 2019), an advocacy organization supporting MA plans, has indicated that plans may partner with CBOs to provide programs to their members like evidence-based falls prevention. Offering an EBP for something like falls prevention can reduce the number of enrollees experiencing a fall, in turn also reducing the likelihood of unplanned inpatient hospitalizations and costs associated with fall-related injuries (Aging and Disability Business Institute, 2022a).

CBOs benefit from working with MA plans because of the funding variation these partnerships bring. CBOs typically rely on short-term federal grants to support service delivery, and these grants often do not cover all organizational operating expenses (CMS, n.d.). Accordingly, CBO leaders seek public resources (e.g., state or local funding) and private funds (e.g., private grants) to help support their programming. Some CBO leaders also initiate outreach directly to MA plans, seeking partnership and associated financial benefits (NCOA, 2020). These MA plan partnerships may provide reimbursement to CBOs based on criteria such as the number of plan members who enroll in an EBP or the number of EBP sessions that plan members attend (Better Medicare Alliance, 2019). Thus, partnering with MA plans is an appealing choice for establishing an additional source of funding that CBOs, including AAAs, can use to grow and sustain their EBP offerings.

In the past few years, Community Care Hubs (CCHs) have enabled partnerships between CBOs and MA plans, coordinating supplemental benefits to plan members through multiple CBOs (Breslau et al., 2023; HCPLAN, n.d.; Kunkel & Lackmeyer, 2024; Pferr, 2023). CCHs are community-focused entities that organize and support networks of CBOs, providing the administrative and operational infrastructure to enable health care contracting. CCHs are well positioned to connect the MA plans with health promotion programs though providing coordinated administrative functions in support of health-related service delivery, like EBPs (Health Management Associates, 2024; Hughes, 2025).

A 2023 ASPE and ACL report on CCH models highlighted the benefits of coordinating health and community-based services to better address needs. The ASPE report also detailed how CBOs, MA plans, and CCHs work together to identify effective strategies that integrate services, improve the efficiency and effectiveness of care, and reduce negative health events, while achieving better health outcomes (ASPE & ACL, 2023).

Examples of MA Plan EBP Implementation

Although few MA plans publicly share the details of their EBP offerings, the environmental scan revealed some details about these supplemental benefits. **Table 4** highlights examples of MA plans that are implementing EBPs, including through CBO partnerships.

Table 4. Examples of MA Plans Offering EBPs

MA plan Examples
▪ Early in their founding, the **Western New York Integrated Care Collaborative (WNYICC)** contracted with MA plans to deliver services, regularly expanding their offerings. Examples **include Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and**

MA plan Examples
Diabetes Self-Management Program (DSMP) (ASPE & ACL, 2023). WNYICC partnered with **Independent Health** MA plan to implement Healthy IDEAS (ACL, 2023; ASPE & ACL, 2023; Health Management Associates, 2024; Michigan Department of Health and Human Services, n.d.).
▪ The **Mid-America Regional Council (MARC)**, an AAA and CCH in the Kansas City area, provides health-related social services and home-based care through a network of CBOs. MARC has partnered with a local MA plan to offer care transitions, case management, and health services to high-risk members, including the evidence-based **HomeMeds** medication reconciliation intervention, with a reimbursement model based on a fee schedule and claims for services rendered to MA members (ACL, 2023; Michigan Department of Health and Human Services, n.d.). MARC also partners with **Blue Cross and Blue Shield of Kansas City** (Blue KC) MA plan (Blue Cross and Blue Shield of Kansas City, 2025).
▪ **Harvard Pilgrim Health Care** MA plan partnered with **AgeSpan**, an AAA and CCH in Massachusetts, to provide evidence-based programs like **Healthy Eating for Successful Living for Older Adults, Savvy Caregiver**, **A Matter of Balance,** and **Tai Ji Quan Moving for Better Balance** to members across Massachusetts, Maine, and New Hampshire. The collaboration expanded into a multistate network with AgeSpan acting as the lead entity, utilizing a network of over 80 CBOs to deliver these programs and manage care for members at risk for falls (AgeSpan, 2022; Aging and Disability Institute, 2022b).
▪ **UPMC for Life HMO Premier Rx** MA plan offers nonmedical supplemental benefits, including in-home support services and caregiver assistance. The plan offers the **Powerful Tools for Caregivers** program to help caregivers manage responsibilities (ATI Advisory & Long-Term Quality Alliance, 2023).
▪ An unnamed MA plan in California partnered with CBO and CCH **Partners in Care Foundation** (Partners) for case management support and implementation of the **Chronic Disease Self-Management Program**, generating buy-in among plan staff related to the value of EBPs. The MA plan also chose to implement the **Care Transitions Intervention** (NORC, 2022).

Source: RTI environmental scan, 2025.

Interview Findings

Following the environmental scan, we conducted a series of interviews to understand whether and how MA plans offer EBPs and partner with aging network entities for program delivery. We identified a few key themes across these interviews, including variation in definitions of evidence-based, program selection by MA plans, aging network and MA plan partnerships, benefits and facilitators, challenges and barriers, and the future of MA plan EBP delivery.

Defining Evidence-Based

Interviews revealed variation in the way that MA plan representatives thought about evidence-based interventions relative to how ACL designates programs as EBPs. One MA plan interviewee defined "evidence-based" as being rooted in science, meaning there is peer-reviewed literature, with clinical studies that have sufficient sample size, address bias, and show evidence of outcomes that are "*real and applicable to the population that you're going to apply it to*." This definition is similar to how ACL defines evidence-based. The interviewee also shared that their MA plan will consider guidance from professional associations, such as that offered by the Neurological Society or the Orthopedic Society. The other MA plan interviewee offered a higher-level definition, describing EBPs as either packaged programs or benefits that are based on research evidence, like providing post-discharge meals to a patient at home.

Some aging network interviewees described partnering with MA plans to offer evidence-informed programs, meaning programs that may be similar in topic or structure but lacking the rigorous evidence of programs that appear on the list of ACL-vetted EBPs. These evidence-informed programs were said to closely mirror EBPs, meaning that they may deliver a modified version of an EBP that has been adjusted to fit local needs. Some of these evidence-informed programs are adapted from NCOA-designated EBPs, such as the care transition programs administered by one interviewee organization, which are a modification of the Care Transitions Intervention EBP.

Aging network interviewees also partnered with MA plans to offer services that are rooted in research evidence but are not packaged programs like those included on the ACL list. One aging network interviewee noted a challenge with delivering a packaged program, suggesting that it may force the aging network organization "*to get too narrow*" and limit their ability to respond flexibly to client needs. Instead, the organization may weave together components of evidence-based programs or practices to try to meet the diverse needs of their clients. According to the interviewee, this flexibility may also appeal to potential MA plan partners who are looking for an organization that can "adapt to help" in their areas of expertise, beyond delivering a single program. Interviewees shared that both EBPs, evidence-based health promotion programs, and evidence-informed programs are often implemented together to "fill a gap" in services for older adults served through the aging network.

Benefit Selection by MA Plans

MA plan interviewees explained that when their organization is exploring options for supplemental benefit options to offer, including evidence-based and evidence-informed health promotion programs, they draw information from several sources. Strong partnerships with CBOs, participation in industry conferences, and engaging directly with program developers who approach them with partnership offers provide information on available programs and services. The MA plan may also use their clinical team to review published research studies on the effectiveness of emerging interventions. Neither interviewee mentioned referring to databases of evidence-based health promotion programs, such as the ACL-supported NCOA database.

Federal interviewees felt that MA plans select benefits based on ease of distribution, competitive advantage, scalability, impact on CMS quality ratings, and ROI, perhaps before assessing the rigor of the evidence supporting the benefit. One federal interviewee shared, "*I think there is some consideration of the evidence, and they do want to know what has the strongest evidence base, but I personally think that's just one of the factors they're considering*." When deciding which supplemental health benefits to offer, the MA plan interviewees said they prioritize their members' existing needs and consider how new services will impact the health of their Medicare beneficiary communities. One interviewee said that their organization analyzes population-level data to understand characteristics of the communities where they offer services. They assess demographics, socioeconomic indicators, and rurality, among others. They may conduct some analysis of comorbid conditions and social determinants. They also

base their decisions on the anticipated impact of the program or service on Healthcare Effectiveness Data and Information Set (HEDIS) measures, Star Ratings, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures—all of which are CMS quality measures that can be compared across MA plans.

When asked more generally about program offerings, MA plan interviewees agreed that it is important to provide programs rooted in evidence. One MA plan interviewee added that they would not consider offering a program that did not have evidence of success. The interviewee indicated that evidence-based programs are an important part of being "*good stewards of members' dollars*" because they have proven efficacy. MA plan interviewees explained that the overall goal of offering EBPs is to improve the health and wellness of MA plan members by meeting an expressed need in the community.

When asked about the ACL-supported registry of EBPs, neither MA plan interviewee seemed very familiar with it. During the interview, the interviewer screen-shared the spreadsheet of 74 available EBPs (NCOA, n.d.). Upon a cursory inspection of the list, the MA plan interviewees recognized some programs but indicated that they did not believe their organization offered any of the programs on the registry. However, they said they follow evidence-based guidelines and provide programs that are similar to some of those listed on the registry. One interviewee shared, "*We definitely parallel, mirror what is out there from the guidelines*." The exact meaning of this program "mirroring" could not be discerned from the interviews, but it seemed that interviewees were more focused on topical content than EBP model fidelity (e.g., the NCOA website might highlight specific falls prevention EBPs, and the MA plan also offers programs for falls prevention, which they believe are similar).

Aging Network and MA Plan Partnerships

MA plan interviewees described delivery of supplemental benefits as being carried out through a combination of in-house and partner vendor services. As representatives of an integrated delivery system, both MA plan interviewees shared that their organization meets many of the needs of its members using its own internal delivery system. However, they shared that their plan has a few partnerships with external vendors and CBOs. For example, one MA plan interviewee said they deliver falls prevention and chronic disease management programs in-house through their Care Management team, but they work with outside organizations to provide home-delivered meals.

Developing Partnerships

Aging network interviewees described various methods for engaging and managing partnerships with MA plans to deliver EBPs. For example, when legislation in one aging network interviewee's state required MA plans to offer diabetes management services, MA plans sought out the interviewee's aging network organization. Although the state legislation did not require use of a specific EBP, the MA plans were aware of the aging network organization's existing and successful diabetes management EBP offerings. According to the interviewee, these MA plans viewed a partnership with the interviewee's organization as a means of differentiating

themselves in the MA plan market, while meeting the state requirement for diabetes management services.

Another aging network interviewee mentioned their participation in a highly successful CMMI pilot program as the "*springboard for all work"* with their MA plan partner. Through the pilot program, the organization established relationships with multiple hospitals across the state, cementing their reputation as a reliable partner with an effective program. However, when the pilot project ended, hospitals declined to continue the program, and the organization pivoted to MA plans. Within a year of the pilot program ending, the organization had partnered with an MA plan to continue service delivery.

Sometimes aging network organizations initiate partnerships with MA plans, marketing specific EBPs or related services they offer for older adults. One aging network interviewee stated that their organization had reached out to multiple MA plans but had not yet achieved any partnership agreements. Another aging network interviewee said they reached out to multiple MA plans before establishing a partnership with one. When asked about the challenges of partnership development, aging network interviewees described difficulties communicating with MA plans because they are structured differently (i.e., MA plans have more staff than CBOs, making it challenging to find the right person to initiate partnerships).

Aging network interviewees shared that in their experience it is more common for successful partnerships to result when MA plans to reach out to CBOs, and they also mentioned use of outside entities (e.g., private consultants, CCHs) to help facilitate partnership development. Ultimately, however, MA plans do not always view a partnership with the aging network as necessary for delivery of EBPs or evidence-informed programs. Partnerships originate only when there is mutual benefit and alignment between the needs of both the MA plan and CBO.

Partnership Offerings

One MA plan interviewee noted that when their organization partners with a CBO in the aging network (i.e., AAAs and other aging and disability service providers) they may do so through a combination of contracts and informal agreements. The MA plan's members are made aware of supplemental benefits via phone call, mail, the member website, and referrals made by providers in their integrated system. As such, MA plan member needs are identified bidirectionally: sometimes the CBO identifies the need and connects the individual with the health plan; other times the health plan identifies the participant need and then connects them with the CBO for additional support. Aging network interviewees shared that their organizations partner with MA plans to create long-term solutions through EBPs. The interviewees reported that they offer the following health management EBPs most often through MA plan partnerships:

- Chronic Disease Self-Management,
- Chronic Pain Self-Management, and
- Diabetes Self-Management.

Benefits and Facilitators

All aging network interviewees described the opportunity to reach more people as a benefit of partnering with MA plans. According to aging network interviewees, MA plans extend the reach of aging network programs by connecting aging network CBOs to more potential participants and by providing an additional source of funding for programs. For some interviewees, partnering has resulted in a more efficient referral system and access to MA plan participant data, such that they can reach more prospective program participants who may benefit most from EBPs. To facilitate aging network and MA plan partnerships, one aging network interviewee suggested that onsite engagement with partners is important. The interviewee cited a successful example of a CBO's partnership with a large health care provider that led to having staff onsite who engage directly in EBP delivery. Accordingly, the interviewee insisted that aging network CBOs cannot solely rely on promoting their programs at local senior centers; instead, they must "*get out of [their] comfort zone and go where the population is*."

A common benefit that aging network interviewees shared was the ability to expand marketing of their EBPs. Aging network interviewees said that although they engage in their own marketing of EBP services by hosting events, sending letters, and even advertising by radio, MA plan partnerships provide additional participant recruitment opportunities. Aging network organizations leverage their partnerships by hanging flyers in partner providers' offices, accepting referrals from partner providers, and advertising EBPs within MA member information booklets.

One aging network interviewee shared that their organization has a data-sharing agreement with their MA plan partner that allows them to use MA member data to accurately target their EBP marketing. The aging network CBO staff contact plan members identified by the MA plan who might benefit from certain EBPs, such as programs to address a specific chronic condition (e.g., diabetes). Then they share with that plan member details of the CBO offering that might be relevant (e.g., diabetes management programs), encouraging their participation. This example highlights the collaborative nature of the relationship with the MA plan, which the aging network interviewee described as "*very much a partnership*."

Aging network interviewees also stated that MA plans may benefit from partnerships because of the aging network's EBP experience and efficiency. MA plan leaders may perceive this efficiency as a way of improving their plan performance on CMS quality measures like HEDIS and Star Ratings. Aging network interviewees added that MA plans look at hospital readmission rates as a key clinical metric, and organizations with well-established EBPs may be well positioned to deliver services that MA plans perceive as beneficial for reducing costly hospital visits.

Additionally, one aging network interviewee stated that MA plans may benefit from the aging network's reputation within local communities and systems for getting people enrolled in programs. The aging network builds relationships with their served population over many years, establishing familiarity and trust. According to the interviewee, "*Community members know us, they trust us…whereas an insurance company, when they call their member, what they were*

experiencing is a lot of resistance, a lot of suspicion, scams, concerns, and just not wanting to engage with the health plan." These kinds of partnerships between MA plans and aging network partners can bridge communication gaps, support varied needs of older adults, and provide mutual benefits.

Challenges and Barriers

Although partnerships can be beneficial to both MA plans and aging network entities, the fundamental differences in the way these organizations operate also present challenges.

Cost and Articulating the Value of Administering EBPs

Aging network interviewees shared that EBPs often include multiple components that can be costly to administer. Federal interviewees also acknowledged the cost for MA partnership and EBP delivery. MA plans are not currently incentivized to conduct rigorous analysis of potential benefits, which may serve as a disincentive for some MA plans to accept the rigor and intensity of EBPs. However, according to one federal interviewee, federal organizations have a key role in supporting the scaling of rigorously tested prevention programs delivered by aging network CBOs to ensure that they are not overlooked, especially as the market for prevention-related supplemental benefits expands. One MA plan interviewee also acknowledged cost as a potential barrier for delivering some programs.

In addition to EBP administration costs, the aging network and federal interviewees shared a similar sentiment around the challenge of the aging network needing to make the case for their value in a partnership with MA plans. Although MA plans may provide additional financial resources to CBOs for EBP implementation, aging network interviewees suggest that MA plan leaders typically expect to see strong ROI from these EBPs. Aging network interviewees shared that some EBPs may not demonstrate a high enough ROI to interest MA plans. Moreover, one federal interviewee commented that even when a program promises a large ROI, if it only reaches a handful of participants, it may not make sense financially for the MA plan to adopt the EBP.

One aging network interviewee summed the concern, saying, "*The biggest challenge in my opinion, dating back again all the way to 2017, is convincing payers that our service is indeed worth it, which all links to that return on investment of, 'yes, it feels like we're just going and doing a friendly visit on a member who's already home, but if we prevent a readmission we can save you X dollars.' And that's very difficult to put on paper because it's an event that hasn't yet occurred*." One federal interviewee concurred that the value-add of CBOs is not just their ability to deliver EBPs, but also *"[it is] what comes with that, too. It's not a program alone. It's all these other softer skills and the presence [of CBO staff] in the home that can really make the difference*." Federal and aging network interviewees agreed that the benefits of these kinds of soft skills can be challenging to market to MA plans.

Scalability of EBPs

Aging network and federal interviewees shared another concern pertaining to implementation scalability. Aging network interviewees said that some EBPs cannot be scaled to enough

participants within a given service area to achieve the financial outcomes that MA plans seek. Relatedly, federal interviewees speculated that MA plans may refrain from adopting EBPs like those recognized by ACL because of the limited ability to scale most of these programs to a degree that makes sense financially for their plans. There may be a perception among MA plans that CBOs, which are most likely to deliver these programs, lack the infrastructure and reach to deliver consistent services to a large enough population to generate the desired ROI. Importantly, federal interviewees added that EBP scaling should not come at the expense of the close personal relationships and engagement with participants that CBOs can offer. One MA plan interviewee also shared that the requirement to adhere to competing state and local mandates and differing regulatory environments can make offering services to members in different locations challenging. This geographic variation could represent another barrier to scaling, particularly for MA plans that serve members across multiple states.

Flexibility vs. Fidelity

Aging network interviewees said that some EBPs are challenging to implement because of the steps required and components needed (e.g., requiring multiple aging network staff members or other resources). Coinciding with this perception, federal interviewees noted that there may be concern on the part of MA plans about the effects of inconsistent service or program delivery on member satisfaction and retention. Consistent service delivery requires a ready workforce, which can be an issue in this field. One aging network interviewee characterized some EBPs as being "*too rigid*" to adequately meet the needs of the organization's population of older adults. As a result, some aging network organizations may tweak EBPs to fit local needs or to align with MA plan requests, which may diminish fidelity to the original EBP design. As one interviewee stated, "*I can't remember the last time we had a conversation with a new potential MA partner that led with the evidence-based programs*." Another interviewee echoed these thoughts, saying, "*The evidence-based programs have been more of the secondary or tertiary piece of a larger task [in their partnership with the MA plan], and I think that will continue to be the case*." These statements indicate that MA plans may be more interested in *any* financially viable supports for their plan participants, rather than focusing explicitly on EBPs.

Communication and Data Sharing

A challenge that was uniquely identified by the aging network interviewees was communication difficulties. Some aging network interviewees shared that they have had trouble finding the right points of contact within the MA plan to establish partnerships, and they have also had challenges establishing mutual buy-in once an initial connection was made.

Even after partnerships are established, communication difficulties persist, particularly with data sharing, which aging network interviewees noted is a substantial challenge for working with MA plans. Most plans will not share participant information with CBOs because of privacy concerns (i.e., HIPAA), and many CBOs are not equipped to collect the types of participant data that MA plans seek (e.g., data related to health needs or diagnoses). Interviewees indicated that CBOs often lack the data infrastructure, interoperability, and capacity to share data with MA plans.

These communication challenges can hinder both successful program implementation and potential EBP outcome measures.

Emerging Competition for CBOs

One federal interviewee cautioned that CBOs with EBP offerings have the potential to be crowded out of the MA plan landscape as other commercial companies capitalize on the momentum and emphasis from CMS on prevention and supplemental benefits. Many such companies offer prevention-related services that have not been rigorously tested to the standard that EBPs must meet. For example, MA plans are increasingly investing in Flex cards that plan members use to pay for eligible health-related services (June et al., 2025). Although Flex cards are becoming more popular, likely because they are simple to administer and appeal to many MA plan enrollees, it is unclear whether they are an effective tool for preventing costly health needs or care episodes.

Fundamental Priority Differences

Finally, differing priorities are a significant challenge for the aging network partnerships and EBP delivery. Interviewees suggested that MA plans emphasize meeting the demands of their specific plan member population, market differentiation, and ROI —none of which are typical priorities for CBOs. As one aging network interviewee observed, "*When we look at the level of priorities that MA plans have had to deal with, particularly in the last five years, trying to push the value of evidence-based programs to the top of that list has been incredibly challenging*." Another aging network interviewee reflected that MA plans tend to be focused less on "*upstream*" prevention efforts and more on "*dealing every day with what's already downstream*" (i.e., responding to existing health concerns, not preventing those that have yet to materialize). CBOs prioritize broad support to older adults in their communities, rather than narrowing to a population subset (e.g., MA plan participants). Again, these differing perspectives present a fundamental difference in the way that MA plans and aging network CBOs operate and in how they determine which services to deliver.

Future of MA Plan EBP Delivery

As both the environmental scan and interviews revealed, partnerships with aging network CBOs are an important part of a strategy to increase MA plans' use of EBPs. The few interviewees from the aging network and MA plans that participated in this study indicated their intention to pursue these partnerships in the future. Aging network organizations understand that it is not enough to offer programs with proven efficacy; to attract MA plan partners, they must also show they have the capacity to deliver interventions consistently to a sufficient number of plan enrollees. In the short term, some aging network interviewees whose organizations are not currently contracted with MA plans described ongoing efforts to enhance their systems and infrastructure to be more appealing to prospective MA plan partners. For example, one aging network interviewee shared that their organization plans to seek recognition as a provider so they may bill Medicare and Medicaid for programs they offer. Two other aging network interviewees discussed strengthening statewide partnerships across the aging network (i.e.,

combining forces to expand the scope and scale of their aging network organizations, thus getting closer to the population size and associated ROI that might appeal to prospective MA plan partners). One interviewee described their organization's efforts to join with several other regional AAAs and the statewide extension office—which is licensed to deliver a falls prevention EBP—to allow them to serve more of their MA plan partner's geographic coverage area.

Federal agency interviewees also saw the need to support capacity-building among aging network CBOs. Specifically, they recommended greater investment in CCHs. As reported in the environmental scan findings, CCHs can manage many of the administrative and contracting functions for which some CBOs lack capacity. One federal interviewee noted that CCHs can help pool CBOs to achieve sufficient participant volume, and they can help to ensure accountability by managing training for program delivery staff and tracking participant outcome data. In some regions, CCHs have already succeeded in serving as a central point of contact between MA plans and aging network CBOs that are delivering EBPs, but there is room for growth.

One federal interviewee recommended field-testing MA plan implementation of EBPs—starting with ACL's most popular and scalable offerings—through CCHs or a similar structure that supports regional implementation of a national model. The interviewee compared this approach to the model used to deliver the popular Silver Sneakers program in locations across the country. Aging network interviewees also offered specific recommendations related to CCHs. One aging network interviewee suggested federal incentives for the use of CCHs, specifically suggesting an incentive for the billing codes that came out of the Medicare Physician Fee Schedule for care management; that way, the MA plans would not need to create multiple contracts for EBPs. Instead, a CCH could serve as their central contract, bringing the entire community together and leveraging existing partnerships in their network to make sure that the CCH can reach all MA plan members.

Federal Support for EBP Uptake

Our interviewees suggested ways federal agencies could better align to support broader use of EBPs. One MA plan interviewee would like to see more alignment at the federal level on understanding "*what is evidence*." Presumably, not having a consistent definition or application of the term "evidence-based" complicates efforts to encourage implementation of programs that are backed by research. MA plan interviewees suggested that there may be a difference between how HHS offices describe evidence, wherein ACL's definition, for example, may be stricter than the CMS definition. Since CMS oversees MA plans and measures plan quality, MA plans may be more focused on meeting CMS requirements, which were said not to include proof of alignment to specific EBPs. Relatedly, several aging network interviewees suggested that EBP delivery could become a component of Star Ratings or HEDIS and CAHPS quality measures.

To that end, aging network interviewees noted some potential systemic improvements that they hope might increase EBP uptake and facilitate increased partnerships with MA plans. Most notably, all aging network interviewees said they wish that CMS would reward MA plans for

establishing partnerships with CBOs, CCHs, and the aging network more broadly. For example, endorsement of the list of EBPs approved by ACL might increase MA plan awareness and uptake. However, multiple aging network interviewees also shared that the existing list of EBPs on the NCOA website may include programs that are too rigid for MA plans to embrace; they would like to see both endorsement for that list and options for flexibility in program implementation.

Our interviews pointed to a third potential issue impeding MA plan adoption of EBPs listed on the NCOA website: lack of awareness. Neither of the MA plan interviewees seemed very familiar with the ACL/NCOA EBP registry. After reviewing the list, one interviewee suggested that the list might benefit from improved marketing and brand consistency so that MA plans would know, "*Oh, that's an ACL program…I know how they get their evidence. I trust that program*." The interviewee said that kind of marketing would make EBPs more appealing to MA plans.

Funding to Support EBP Delivery

All aging network interviewees hoped for additional financial resources to support both MA partnership development and broader EBP implementation. One aging network interviewee suggested, "*I think there's a lot of misconceptions for policymakers that they have done the right work to make evidence-based programs sustainable. And they'll point to things like the Older Americans Act and the dollars that are there that are designed to support the Older Americans Act... and a lot of that work has been great and wonderful, but a lot of that work doesn't come with the right kind of resources to sustain*." This interviewee also stated that the misconception that OAA funding fully covers the costs of EBP- or evidence-informed program implementation may lead some MA plans to feel less compelled to provide additional funding to aging network partners.

Some aging network interviewees added that funding would enable them to develop secure data management systems to share electronic health records with MA plan partners. This data sharing process was said to improve efficiencies, while also facilitating outcome measurement—a known priority for MA plans. One MA plan interviewee agreed that dedicating more resources across the aging network and MA plans could help bridge some of the operational differences between MA plans and CBOs, while also providing better support for data sharing, identified as one of the main obstacles to effective partnering. Other proposed uses for funding included hiring more aging network staff to scale existing programs, building or expanding infrastructure to reach more participants, and offering training across CBOs to help increase EBP implementation capacity. One aging network interviewee added that they would like to hire a medical director who could serve as a liaison for MA plans to share patient information and connect patients to needed programming.

Other Support for EBPs

Federal interviewees offered other suggestions for increasing EBP adoption among MA plans. One interviewee recommended that to support EBP uptake by MA plans, the plans need something like an "*interactive dashboard map*," maintained by the federal government. The

dashboard would include all CBOs offering EBPs in their market, with associated program details and contact information for each. Another federal interviewee suggested the creation of opportunities for MA plans to share lessons learned and resources with each other, like a community of practice. This community structure, which would likely be facilitated externally (e.g., by an industry association or federal entity), could also be used to share information about best practices, quality measurement, population health, and available research and tools with MA plans. Finally, with the implementation of new CMS data reporting requirements for MA plans, federal interviewees said they look forward to insights on how plans are using their rebate dollars and which benefits are most utilized by enrollees. These data may provide a clearer picture of the extent to which MA plans are offering—and enrollees are using—EBPs. Such data can inform policy adjustments to encourage expanded EBP adoption in the future.

Discussion

Our interviews revealed key takeaways that corroborate and build on the literature found in our environmental scan, particularly relating to factors influencing MA plan benefit selection and use. Interviews also added to the literature by revealing policy suggestions from stakeholders to support increased uptake of EBPs.

RQ1 Topic: MA Plan EBP Selection and Use

Although the team identified only a few examples from the environmental scan and interviews, the use of evidence-based health promotion programs by MA plans is variable. MA plans appear to prioritize ROI, benefits to their plan participants, and the ability to provide a consistent service across a large volume of members. Although they may recognize the importance of rigorous research, our findings suggest that they may also be apt to adapt EBPs to suit their needs. Federal entities like ACL rely on a rigorous and scientific definition of EBPs with an emphasis on implementation fidelity. MA plans may struggle to deliver those more rigorous EBPs because of concerns about implementation costs and consistency compared to anticipated outcomes or benefits.

Key Findings

- MA plans may offer supplemental benefits, including EBPs, for a variety of reasons, including to meet the needs of members, to differentiate themselves from the competition, and to improve their quality ratings.
- Because there is no requirement for Medicare Advantage plans to ensure that supplemental benefits are evidence based, actual use of evidence-based programs varies widely, as do definitions of what it means to be “evidence-based.”
- Publicly available details are limited regarding what is offered or why a given benefit was selected.

Instead, MA plans offer health promotion and disease prevention programs that they believe will be cost-effective: the costs to implement programs are weighed against the perceived benefits and ability to engage participants. Moreover, MA plan leaders seek supplemental benefits that

can support the needs of a large share of their plan participants. There are challenges to widely implementing EBPs with fidelity to the model, which reduces their potential value to MA plans as well.

Interviewees also highlighted the importance of earning good scores across CMS quality measures, as MA plans rely on strong quality scores as a way of attracting new plan members and outpacing competitor plans. Although EBPs may improve certain quality metrics (e.g., reducing hospitalizations), the volume of reduction may not be sufficient to improve scores if EBPs cannot reach a large enough share of MA plan participants.

These findings underscore the differences in perception of EBPs. Where federal staff may focus on the scientific rigor of EBP designs and outcomes, MA plans may be less concerned with implementing EBPs with strict fidelity and, instead, are more focused on cost-benefit implications, meeting plan participants' immediate needs, and achieving potential market advantage. As our results show, when MA plan leaders select benefits based on these metrics, they may modify existing EBPs to suit their needs, such as focusing on the overarching topic (e.g., diabetes management or falls prevention) but including only some components of the original EBP. MA plans might also implement evidence-informed, rather than evidence-based, programs; offer benefits (e.g., meal plans, gym memberships) that are perceived as being more easily scalable; or select benefits they expect to have immediate member impacts, rather than the anticipated, longer term outcomes promised by many prevention-focused EBPs.

RQ2 Topic: MA Plan & Aging Network Partnerships

Findings from the environmental scan and interviews point to partnerships with aging network organizations as key to increasing MA plan support for EBP program delivery. Although some MA plans—particularly within integrated health systems—may have the internal capacity to implement EBPs like those on the ACL/NCOA list, most rely on external organizations to deliver prevention programs. Both partners and MA plan members, who benefit from expanded access to proven prevention programs, stand to gain from the collaboration to deliver EBPs. These partnerships can better support MA plan members, in turn reducing their need for other types of costly care (e.g., hospitalizations). Well-supported plan members who have fewer high-cost care episodes can improve overall MA plan scores on CMS quality measures. These

Key Findings

- Partnerships between MA plans and aging network CBOs benefit the plans by increasing quality ratings, benefit CBOs by providing a sustained source of funding, and benefit beneficiaries by supporting their health and wellness.
- There are challenges to establishing partnerships, including operational differences and difficulties sharing data.
- CCHs may represent one opportunity to link MA plans to CBOs that deliver EBPs, providing needed coordination and communication between both entities.

outcomes also support current administrative priorities, including a focus on EBPs and chronic disease self-management (CMS, 2025c, 2025d).

Partnering with a CBO also allows for more community connection and customization, as the CBO is more likely to know the nuances of the local neighborhoods and populations. For something like home-delivered meals, that may translate to greater awareness of the communities that would benefit most from their services and an understanding of local dietary preferences or cultural needs (e.g., the prevalence of requests for Kosher or Halal meals). Without these local partners, MA plans may not be able to offer this level of community-specific supplemental benefits and EBPs.

Despite these benefits, establishing partnerships can be challenging. Aging network organizations and MA plans have different structures and priorities and may not communicate or operate in the same ways, which may present difficulties finding common ground to establish partnerships for EBP delivery.

CCHs represent a possible opportunity to address some of these operational differences between MA plans and aging network organizations. CCHs can link multiple organizations, which increases the reach of service provision and potential ROI for MA plans. Additionally, CCHs bridge some of the potential obstacles of partnership by taking on functions like data collection and management so that MA plans receive needed participant information, without overburdening individual CBOs that may not have data capacity. CCHs can also help bridge understanding of EBPs to ensure that MA plan offerings align to EBP designs (i.e., programs that are rigorously tested to demonstrate evidence, not just programs that are topically similar). Despite these advantages, actual use of CCHs remains limited. However, recent research indicates growth in the percentage of CBOs contracting with health care entities as part of a network led by a CCH (ASPE & ACL, 2023). This growth also may signal the potential to strengthen partnerships and enhance MA plan EBP delivery options.

RQ3 Topic: MA Plan EBP Considerations

Although we set out to understand more details about the specific frameworks and criteria MA plans may use to select EBPs, those details are somewhat misaligned with how MA plans make decisions about which benefits to offer. Rather than prioritizing a specific evidence framework, MA plans view supplemental benefits as an avenue to meet plan member needs and remain competitive in their industry. EBPs may not be the best way to achieve those goals, as the cost of maintaining fidelity to

Key Findings

- Establishing clear guidelines for both EBP implementation and more flexible evidence-informed programming would ensure that MA plans are prioritizing delivery of high-quality programs.
- Federal guidelines around EBP delivery, including potential ties to quality measurement would encourage increased EBP uptake by MA plans.

rigorous evidence-based designs may not align with MA plan needs. Accordingly, identifying EBPs that can be modified slightly (e.g., evidence-informed, rather than evidence-based) to align with federal requirements, while also meeting MA plan needs for cost efficient delivery, may be a real path forward for increasing EBP uptake.

All interviewee types also suggested that MA plans may need more of an incentive to prioritize EBP delivery. For example, if evidence-based components or EBP use became a component of existing MA plan quality measures, MA plans would be compelled to increase EBP delivery and potentially enhance fidelity to existing evidence-based designs. Additional research would provide a clearer roadmap on how best to initiate these types of requirements, and following their implementation, future studies could explore MA plan EBP use compared to findings from this study.

Limitations

This study included a total of 10 interviews, 8 of which represented aging network and federal perspectives on MA plans and EBPs. MA plans proved exceedingly difficult to recruit and had very limited participation in this study. We contacted a total of 34 MA plan representatives to participate, with up to three follow-up reminders for each, but just two agreed to participate. The two MA plan interviewees do not represent the view of all MA plans. However, they did provide detailed insights and highlighted how their MA plans select and deliver supplemental benefits, including evidence-informed health promotion programs.

We recognize that our MA plan recruitment efforts were “cold calls” in the sense that prospective interviewees were unfamiliar with this project work and may also have had limited familiarity with RTI, ASPE, or ACL. Some aging network and MA plan interviewees suggested that other MA plan representatives may have been reluctant to speak with us about what they may have perceived as business-sensitive or proprietary program features (i.e., how they select and deliver EBPs), despite our assurance that interviews would be confidential. The current MA plan landscape may have also served as a disincentive for some MA plan leaders to participate in our interviews. In 2024, CMS announced that the 2025 MA payment rates would represent a smaller percentage increase than MA plans had anticipated, with the change being attributed to a broader initiative to increase consumer protection and MA plan accountability (Center for Medicare Advocacy, 2024). Similarly, a 2025 CMS change to SSBCI coverage resulted in a reduction of supplemental benefits; for example, life insurance and funeral planning will no longer be covered as supplemental programs (CMS, 2025b). In response to these recent policy changes, some MA plans have begun reducing their service offerings, including supplemental benefits (e.g., EBPs). Accordingly, they may not have wished to discuss these shifts with our team.

In contrast to the MA plan outreach, the team succeeded in interviewing all the ASPE- and ACL-provided federal and aging network contacts. These interviewees may have viewed our outreach efforts more favorably, since all were already familiar with ASPE and ACL, and most also had familiarity with RTI. Future research might focus more exclusively on outreach to MA

plans, perhaps finding more direct inroads for initial interview requests or offering incentives for MA plan representatives to engage with researchers.

Conclusion

Although our environmental scan and interview sources noted that an increasing number of MA plans are offering supplemental benefits, including some EBPs and evidence-based or evidence-informed health promotion programs, there are factors that limit uptake and implementation of these services. Options for encouraging potential growth in EBP uptake include the following:

- Identifying a shared definition of what evidence-based means;
- Understanding appropriate implementation flexibilities, while still maintaining core evidence-based components of a program;
- Communicating how specific EBPs can meet MA plan member population needs;
- Leveraging CCHs to enhance partnerships with aging network CBOs; and
- Focusing on the benefits of EBP delivery for enhancing care quality and reducing health care costs.

With additional federal guidance for MA plans and the introduction of potential incentives-- such as quality measurement tied to EBP use, EBP uptake is likely to increase. Future research could enhance understanding of the specific ways federal agencies support MA plans, including more engagement with MA plan leaders and testing to determine how EBPs could fit into existing quality measurement practices. Lastly, additional studies should examine the needs and interests of MA plan participants to determine how EBPs may best support them.

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Appendix A: Discussion Guides

Medicare Advantage Plans &

Evidence-Based Prevention Program Uptake

Medicare Advantage Plan Representative Discussion Guide

Consent

Thank you for taking the time to speak with us today. My name is [name], and I am here with [name]. We work for RTI International, a non-profit research company. We have been hired by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in partnership with the Administration for Community Living (ACL) to learn more about how Medicare Advantage (MA) plans support evidence-based prevention programs (EBPs) for their plan members. EBPs are rigorously evaluated programs that facilitate things like falls prevention, caregiver supports, and post-acute care transitions.

We are conducting interviews to understand MA organization decision-making and delivery of supplemental benefits, particularly EBPs. Once we have completed our interviews, we will summarize our findings in a report that we will share with ASPE and ACL. That report will help ASPE and ACL understand potential next steps for broader EBP engagement.

We anticipate that our conversation today will take about an hour. Before we get started, we would like to remind you that there are no “right” or “wrong” answers to our questions. We are interested in your perspective and experiences. If there is a question that you do not wish to answer, please let us know, and we will move to the next question. You are also welcome to stop the interview at any time. Your participation or decision to end your participation will not affect your relationship with ASPE or ACL. As we chat, please remember that your name and role will be kept confidential. Only organization names will be referenced in our report to ASPE and ACL.

Do you agree to be interviewed today? Great, thank you.

We will be taking notes as we chat, and, with your permission, we would also like to record this discussion. The audio-only recording will be used to help us ensure we remember the details of our conversation. The recording can be stopped at any time during today’s call. The recording, transcript, and notes from this interview will be stored in a secure data system at RTI during the study. We will not be sharing the recording with anyone outside of our team, and it will be deleted at the conclusion of the project. If you prefer that we not record today’s session, we can proceed without recording.

Do we have your permission to record?

[At this point pause to turn the recording on if participant has agreed to be recorded]

Do you have any questions for us before we begin?

Interview Questions

Introduction and Screening Questions

S1. To start, we'd like to know a bit about your background and role at your organization. Please also tell us how long you have been in your role.

[The following three questions could potentially be emailed in advance for participants to respond to via email.]

S2. How many MA plans does your organization offer?

S3. Do you offer Special Needs Plans? If so, which type?

S4. How many people are enrolled in your MA plans, in total?

We'd like to talk now about supplemental benefits offered through your MA plans. For these questions, we would like to hear about benefits you offer other than vision, hearing, and dental services.

Plan Structure and Role of EBPs

Q1. Would you please describe the types of non-clinical, health-related benefits you offer?

Can you describe the eligibility criteria for members accessing these benefits?

Q2. How do you prioritize which benefits to offer? What information do you consider?

A key goal of this project is to understand how often MA plans offer their members evidence-based health promotion programs.

Q3. How would you define evidence-based health promotion programs? What do you think it takes for a program to be designated as evidence-based? How important is it for you to offer programs/interventions that are evidence-based to your plan members? Are there any criteria you consider when determining if a program is evidence-based?

Evidence-based health promotion programs include those listed in the National Council on Aging/ACL's registry of evidence-based health promotion programs.

Q3a. Are you familiar with this registry?

[If **Q3a** is '*yes'* go to **Q4a**; if **Q3a** is 'no' go to **Q4b**]

Q4a. Does your organization offer its MA plan members any of the evidence-based programs *listed in this registry*?

[If **Q4a** is '*yes'* go to **Q5**]

[If **Q4a** is '*I don't know/I'm not sure which programs are listed in the registry*'] say "*Okay, no problem. We don't expect that you would have committed to memory the names of the 70+ programs listed in the registry."* [continue to **Q4b**]

[If **Q4a** is '*No'* continue to **Q4b**]

Q4b. Does your organization offer its MA plan members *any evidence-based* health promotion programs?

[If **Q4b** answer is '*no*,' skip to **Q10** [OTHER PROGRAMS]; if **Q4b** answer is '*yes'* continue with **Q5**]

Q5. Which program(s) do you offer? To which MA plan members do you offer them?

Q6. How did your organization decide to offer this/these program(s)/what factored into the decision to offer this/these program(s)?

Q7. What are your main objectives with offering this program/these programs?

Q8. How is this program/are these programs made available to plan members (i.e., through CBO partnerships, through Flex Cards)?

[If they mention 'CBO partnerships' ask **Q8a** and **Q8b** and continue with **Q9**]

- **Q8a**. We'd like to hear more about this partnership. Could you tell us how it started and what it looks like now?
- **Q8b.** What are the benefits of partnering with this organization? What are the challenges?

Q9. How are members made aware of this program/these programs?

- **Q9a.** Are these programs advertised in your plan overview? [PROBE – do prospective plan members know about evidence-based programming prior to enrollment?] Why or why not?

NEXT, SKIP TO **Q11 [**PARTNERSHIPS]

Other Programs

Q10. Which specific health promotion programs, if any, do you offer? (e.g., Silver Sneakers, Silver & Fit)

[If they list programs, ask **Q6-Q9** above then continue below with **Q11**]

[If they say they do not offer any specific programs continue below with **Q10a**]

- **Q10a**. What are some of the reasons you do not currently offer any *specific* health promotion programs? (e.g., member interest, data, cost, vendors)

Partnerships

Q11. Do you partner with the aging network in any/any other way? When we say "Aging Network" we mean Area Agencies on Aging, Community Care Hubs, or other community-based aging service organizations serving older adults.

[If **Q11** is '*yes*,' ask Q11a]

- **Q11a**. With what types of such organizations do you partner?
- **Q11b**. How do you partner with these organizations?
- **Q11c**. What was the process for establishing partnerships with these organizations? How long have the partnerships been in place?
- **Q11d**. What factors or circumstances facilitate aging network partnerships? What about factors or circumstances that may serve as barriers to these partnerships?
- **Q11e**. How, if at all, do these partnerships support delivery of evidence-based programming?

Future Needs

Q12. In your opinion, what might help MA plans work more cohesively with aging network partners to implement EBPs?

- Q12a. [*If not already described*] What challenges, if any, have MA plans faced in working with aging network partners on implementing EBPs?

Q13. In general, how do you learn about/how are you made aware of existing services or health promotion programs to potentially offer as supplemental benefits?

Q14. What information source(s) or data would enhance your decision-making around which evidence-based health promotion programs are available and whether you should offer them to plan members?

Q15. What role, if any, do independent effectiveness or research studies play in your decision to offer a specific program or service?

Q16. What is the number one motivator for your plan to offer a new service, such as an evidence-based health promotion program?

Conclusion

Q17. What advice would you offer ACL to support increasing the uptake of its evidence-based programs by MA plans?

Q18. Is there anything else you would like to share with us about your organization's experience offering supplemental benefits, including evidence-based programs?

Thank you very much for taking the time to provide your feedback and suggestions today. We appreciate your willingness to share your experiences and ideas with us.

Medicare Advantage Plans &

Evidence-Based Prevention Program Uptake

Aging Network Interview Discussion Guide

Consent

Thank you for taking the time to speak with us today. My name is [name], and I am here with [name]. We work for RTI International, a non-profit research company. We have been hired by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in partnership with the Administration for Community Living (ACL) to learn more about how Medicare Advantage (MA) plans support evidence-based prevention programs (EBPs) for their plan members. EBPs are rigorously evaluated programs that facilitate things like falls prevention, caregiver supports, and post-acute care transitions.

We are conducting interviews to understand how the aging network may interact with Medicare Advantage plans to support EBPs. Once we have completed our interviews, we will summarize our findings in a report that we will share with ASPE and ACL. The report will help ASPE, ACL, and other federal government partners understand potential next steps for broader EBP engagement.

We anticipate that our conversation today will take about an hour. Before we get started, we would like to remind you that there are no “right” or “wrong” answers to our questions. We are interested in your perspective and experiences. If there is a question that you do not wish to answer, please let us know, and we will move to the next question. You are also welcome to stop the interview at any time. Your participation or decision to end your participation will not affect your relationship with ASPE or ACL, including any existing or future funding. As we chat, please remember that your name and role will be kept confidential. Only organization names will be referenced in our report to ASPE and ACL.

Do you agree to be interviewed today? Great, thank you.

We will be taking notes as we chat, and, with your permission, we would also like to record this discussion. The audio-only recording will be used to help us ensure we remember the details of our conversation. The recording can be stopped at any time during today’s call. The recording, transcript, and notes from this interview will be stored in a secure data system at RTI during the study. We will not be sharing the recording with anyone outside of our team, and it will be deleted at the conclusion of the project. If you prefer that we not record today’s session, we can proceed without recording.

Do we have your permission to record?

Do you have any questions for us before we begin?

Interview Questions

Introduction

Q1. To start, we'd like to know a bit about your role at your organization. Please also tell us how long you have been with your organization.

Q2. What types of health promotion and falls prevention programming does your organization provide for older adults?

a. How long has your organization been providing those services?

b. How many older adults does your organization serve with these programs? Across what geographic area?

Q3. How is your organization structured (e.g., AAA, CCH)?

EBP Applications

Q5. Which evidence-based prevention programs that your organization currently offers are evidence-based?

Q6. What funding sources does your organization use to support evidence-based prevention programs (EBPs)?

Q7. How does your organization decide which EBPs to offer?

Q8. How, if at all, does your organization advertise EBP offerings to older adults?

Q9. What familiarity do you have with the EBP registry on the National Council of Aging website? [screenshare program list, as needed]

MA Plans & EBPs

Q10. Have you partnered with Medicare Advantage (MA) plans to deliver specific services?

Q11a. IF YES, which MA plans?

a. How did that partnership originate? How long has it continued?

b. What services do you provide in partnership with the MA plan?

c. Do you support EBPs through your MA plan partnership?

   I. If so, which ones? In what ways?

   II. How do plan participants learn about the EBPs?

   III. Could you walk me through the process of an MA plan participant engaging in your EBP services from start to finish? What does their experience look like?

   IV. What has the response been to these EBPs from MA plan participants?

d. What outcomes and corresponding metrics do your MA plan partners require, either to demonstrate success or for other purposes?

e. Can you describe the process through which these outcomes and metrics were selected? Who was involved?

f. What are the benefits of partnering with an MA plan to deliver services or EBPs?

g. What are the challenges or drawbacks?

Q11b. IF NO, why have you not partnered with an MA plan?

a. Have you been approached by an MA plan and opted **not** to partner with them?

    I. If yes, why did you choose not to partner with them?

b. Have you been approached subsequently by the same or another MA plan?

c. Have you approached an MA plan to partner and had them decline to work with you?

d. If you're willing to share, what were the plan's barriers or reasons for not wanting to pursue a partnership?

e. What would influence you to partner with an MA plan in the future?

f. What EBPs would you feel comfortable supporting in partnership with an MA plan, if any?

Overarching Thoughts

Q12. What are your organization's future plans, specifically related to MA plans and EBPs?

Q13. Are there additional needs you have to better support MA plan partnerships? What about needs to support delivery of EBPs?

Q14. What would you like policymakers to understand about your organization, partnerships with MA plans, and EBP delivery?

Q15. Is there anything else that we haven't talked about today that you feel we should understand about your organization, MA plan partnerships or EBP delivery?

Thank you for your time and thoughtful responses today**. If you are willing to offer any MA plan contacts to whom we might reach out for their perspectives regarding evidence-based programming, we would be very grateful for any names or email addresses you may be able to share.**

Again, we appreciate your willingness to share your experiences and ideas with us.

Medicare Advantage Plans &

Evidence-Based Prevention Program Uptake

Federal Government Agency Interview Discussion Guide

Consent

Thank you for taking the time to speak with us today. My name is [name], and I am here with [name]. We work for RTI International, a non-profit research company. We have been hired by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in partnership with the Administration for Community Living (ACL) to learn more about how Medicare Advantage (MA) plans support evidence-based prevention programs (EBPs) for their plan members. EBPs are rigorously evaluated programs that facilitate things like falls prevention, caregiver supports, and post-acute care transitions.

We are conducting interviews to understand what agencies like ACL can do to support the uptake of EBPs among MA plans. Once we have completed our interviews, we will summarize our findings in a report that we will share with ASPE and ACL. The report will help ASPE and ACL understand potential next steps for broader EBP engagement.

We anticipate that our conversation today will take about an hour. Before we get started, we would like to remind you that there are no “right” or “wrong” answers to our questions. We are interested in your perspective and experiences. If there is a question that you do not wish to answer, please let us know, and we will move to the next question. You are also welcome to stop the interview at any time. Your participation or decision to end your participation will not affect your relationship with ASPE or ACL. As we chat, please remember that your name and role will be kept confidential. Only organization names will be referenced in our report to ASPE and ACL.

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Do you have any questions for us before we begin?

Interview Questions

Introduction

Q1. To start, we'd like to know a bit about your background and role at your agency. Please also tell us how long you have been in your role.

Role of federal agencies: MA plan uptake of EBPs

Our focus today will be on Medicare Advantage plans' uptake of evidence-based health promotion and falls prevention programs for older adults. When we say "evidence-based" we mean programs that have been rigorously tested and found to improve outcomes for participants.

Q2. How does your office or division currently support the uptake of evidence-based prevention programs by Medicare Advantage plans? For example, are there specific policies or resources that you leverage to encourage coverage of EBPs?

Q3. In your experience, what facilitates Medicare Advantage plan coverage or adoption of evidence-based prevention programs?

Q4. What are the challenges you face in encouraging the uptake of evidence-based prevention programs by Medicare Advantage plans?

Q5. How do Medicare Advantage plans and their members benefit from offering or having access to evidence-based prevention programs (i.e., What is the value proposition of evidence-based prevention programming)?

Q6. What could ACL and related federal agencies, like CMS, do better to support the uptake of evidence-based prevention programs by Medicare Advantage plans?

Q7. What would it take to implement these suggestions?

Q8. What changes do you anticipate in the next 1 to 5 years that will affect the uptake of evidence-based prevention programs by MA plans?

Conclusion

Q9. Is there anything about the federal government's role in supporting the uptake of evidence-based prevention program that we haven't covered that you think is important to note?

Thank you for your time and thoughtful responses today. We appreciate your willingness to share your experiences and ideas with us.