



advocacy | action | answers on aging

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Lance Robertson  
Assistant Secretary on Aging  
Administrator, Administration for Community Living  
330 Independence Ave., SW, #4760  
Washington, DC 20237

*Re: Request for Feedback on Strategic Framework for Action:  
State Opportunities to Integrate Services and Improve Outcomes  
for Older Adults and People with Disabilities*

Dear Assistant Secretary Robertson:

On behalf of the National Association of Area Agencies on Aging (n4a), which represents the country's 622 Area Agencies on Aging (AAAs) and serves as a voice in the nation's capital for the 256 Title VI Native American aging programs, we are writing in response to the Administration for Community Living's (ACL) request for comment on its Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities (Framework).

n4a is also the home of the Aging and Disability Business Institute (Business Institute), which seeks to build and strengthen partnerships between aging and disability community-based organizations and the health care system, and which has been a key partner to ACL in advancing business acumen among the Aging Network.

AAAs and other aging and disability community-based organizations (CBOs) have been on the frontlines of the efforts to integrate health care and social services and build community integrated health networks (CIHNs) across the country. AAAs serve as regional and local leaders and key partners of the State Units on Aging (SUA) in ensuring the health and safety of older adults and supporting their caregivers. They provide services and supports that target the social determinants of health (SDOH) and help older adults age with dignity and independence in their homes and communities, and, as such, are integral partners with health care entities to address the holistic, person-centered needs of older adults, people with disabilities and caregivers.

In 2018, nearly 44 percent of AAAs that responded to the Business Institute’s Request for Information survey on CBO–health care contracting reported having established contracts with health care entities, such as health plans, health systems, Accountable Care Organizations and more. Many of these agencies, in fact, had multiple contracts.

**We appreciate ACL’s work to provide guidance and a roadmap for states in supporting the Aging and Disability Networks through integrated care implementation.** As the examples in the Framework point out, SUAs can be important partners and supporters as AAAs and CBOs engage in this critical work of health care contracting and network development. However, as you will see in our comments below, *this work must be done in partnership with AAAs and other aging and disability CBOs and with other state agencies, rather than in siloes.*

To inform our response to the Framework, n4a solicited feedback from our members, as well as several of our partners in the work of building business acumen. Our reactions and recommendations follow.

- **AAAs as Key Stakeholders from the Outset:** While health plans and providers are typically involved in a state’s contracting process from beginning to end, too often AAAs and other aging and disability CBOs are left out of the stakeholder process until after contracts are set. As critical partners to health plans in the delivery of services addressing the SDOH and home and community-based services (HCBS) needs of older adults, people with disabilities and caregivers, AAAs can provide valuable insights to the contract development and implementation processes at every stage. *SUAs can play an important role in getting their state’s AAA and provider networks to the table from the outset, so that contracts can be developed and implemented in such a way that maximizes the skills, expertise and existing beneficiary relationships of existing AAA networks, and minimizes the barriers to implementation that can arise in service delivery and provider billing.*

In addition, as SUAs use the Framework and see the potential of their role in supporting these efforts, it should be stressed that that they understand and recognize that the AAAs in their state, whether some or all, may have already developed relationships, contracts and infrastructure related to fostering integrated care, and should commit to *build upon* this work, and not disregard, supplant or inadvertently undermine the historical and existing efforts by AAAs and their provider networks. *The Framework should make specific mention of this and urge the SUAs to solicit feedback from the AAAs as to what may be helpful for the SUA to do to support this existing work or how best to help AAAs secure additional opportunities.*

- **Management and Oversight:** In attempting to narrow this section to apply only to the SUA oversight role of AAAs under the Older Americans Act, yet raising many points about non-OAA activities alongside the OAA duties listed, the author(s) may unintentionally cause more confusion than provide clarity. *We*

*suggest several changes to draw the necessary distinctions for the reader on pages 13 through 15, which often become blurred in practice.*

- In the Overview section that begins on page 13, ACL should add a direct reference to P.L. 116-131, the federal Older Americans Act Sec. 202(b)(9), which was recently updated to clarify that nothing in the Act “shall restrict an area agency on aging providing services not provided or authorized by this Act, including through contracts with health care payers, consumer private pay programs or other arrangements with entities or individuals that increase the availability of home and community-based services.” The inclusion and intent of this provision, which was added in the most recent reauthorization of the OAA, is a vitally important point to include in the ACL’s Framework for SUAs. SUA leaders must fully understand and recognize that such activities are absolutely permissible when conducted outside of the OAA and its funding streams. This notation should also be made at the bottom of page 14 before the Framework delves into what is permissible *within* the Act or using OAA funds (per the restrictions in statute). Establishing this important context and foundation would improve the many helpful examples of how AAAs can offer services through CIHNs on page 15 and make a clear distinction that there are two foundational OAA provisions pertaining to AAA roles beyond the OAA.
- On page 14, in the second paragraph, we strongly disagree with the final sentence: “States should engage with AAAs to ensure agencies *prioritize* their responsibilities to fulfill their OAA requirements *over other contract activities*.” (Emphasis added.) n4a does not believe this statement is appropriate and that it extends the SUA’s role beyond its intended statutory scope. While we agree that SUAs have an obligation to ensure that AAAs meet their *responsibilities* under the OAA, we do not agree they have the power to tell AAAs to *prioritize* that work over another body of work performed outside of the OAA. This is simply beyond the SUA’s role and inappropriate for SUAs to dictate this to independent entities such as AAAs.
- As mentioned, we find the back and forth between what is an OAA role and what potential roles and supports that states can offer AAAs within the same sections to be potentially confusing to newer state (or AAA) leaders. For example, the section “Developing Oversight Policies and Practices” should come after the “Financial Oversight Related to the OAA” section. Essentially, all of the OAA-related pieces of the Management and Oversight section should be carefully walked through before addressing possible state roles in supporting CIHNs.
- In addition to moving the “Developing Oversight Policies and Procedures” to later in the document, we suggest it be renamed entirely. As we read it, this section is not about oversight policies related to OAA, but it is instead a series of questions to help states think about what would need to be in

place for them to support the CIHN work, which most often occurs outside of the scope of the OAA. Perhaps a better name for this would be “Questions to Consider in CIHN Roles” or similar.

- **Conflict of Interest Guidance and Alignment:** In the absence of detailed guidance from the Centers for Medicare & Medicaid Services (CMS), states have significant latitude in defining what constitutes conflict of interest with regard to the provision of Medicaid services. A narrow definition of and restrictive rules around conflict of interest issues can impede innovation and make it difficult, if not impossible, for AAAs to be involved in health care contracting with Medicaid, Medicare and duals health plans that would enhance the health and wellness of clients as well as generate sustainable revenue sources. *We recommend that states and AAAs be involved in any CMS and/or ACL processes to develop guidance and/or case studies and in developing acceptable firewalls that can mitigate conflict of interest.*
- **Relationship Building and Alignment with Other Agencies:** As the Framework rightly points out, relationships among state agencies are pivotal to the implementation of integrated care program design and implementation. This Framework can be a valuable tool to develop and build these relationships and facilitate ongoing conversations between SUAs, State Medicaid Agencies, State Departments of Insurance (which approve Medicare Advantage plans and commercial plans), and AAAs and aging and disability CBOs to advance health care integration. ACL can work with SUAs to continue to build and sustain this ongoing dialogue among these parties. This can help to bridge the information gap between managed care organizations (MCOs) and AAAs and facilitate MCOs’ understanding of the work and value of AAAs.
- **State Roles in Network Development and Start-Up:** As we know from our work through the Business Institute, lack of start-up capital and agency reserves hinders the ability of CBOs to invest in staffing and infrastructure (e.g., information technology, billing systems, etc.) needed for health care partnership development and contracting. CBOs that serve older adults and people with disabilities under integrated care contracts typically are paid retroactively for these services and there can be significant lag time in reimbursement. This can impede their ability to scale or even maintain service capacity without sufficient infrastructure and funding reserves in place.

As evidenced by the Framework examples from Alabama and New York, *SUAs can play an important role in providing the training and certification opportunities (and where possible, funding) that can continue to build the capacity of their networks and communities.* These opportunities foster and incentivize the continued development of CIHNs. SUAs can also help to build relationships with private philanthropies in their states, helping AAAs (or their state associations) secure seed money to help them build the infrastructure needed to develop health care partnerships that address the social determinants of health and community living needs.

- **Data and Interoperability:** In order to effectively address the holistic, person-centered needs of older adults through integrated care systems, *data about the services provided by AAAs and other aging and disability CBOs must be incorporated into State Health Information Exchanges*. SUAs, in partnership with State Medicaid Agencies, can advocate for and facilitate such inclusion. In addition, as part of state contracts with MCOs, state agencies can include provisions that ensure that CBOs have access to data about the services that they provide under contract so that they can troubleshoot problems that may arise, and further build their value propositions for future contracts.
- **Other Social Determinants to Address:** While the SDOH addressed in the report are critical, we would also recommend addressing social isolation and loneliness, which can have negative impacts on older adults' mental and physical health. Research suggests that remaining socially engaged improves the quality of life for older adults and is associated with better health. Social engagement contributes to greater physical, mental and emotional health, and well-being in older adults, thus avoiding the negative impacts of social isolation and loneliness. Our members know this from decades of first-hand experience in combatting the social isolation among older adults.

As our nation continues to grapple with the impact of the COVID-19 pandemic and continued safer-at-home guidelines for older adults as one of the most at-risk populations, AAAs and their provider networks offer programs and services (virtually and in-person, when safe) that can mitigate social isolation, provide outlets for social engagement for older adults, and address the root causes of social isolation and loneliness. These programs can and should be part of the benefits offered by Medicaid health plans and Medicare Advantage plans (under the Special Supplemental Benefits for the Chronically Ill), and CBOs should be part of the plan networks that provide these services.

- **Transportation:** In partnership with Easterseals, n4a co-leads the National Aging and Disability Transportation Center (NADTC), which is an important resource for states and CBOs alike as they pursue opportunities. State health and human services leaders can reach out to the State Department of Transportation (DOT) to learn from each other, share priorities and identify common goals. This can serve as an opportunity to bring the transportation concerns of older adults, people with disabilities and people with chronic health conditions into the conversation, and to learn about the programs administered by the State DOT that could benefit those populations.

State health and human services leaders should also review their state's Non-Emergency Medical Transportation (NEMT) program and identify opportunities for partnership of NEMT and Medicare Advantage transportation programs with other transportation services that serve older adults and people with disabilities (such as those operated by local health and human services agencies, including volunteer transportation services). *Rather than name a specific training course,*

*we suggest that ACL advise states and CBOs to subscribe to the NADTC monthly e-newsletter* and regularly check the National Aging and Disability Transportation Center website ([www.nadtc.org](http://www.nadtc.org)) to identify relevant training events, webinars and publications.

Thank you for considering our comments, and we look forward to continuing to work on these important issues with ACL, our members, states and other stakeholders across the country.

Sincerely,

A handwritten signature in black ink that reads "Sandy Markwood". The signature is written in a cursive, flowing style.

Sandy Markwood  
Chief Executive Officer