Administration for Community Living

# STRATEGIC FRAMEWORK FOR ACTION:

## State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities

**June 2020**

**Version 1 for Public Comment**
Share feedback via email at ACLFramework@acl.hhs.gov. Comments are requested by August 31, 2020.

ACL
Administration for Community Living

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# Foreword

Dear State Health and Human Service Leaders:

We are at an unprecedented time in which our nation faces increasing demands to serve a rapidly growing population of older adults and people with disabilities. Concurrently, we have an opportunity to partner across health care and social service organizations to ensure that the social determinants of health for these individuals are addressed as part of a person-centered, value-based transformation of health care. It's important for all of us to work collaboratively across federal and state governments to transition from a traditional approach of administering grant programs for social services, to a strategy that expands the capacity of community-based organizations (CBOs) to serve a growing population through partnerships with health care payers and providers. At the time this framework was being finalized, our nation was confronting a pandemic, requiring maximum focus and energy, as well as collaboration across jurisdictions, sectors, and CBOs. This challenging experience has demonstrated how cross-sector initiatives can bring to bear the value of social services in meeting the collective health needs and non-health risk factors of Americans, particularly older adults and people with disabilities, through a holistic approach.

One of my responsibilities under the Older Americans Act is to coordinate the planning and further development of the nationwide network of comprehensive home and community-based services (HCBS) for older adults. In addition, through the Developmental Disabilities Assistance and Bill of Rights Act and Rehabilitation Act of 1973, the Administration for Community Living (ACL) works with states, communities, and partners in the disability networks to improve opportunities for people with disabilities to access quality services and supports, achieve economic self-sufficiency, and experience equality and inclusion in all facets of community life. Accordingly, ACL developed a *Strategic Framework for Action* to support state efforts to address the holistic needs of older adults and people with disabilities through program coordination and integration with health care financing and delivery. This Framework is intended to encourage a collaborative, public-private approach that leverages the collective investments in health and human services for older adults and individuals with disabilities. These investments can create an integrated system that meets unique needs and provides the right services at the right time in accordance with an individual's preferences and values. The first goal of this Framework is to provide best practices and examples of incremental steps state health and human service leaders can take to facilitate the growth of community integrated health networks (CIHNs), which are networks of CBOs that partner with health care organizations within and across states. The second goal is to provide information about how states can leverage federal and state funded programs to address social determinants of health and independence, such as transportation, housing, nutrition, and assistive technology. Collective public and private investments in health care and social services, combined with impactful policy levers to integrate these systems can bring about the holistic transformation we seek.

We recognize we have a host of challenges to overcome, as well as competing priorities across state agencies, but we are committed to supporting all of you in embracing the opportunities in front of us. With current state financial constraints, a partnership based approach offers a proven path for many states and could potentially offset any proposed state budget reductions. We also recognize each state will have its own path forward, building from current levels of readiness. ACL will strive to advance innovative solutions to address workforce challenges, strengthen and expand the capacity of these aging and disability networks and its more than 20,000 organizations and providers to deliver more comprehensive services, and foster partnerships with the health care system to facilitate the integration of social and medical care. By working together, we can modernize and expand the role of aging and disability networks to enable older adults and people with disabilities to thrive in the community and home of their choice.

Sincerely,

Lance Robertson
Assistant Secretary for Aging
Administrator, ACL

**Acknowledgements**

The Administration for Community Living appreciates the thoughtful review and contributions to this Framework from colleagues within the U.S. Departments of Health and Human Services, Transportation, Housing and Urban Development, and Agriculture, as well as current and former state health and human service leaders.

# Introduction

## *Why Now? The Changing Health Care Marketplace and Social Determinants of Health*

The health care system's transition to value-based care has increased awareness about the factors that determine health. Studies have found that 60% of the factors that influence health are non-medical social, behavioral, and environmental factors, while 20% are genetic and the remaining 20% are health care factors.[1] Early efforts to address social determinants of health (SDOH), which include social risk factors and social needs, have occurred within separate delivery systems, with health care providers addressing individuals' needs from a clinical perspective and community-based organizations (CBOs) addressing social, functional, and environmental needs from a social service perspective. There is a growing recognition that addressing SDOH as part of person-centered care can reduce health care costs and improve well-being. Successful integration of health and social care requires taking into account the respective cultures, payment mechanisms, and performance

The Administration for Community Living (ACL) sees two opportunities for action to ensure older adults and people with disabilities lead healthy, independent, and inclusive lives in the community. The first opportunity involves strengthening and supporting the sustainability of aging and disability networks to deliver high quality, coordinated services in an increasingly value-based, integrated care environment, such as forming community integrated health networks (CIHNs). State leadership can play an important role in ensuring health care entities understand and leverage the aging and disability networks instead of building their own duplicative referral, care, and service systems. In the absence of state leadership, individual health care organizations are more likely to pursue their own approach to referrals and SDOH services without reinforcing or utilizing the infrastructure, expertise, and trust that has been developed by aging and disability networks over the past 50 years. The second opportunity is to collaborate across state government and beyond to ensure that all public and private resources can be coordinated and aging and disability networks can effectively respond to the growing demand for person-centered services that address social needs as a part of improving overall outcomes. This *ACL Strategic Framework for Action* describes potential roles for state health and human service leaders and partner organizations, provides examples of current innovation, and offers key action items to accelerate the successful integration of health care and social service systems. Many actions and opportunities outlined in this framework are oriented towards state aging and disability leaders, but the Framework also serves as a tool for broader state leadership.

## Section 1: Opportunities for Aging and Disability Networks

The transformation of health care and the broad recognition of the need to address SDOH presents an opportunity for state health and human service leaders and partner organizations to proactively collaborate to integrate health care and social services. Health care delivery and payment is increasingly moving from a volume-based, fragmented system to a value-based, person-centered system. Medicare, Medicaid, and commercial payers are driving many of these reforms through capitation and various alternative payment models tied to clear expectations for quality improvement. This has also heightened the awareness and importance of managing complex, higher need populations that drive a significant proportion of costs and often require a holistic model of health and social care. Addressing SDOH needs is an important component of high quality care that reduces unnecessary healthcare utilization.[2]

One way for health plans and systems to effectively address SDOH is to partner with CBOs. Federal and state governments have made significant investments in CBOs within the aging and disability networks. These networks serve as trusted resources for community-based services and supports throughout the nation and commonly serve higher need, complex populations. While these networks are funded through the Older Americans Act (OAA) and other authorizing statutes such as the Developmental Disabilities Assistance and Bill of Rights Act and the Rehabilitation Act of 1973, in addition to state funds, funding levels have not kept pace with inflation, nor the increased demand for services and supports. The population of people over the age of 65 is expected to double in the next 40 years, and 70% are projected to use long term services and supports (LTSS). [3] In addition, approximately seven in ten people age 90 and above have a disability, and among people between the ages of 40 and 50, almost one in ten, on average, will have a disability that may require LTSS.[4] This growing demand will also have an impact on Medicaid spending, as the largest payer of LTSS in the United States. Medicaid represents a large portion of federal and state budgets, creating an imperative to innovate as need for LTSS grows.[5]

Transformation to a value-based health care system is already underway. In 2018, one in three health care payments were through alternative payment models that require health care providers to be accountable for improving quality and reducing the total cost of care. As health care has shifted to be value based in the last decade, ACL, in collaboration with private foundations and other national partners, has supported aging and disability networks in developing the infrastructure and business processes needed to contract with health care organizations to provide community-based services. These networks need to evolve at a rapid pace to leverage opportunities for partnering with health care organizations, or the health care system will evolve without them. State health and human service leaders play an important role in setting a vision, strategy, and policy for aging and disability networks to respond effectively to the growing need for person-centered services and supports in the community while ensuring that their priority populations are well served through existing resources. No single organization or agency can build integrated networks alone; comprehensive, coordinated services offer tremendous benefits for service providers and the individuals and families they serve, but building integrated networks requires partnership across sectors and public and private funders. To do this, state health and human service leaders will need an organizing framework and approach to developing state-driven roadmaps to integrate health and social services and expand access to SDOH

services and supports funded through federal, state, and private sector programs. In many states this work is well underway, and there's been significant progress across the aging network and many Centers for Independent Living (CILs). In 2018, Area Agencies on Aging (AAAs), CILs and other CBOs had over 1,200 contracts with health care organizations.[6] Many of these contracts focus on serving high-risk or high-need groups, including individuals at risk for nursing home placement as well as individuals at high risk for emergency room use, hospitalization, and hospital readmission.[7] States can evolve aging and disability networks based upon their unique environments, strengths, and capabilities in determining the opportunities that will be most valuable for older adults and people with disabilities. As a part of these efforts, states can also collaborate with stakeholders in the disability community to determine approaches that best meet the needs of individuals with varying types of disabilities.

## Governance and Administration

### Overview

A key aspect of engagement in systems transformation is for state health and human service leaders, in collaboration with aging and disability partners, to have agreed upon roles and responsibilities that support collaboration. Governance and administration involve collaborative efforts among multiple state agencies to strengthen the infrastructure of aging and disability networks, which may include establishing a uniform set of guidelines and expectations about roles and responsibilities.[8] At the state level, a collaborative governance and administration strategy can also encourage innovative approaches to blending and braiding resources to effectively address the underlying social needs of individuals. By blending and braiding, states can use financing strategies at the federal, state, and local levels to integrate and align various funding streams to broaden the impact and reach of services. For example state, Social Services Block Grants and other administrative funding can be blended with other state, local, and federal programs; however, funding through the Older Americans Act, Medicaid, and Community Service Block Grants can be braided – meaning that they would need to be tracked and reported upon separately but used together to deliver seamless services to individuals without them necessarily being aware of the different funding sources.

#### State Opportunity

State health and human service leaders can leverage the existing governance structure that drives the No Wrong Door (NWD) System vision to streamline access to community-based services and supports. A state's NWD System governing body includes the State Unit on Aging, the state Medicaid agency, state agencies that serve or represent the interests of individuals with physical disabilities and intellectual and developmental disabilities, state authorities administering behavioral health services, and often also include other partner organizations.

Governor and legislative support, in addition to the involvement of key state agency leaders, proves critical in building a solid governance structure. For example, Virginia's NWD System governing body is led by a strategic state leadership team, with council representatives from LTSS providers and a hospital and health care association. They meet quarterly to ensure informed governance and strong leadership to address enhanced marketing and communications, strengthen person-centered practices, and inform policy decisions around streamlining access to services. In addition, at the community level, 25 Local Advisory Councils in Virginia focus on

strengthening community partnerships and regional expansion of the state's NWD System vision. Through these state- and community-led approaches to governance, Virginia integrated statewide training opportunities and utilized an analytic tool with data dashboards and consumer portals with self-referral tools used by over 100 CBO partners. This has improved service development across the state, which affects the integration of intake and referral processes for CBOs and allows for an assessment of the array of financing mechanisms necessary to partner with health care systems.

No single state agency acting alone will be able to respond to the projected growth in SDOH-related service and support demands and associated costs. State health and human service leaders have an important and timely opportunity to evolve from focusing not only on administration and oversight of federal and state funding, but can also serve as strategists working across state government and beyond to ensure adequate growth and modernization of aging and disability networks in their states. Developing strong relationships across state agencies and with other partner organizations is essential to identifying and implementing the most effective and efficient strategies to partner with health care payers and providers and to coordinate funding for SDOH services and supports in the future.

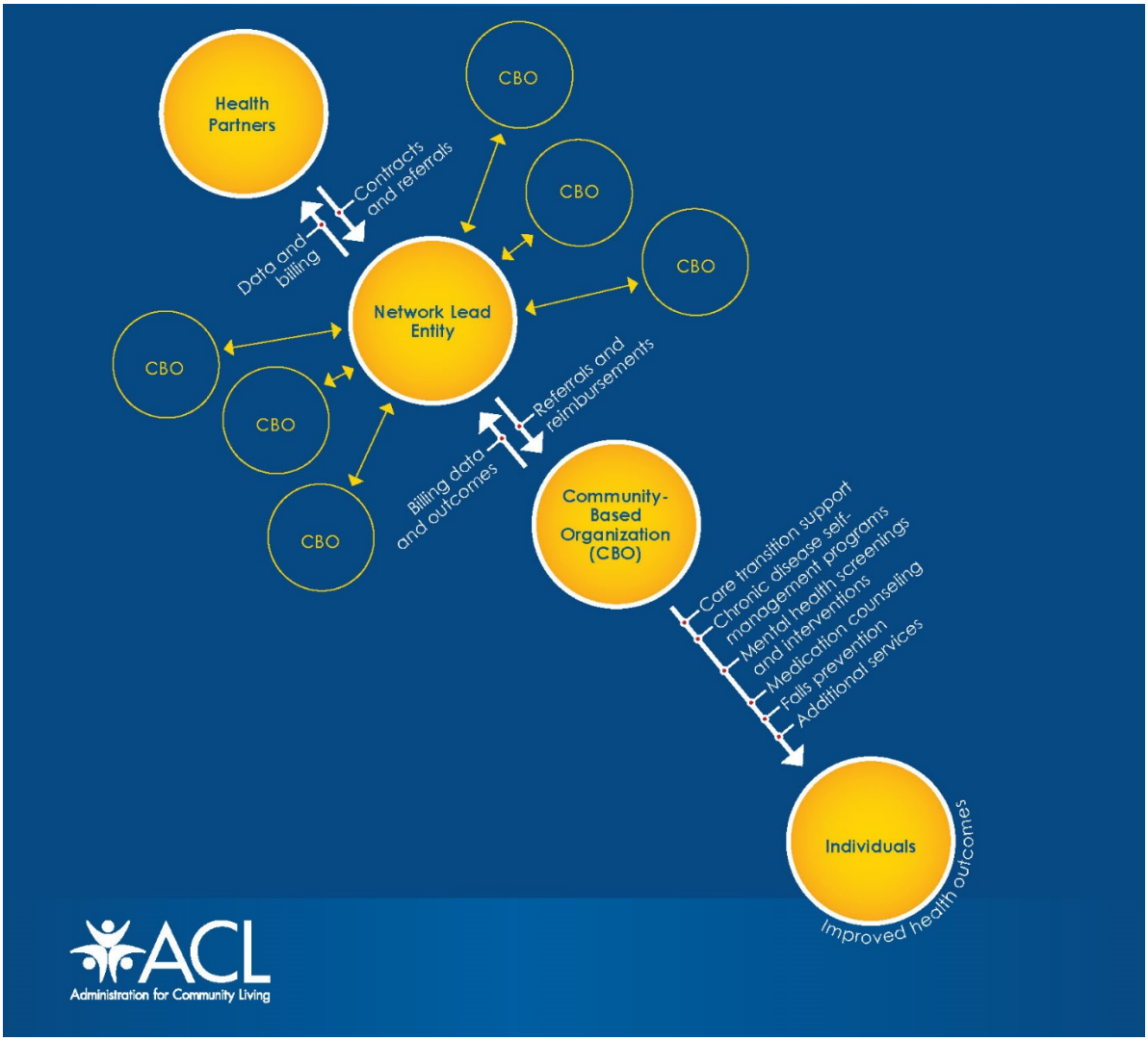
## State's Role in Supporting Community Integrated Health Networks

Many states have supported CBO partnerships with health care systems and health plans. In recent years, these partnerships have increasingly been statewide in response to opportunities through Medicaid Managed Care, Medicaid Managed Long Term Services and Supports, and programs for those dually eligible for Medicaid and Medicare. Since CBOs are at varying stages of readiness and have varying interest in contracting with health care organizations, networks of CBOs, called **community integrated health networks (CIHNs)**, are rapidly forming with a Network Lead Entity (NLE) that acts as a single point of accountability for health care organizations **(see Figure 1)**. CIHNs allow CBOs to be part of a larger group that has a lead entity to assume responsibility for contracting with health care and acquiring and implementing necessary information technology systems. NLEs can curate a network of CBOs to deliver services based on their core competencies and strengths, and create a culture and system of accountability, including quality improvement strategies to ensure CIHNs are performing satisfactorily.

ACL recognizes the critical role and partnership that state agencies provide in the development of CIHNs. State health and human service leaders can support and evolve these networks at the local, state, and multi-state level and have the ability to recognize that some local networks are more skilled in this area than others. These networks can vary in structure and delivery based on community needs and assets, but they all provide a common pathway for private health care entities to contract with multiple CBOs. CBOs are rapidly forming new legal structures, models, and CIHNs to help streamline and coordinate payment, implement a consistent referral and service delivery process, manage data flow, expand geographic coverage, and improve risk management. These networks can be formed regionally, statewide, or interstate to meet the market demand of health plans and system's geographic footprint. For example, the Virginia Area Agencies on Aging – Caring for the Commonwealth[9] (VAAACares) is a statewide CIHN developed to enable streamlined contracting with managed care plans. Building on its success with the Centers for Medicare and Medicaid Services (CMS) Community-Based Care

Transitions Program and through state NWD grant support, VAAACares grew its network to create a one-stop shop for referrals, billing, reporting, data analytics, training, and quality assurance. VAAACares provides evidence-based complex care coordination, care transitions support, and other home and community-based services that support positive health and improved outcomes for Virginians with chronic health conditions. Through VAAACares, the aging network in Virginia is poised for business expansion through additional contracts with insurers and health care providers, leveraging the important role AAAs play in reducing health care costs and improving quality of life through client empowerment and services provided in the home.

**Figure 1. Community Integrated Health Networks**




States are increasingly demonstrating how aging and disability networks serve as critical points of contact for providing objective, unbiased counseling, care coordination, and streamlined access to services addressing SDOH for consumers and their caregivers and family members. Trust among people in communities matched with expertise in intake, care coordination, and available community resources is the foundation of the work CIHNs bring to partnerships with

health care systems. The aging and disability networks are trusted, independent, and able to integrate an array of programs and services to address people's needs, which positions them to better manage publicly funded programs. Coordination and integration of statewide programs, which include information and referral as well as person-centered counseling and assistance, creates a sustainable system and ensures streamlined eligibility and access to services and supports that address SDOH. State health and human service leaders and their partners play a role in setting a vision and strategy for ensuring that the workforce of aging and disability networks are innovating and evolving to address the growing need for person-centered services and supports in the community.

## Policy Levers to Support Evolution of Aging and Disability Networks

### Overview

With health care transformation underway and broad recognition of the need to address SDOH, state health and human service leaders and partner organizations must collaborate across state government and beyond to establish new partnerships with health payers and providers and to implement innovative models of integrated care. States can consider many policy levers to foster the integration of CIHN services into health care delivery and enable access to social benefits. This may be achieved in the design of the service delivery system or may be achieved through partnerships involving Managed Care Organizations (MCOs) and CBOs at the community level. This section offers ideas for many of those policy levers, including Medicaid waiver and managed care requirements, performance incentives, continuity of eligibility and enrollment, care coordination, and guidance to Medicare Advantage Special Needs Plans regarding how to partner with the aging and disability networks.

### State Opportunity

State health and human service leaders and their partners have the opportunity to promote collaboration with state Medicaid agency leadership on Medicaid program design and implementation to integrate aging and disability networks into health care delivery, including through managed care contracting, and the development and implementation of scalable technology platforms that can connect health care systems and CBOs within and across communities in a state.

### Medicaid Policy Levers

There are a variety of policy levers state leaders may consider when exploring collaborations with state Medicaid agencies. Examples states have leveraged include waivers, demonstrations, state plan amendments, and managed care models and others.[10]

**Massachusetts:**

Massachusetts' **Section 1115(a) demonstration** is an example of collaboration between state human service leaders and Medicaid. Section 1115 demonstrations offer states more flexibility to extend coverage to populations typically not covered by Medicaid, provide services that are not

otherwise offered, and deploy delivery system innovations to increase quality and efficiency while lowering costs, so long as the Secretary determines such demonstrations promote the objectives of Medicaid.[11] These demonstrations are designed to help states "institute reforms that go beyond just routine medical care" [12] which provides an opportunity for state health and human service leaders and their partners to work with their Medicaid partners on coordinated care innovation.

CMS authorized $1.8 billion in state and federal dollars for the Massachusetts Delivery System Reform Incentive Program (DSRIP).[13] One of the three DSRIP objectives in Massachusetts is supporting Community Partners (CPs). Networks of AAAs and CILs are recognized by MassHealth (the state's Medicaid and Children's Health Insurance Program) as LTSS Medicaid Accountable Care Organizations (ACOs). In 2018, ACOs were expected to partner with at least two LTSS CPs in their service region.[14] The CPs are responsible for providing "choice counseling, needs assessment, member and family support, and referral and navigation assistance." DSRIP funds will be used by CP's for care coordination and navigation, as well as infrastructure and capacity development.[15]

**Alabama:**

The state of Alabama invested NWD grant funding to develop the expertise of the AAAs to screen, assess, and implement a range of interventions that address SDOH and achieve National Committee for Quality Assurance (NCQA) accreditation for case management. This network of AAAs has since assumed responsibility to perform community-based case management for a **provider-sponsored primary care case management (PCCM) model** that serves skilled nursing facility eligible Medicaid beneficiaries statewide. Since the state defines the benefits package that integrated care models are charged to deliver, there may be opportunities for state human service leaders to collaborate with their state Medicaid agency colleagues to recognize and define a role for the aging and disability networks within the state's model requirements.

**Georgia**:

The Georgia Department of Community Health (DCH) contracts with the Georgia's 12 AAAs to provide case management for the **1915c waiver** and to serve as the Local Contact Agency and Aging and Disability Resource Center (ADRC). DCH also contracts with the Georgia Department of Human Services Division of Aging Services (DHS/DAS) to administer the **Money Follows the Person (MFP)** grant to transition persons from facilities back into the community. MFP data is captured by the DHS/DAS data system used for the 1915c waiver and ADRC. These state-initiated activities served to strengthen the state's aging and disability networks, enhance their business acumen, and prepare them for competing for the **Community-based Care Transitions Programs** and subsequent contracts with local hospitals and health systems to reduce readmissions.

As part of DHS/DAS' strategic plan, one strategy is to develop and expand targeted efforts to increase awareness of social determinants of health. A multi-agency workgroup was formed with Medicaid, Family Assistance, and the State Unit on Aging to evaluate the senior supplemental nutrition assistance program. This led to:

- Partnerships with family services to educate older adults about the **Supplemental Nutrition and Assistance Program (SNAP)** in urban and rural Georgia.
- An increase in referrals to the ADRC for information about SNAP and financial assistance programs for seniors identified as food insecure.
- Over a three-fold increase in nutrition benefits for older adult SNAP beneficiaries.

## Medicare and Medicaid/Medicare (Dual Eligible) Policy Levers

State health and human service leaders may want to consider a number of different Medicare policy levers to support healthcare and CIHN partnerships. The Chronic Care Act (CCA), passed by Congress in 2018, enacted substantial policy changes to advance the goals of integrated, person-centered care for Medicare beneficiaries and those dually eligible for Medicaid and Medicare. A key component of this legislation is the expansion of supplemental benefits to meet the needs of chronically ill Medicare Advantage enrollees. Referred to as Special Supplemental Benefits for the Chronically Ill (SSBCI), this includes supplemental benefits that are not primarily health related and may be offered non-uniformly to eligible chronically ill beneficiaries.[16] There are considerable parallels between the services allowable under SSBCI and those traditionally provided through state-administered HCBS programs such as the OAA and Medicaid waivers. Accordingly, state leaders should consider how their traditional coordination of services might be impacted by Medicare Advantage plans offering services such as meals and transportation via SSBCI. It may be necessary to evaluate policies and taxonomy to determine whether there is duplication of services and how services should be coordinated and paid for. Some states have addressed these risks through coordinated purchasing, as well as by ensuring Medicaid and non-Medicaid HCBS policies are aligned on service definitions and training or certification requirements. This could also expand number of people served by and the reach of OAA funds when used to complement, but not subsidize home delivered meals when an individual is eligible for this service through their Medicaid or Medicare Advantage plan.

State health and human service leaders can also support CBOs within CIHNs to play an important role in maintaining continuity of enrollment of dually eligible beneficiaries, as well as increase access to Medicare Savings Programs (MSPs), Part D Low Income Subsidy, and other benefits. State aging directors and state Medicaid directors also have the opportunity to collaborate on Medicare Improvements for Patients and Providers (MIPPA) agreements for Medicare dual eligible special needs plans to ensure aging and disability networks in their state are appropriately involved in delivering services to address SDOH for dually eligible beneficiaries. Some states have demonstrated these partnerships:

**Alabama:**

The state of Alabama made a strategic investment in NCQA accreditations for case management, which led to partnerships within Medicare plans and providers. The AAAs in Alabama are providing case management for high utilizers in a **Medicare Advantage plan** and support care transitions for a Medicare ACO. Most recently, the AAAs collaborated with a physician network to apply to participate in the CMS Direct Contracting model. The proposed approach includes

AAAs receiving a fixed per member per month (PMPM) rate to perform coordinated case management to address medical, social, behavioral, and LTSS needs. Managed care plans are also deploying similar payment approaches with CIHNs across the country. MCOs are incented to focus on high needs members and ensure they are receiving the right services at the right time and many are leveraging the expertise of CIHNs to effectively serve this population.

**District of Columbia and Connecticut:**

**Medicare Savings Programs (MSPs)** help pay Medicare premiums and some cost-sharing for individuals with low-incomes. Connecting low-income Medicare beneficiaries to MSPs can improve economic well-being and health by increasing access to affordable health care and medicine and freeing up beneficiaries' resources to address housing, nutrition, or other needs.[17] For example, in 2020 most beneficiaries pay $144.60 in Part B premium, and a limited number of beneficiaries ineligible for premium free Part A pay $458 a month. States have successfully increased enrollment in these programs by raising the income eligibility thresholds, increasing the asset limits, and/or eliminating asset tests altogether. For example, the District of Columbia increased income limits for the Qualified Medicare Beneficiary (QMB) program, one of the MSPs, to 300% federal poverty level and Connecticut increased the income level in all three MSPs to over 200% federal poverty level. In 2019, nine states had no asset limits for MSP and six increased income limits above the national limit.[18] States can also accelerate MSP enrollments by exchanging data with CMS on a more frequent basis.[19]

**Delaware:**

Another strategy to increase **MSP and Medicare Part D Low Income Subsidy** enrollment involves cross training across the network to troubleshoot common application issues. Addressing application issues early in the process leads to more complete applications, reducing the burden on the staff processing eligibility determinations. For example, the Delaware State Health Insurance Assistance Program (SHIP) partnered with the Delaware Medicaid and Medical Assistance (DMMA) office to streamline the application process and reduce avoidable application processing delays for QMB. One year after beginning this partnership, the Delaware SHIP completed 514 applications and 290 beneficiaries began accessing their QMB benefit.[20] This collaboration "represented a significant part of the state's success in helping low-income Delaware older adults apply for more than $7 million in benefits that make Medicare affordable."[21]

**Ohio:**

The Financial Alignment Initiative (FAI) allows for integrating care within a capitated or managed fee for service model.[22] Ohio is an example of a capitated model with a **Medicare-Medicaid Plan (MMP)** three-way contract between the state Medicaid agency, CMS, and the health plan. The Ohio AAA network negotiated a standard provision requiring that AAAs provide HCBS coordination. This provision requires health plans to contract with AAAs to coordinate HCBS provided under Medicaid waivers for enrollees age 60 and over. This has allowed AAAs to build on their 25 years of experience coordinating services under the Ohio Medicaid waiver for adults over the age of 60.[23]

**All States:**

Another opportunity is with **Dual Eligible Special Needs Plans (D-SNPs)**. D-SNPs are Medicare Advantage plans designed specifically for dually eligible beneficiaries. State Medicaid agencies can define the scope of Medicaid services and financial responsibility of D-SNPs, as well as add state-specific requirements. Since 2013, all DSNPs must have contracts with the state Medicaid Agency which contains a description of how the plan will provide and coordinate Medicare and Medicaid-financed care.

By 2021, D-SNPs will be required to, at a minimum:

1. Cover Medicaid LTSS and/or behavioral health services through a capitated payment from a state Medicaid agency; or
2. Notify the state Medicaid agency (or its designee) of hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dually eligible individuals.

State health and human service leaders could work with the state Medicaid agency to define D-SNP requirements related to SDOH and partnership with aging and disability networks. Some have already specified data sharing relationships with aging and disability networks to support their roles and functions.

## Management and Oversight

### Overview

State leaders have an important role in working with other state health and human service agencies to support the expansion and enhancement of aging and disability networks. As CBOs seek new opportunities to negotiate contracts with MCOs, health plans, and health care providers as one path to sustainability, states can help foster networks by developing and enforcing transparent policies and procedures related to the management of CBO contracting activities. The management and oversight being addressed in this section is relevant to State Unit on Aging leaders and is focused on AAAs as designated recipients of Older Americans Act (OAA) funding, and does not take into account programs administered by the Developmental Disabilities Assistance and Bill of Rights Act or the Rehabilitation Act of 1973. Ongoing support and program management on compliance and oversight will be provided by ACL to other CBOs, such as CILs, outside of this framework.

### State Opportunity

As the recipients of OAA funding, states have significant discretion in determining the appropriate scope of their policies and procedures for oversight under the OAA.

A state might choose to take a tiered, risk-based assessment approach to oversight. A state could develop criteria to assess the degree to which a particular sub-grantee or type of initiative poses a risk of compromising OAA-funded initiatives. If the risk is high, the state could consider increased reporting requirements or rigorous oversight. If the risk is low (for example, if a sub-grantee has a proven track record of responsible fiduciary management, or has engaged in partnerships that expand and improve services to the target

populations identified in the area plan), the state might consider more limited and less burdensome reporting and other oversight requirements.

Management and oversight responsibilities extend to a range of issues, including financial oversight to ensure grant funding is used only as authorized under law, addressing conflicts of interest, accounting and reporting practices, and awareness of privacy and confidentiality requirements, including the Health Insurance Portability and Accountability Act (HIPAA). States should engage with AAAs to ensure agencies prioritize their responsibilities to fulfill their OAA requirements over other contract activities.

States can approach oversight with clear goals in mind. For example, their goal could be to expand the work and impact of OAA programs, through capacity building, organizational development, and increased revenue to stabilize them for the long term, where a portion of the revenue goes back into serving more people who are in need.

## Developing Oversight Policies and Practices

States should consider addressing the following questions as they work to develop policies and procedures to support community integrated health networks:

- How much discretion can a sub-grantee have in determining how funds are used before a state has improperly delegated its oversight responsibilities?
- What are the opportunities to pursue non-federal funding that can be used for developing and implementing new business opportunities?
- How will the state, the AAA, and the sub-grantees track and report on funding use and outcomes? What are the simplest and most streamlined, yet effective reporting requirements that could satisfy a state's oversight responsibilities?
- Based on the populations that are most in need, what funding sources can be used to support expansion of services to those populations?
- What kinds of infrastructure investments would best support a growing network, and are there opportunities for statewide initiatives that maximize cost effectiveness?
- How will the state and sub-grantee agencies mitigate real or perceived conflict of interest (COI) especially related to information and referral functions and ensure compliance with relevant program specifications, including Medicaid regulatory requirements?
- How will the state and sub-grantee agencies ensure information will be used and shared in a way that appropriately maintains privacy and confidentiality protections?
- How will the state address data sharing, coordination, and ownership across CBOs and other state agencies, including Medicaid?

## Financial Oversight Related to the OAA

The state's existing infrastructure will need to be leveraged to support community integrated health networks. States may develop policies and procedures related to infrastructure investments. Subject to terms and conditions, AAAs may use OAA or other federal funding to pay for part or all of the cost of developing and carrying out a contract for services with another entity, so long as that cost is reimbursed as part of the agreement.[24]

For example, evidence-based programs are increasingly seen as best-practice interventions to address disease self-management and fall prevention needs of high-risk populations. As a result, health plans and health systems involved in value-based contracting may want to purchase evidence-based program access for their member population from the aging and disability networks. When presented with an opportunity to contract with a health plan or health system, AAAs may not have an adequate number of access points to meet the needs of the health care market contract. As a result, the AAA may need to invest in their evidence-based program delivery infrastructure before they can successfully meet the requirements of the potential contract.

In many markets, the primary funding mechanism for evidence-based program delivery is Title III OAA funding. Title III funding can be used to expand access and infrastructure to deliver evidence-based programs, but not at the expense of failing to fulfill the approved area plan. When AAAs use Title III funding to build the infrastructure, or to begin providing the services required for commercial contracts, they must account for that investment expense, which will need to be reimbursed as part of the commercial contract. Title III-funded infrastructure investments that will not be reimbursed must result in a net positive benefit to the target population specified in an area plan. For example, if the investment increases the number of program sites and instructors, there should be a corresponding increase in the number of people served as targeted in the area plan.

AAAs should also ensure OAA funds, which serve as a "safety net" for millions of individuals, are administered using OAA eligibility criteria; namely, to serve individuals age 60 and older with the greatest social or economic need. State agencies may develop policies and support reporting practices to assist agencies who may seek to serve populations that are not eligible for OAA-funded services in maintaining adequate records. In particular, agencies should ensure that clients served through contracts with third party entities are not unduly prioritized for OAA-funded services offered by the same agency. For example, a sub-grantee agency could contract with a Medicare Advantage plan to provide 10 days of post-discharge meal delivery to individuals who have recently been hospitalized. After 10 days of meal delivery, the sub-grantee could not then prioritize those individuals for continued meal deliveries under their OAA-funded nutrition assistance program if there were other individuals already on the waitlist. All individuals who receive OAA-funded services from an agency must be screened using the same eligibility requirements. For example, recipients of OAA-funded services may not be subjected to an economic means test.

In addition, AAAs are joining CIHNs that are increasingly pursuing business opportunities that may include billing health insurance for services provided, in which case they likely are "covered entities" under HIPAA. Agencies that are covered entities have infrastructure requirements and other privacy-related responsibilities under that law. Agencies that are not covered entities, but who are performing treatment or health care coordination under HIPAA, may receive Protected Health Information (PHI) from covered entities, and should develop policies for appropriately protecting and maintaining any health-related information in their systems.

## Coordination of Payment Sources

Health plans and health systems typically have their own care managers assigned to higher need individuals. It is common for older adults and people with disabilities using publicly funded programs to have multiple care managers, tell their story often, identify their needs for various services, and then weave together the work of these multiple sources. This approach is inefficient and creates a risk of providing duplicative services from publicly funded programs. It is also confusing for the individual in need of coordinated services and it is challenging for health care providers who at times interface with multiple care managers.

Assessments, person-centered planning, and service activation must be central to the person and not the financing organization. The CIHNs provide these services using a person-centered approach; accordingly, high performing CBOs in these networks are well positioned to work across providers and payers to assist all populations in accessing, financing, and activating their person-centered plan. This approach can help improve the experience of the person, record the cost of assessments and person-centered planning, and ensure appropriate allocation to financially responsible entities.

### Key Point

A common misconception from health care providers and payers is that the OAA is an entitlement program. Title III of the OAA does not create a legal requirement to finance services for any individual. Individuals age 60 and over may receive benefits under the OAA, but no individual is entitled to them. An individual who is eligible for Medicaid may also receive services under the OAA, however the state may not require OAA programs fund benefits that can be funded by Medicaid. Although individuals may not be entitled to specific services under the OAA, Medicaid-eligible individuals may receive such services.

As the approaches to finance health care and social services continue to evolve, the method and vehicles to pay for assessment, person-centered planning, and service activation are evolving. CIHNs will need to use contracting vehicles with payers to assure that when these services are provided to the payer's beneficiaries or members, there is a mechanism for the payer to pay for these services so that the OAA is not subsidizing services that are already financed by Medicare and Medicaid products and other insurance products.

## Addressing Conflicts of Interest

States should identify and categorize COI in terms of risks to the consumers to be served, the state, the services being provided, and underlying federal and state statutory and regulatory considerations. Once conflicts are identified, the state must develop a set of policies or procedures to resolve or where permitted mitigate those risks. Conflicts can arise in a variety of areas such as in the development of the person-centered service plan, management of programs and funding, the provision of services to consumers, or through the assignment of staff duties. In some states, where a separate case management entity is already available, these additional mitigating strategies would not be permissible.

As potentially problematic scenarios arise, it is important that states seek to understand the situation, educate all involved, and formulate a mitigation plan along with their partners and ACL, where appropriate. Whether potential conflicts of interest are actual or perceived, it is essential that grantees pursue solutions that preserve the integrity and mission of the programs and services being provided. Even the appearance of a COI should be avoided. Risk mitigation processes are especially important when dealing with conflicts that directly impact the services being provided.

To assist with this challenge, ACL convened a workgroup to explore COI issues related to the management of the State Health Insurance Assistance Program (SHIP) and the Senior Medicare Patrol (SMP). The workgroup consists of representatives from all levels of the network including states, AAAs, federal staff, and national partners. The ultimate goal of this workgroup is to arm the network with a set of materials to provide technical assistance to states, CBOs, and anyone administering SHIP and SMP programs to help avoid conflicts of interest, manage risk, and share policy and implementation ideas.

As an example, one of the areas addressed by the SHIP/SMP Conflict of Interest Workgroup that could be applicable more broadly includes the management of staff:

- Segregation of Duties – As additional business opportunities are pursued and developed, CBOs should ensure there are clear delineations of duties between the federally funded activities, such as SHIP/SMP, and any privately funded contracts. This includes segregation of duties and staff providing services as appropriate and ensuring that staff have no conflicts of interest in the execution of their duties. Given the statutorily required unbiased nature of SHIP/SMP services, any staff working under health plan contracts cannot also provide SHIP/SMP services.

States also need to consider statutory and regulatory requirements when developing mitigation strategies. For example, the OAA prohibits organizations providing case management from promoting provider services. The individual receiving services must be given a choice of agencies providing the services. The CBO must provide the individual with a statement about choice of provider. Case management services must be coordinated and not duplicative.[25]

The Medicaid-funded home and community based waiver and state plan program regulations include more stringent requirements around COI for HCBS providers than the OAA. CBOs that provide Medicaid HCBS must not also provide case management or develop a person-centered service plan for the same individual except when the state demonstrates that the CBO is the only case management provider available in the area to do so. In that situation, COI protections such as separating entities and provider functions within the provider entity must be developed. These requirements apply only to services funded under a Medicaid HCBS authority. Because Medicaid regulations impose COI requirements that are not imposed under the OAA, CBOs may need additional strategies to provide HCBS under contract to a Medicaid MCO or to the state Medicaid program.

## Data Coordination and Alignment

One of the biggest challenges health care and social service organizations confront when trying to partner with one another is the lack of an information technology (IT) infrastructure with data standards that span across both systems. State health and human service leaders can take a lead role in enhancing IT infrastructure to ensure alignment and coordination with State Medicaid Agencies, state health IT leaders, and aging and disability networks. Health IT and health information exchange (HIE) supports referrals from health care to CBOs, care coordination, identification of patient populations needing interventions, and quality improvement. Approximately 58% of organizations on the state and local level offering HIE exchange data with social service agencies. States should be considering how health IT and HIE can support key components of a state's NWD System including statewide referral systems while ensuring full compliance with HIPAA requirements. Collaboration across state government can ensure the planning and implementation of statewide health IT solutions enable the integration of health care and social services. Some states, such as Oklahoma and Maryland, have statewide HIE services that include alerts to CBOs when an individual is admitted and/or discharged from hospitals and electronic referrals for SDOH services from a health care provider to a CBO.

The IT component to states' strategies for successfully integrating health care and social services systems is also part of a broader state and national effort focused on advancing and achieving interoperability. As such, states should consider how their strategies to integrate health care and social services are consistent with the successful implementation of national health IT policies, including advancements in HIE and advancements in interoperability by considering the following:

- Advancing state-level interoperability by supporting the collaboration and integration of health and other data from various sources, including community health, public health, and research.
- Promoting state use of standards, health IT certification criteria, as applicable, and involvement in developing standards where gaps exist as appropriate.
- Implementing federal regulations and programs by coordinating with Federal partners to ensure state adherence.

To further advance HIE and interoperability nationwide, the U.S. Department of Health and Human Services (HHS) has finalized regulations required through the 21st Century Cures Act to improve individuals' access to their health information through open application programming interfaces (API) and ensure providers and vendors do not block appropriate exchange of health information across the care continuum. States have an important role to play in planning multi-stakeholder supported, statewide solutions that reinforce open APIs, and emerging standards for SDOH data through related procurement processes and requirements. Oregon and Pennsylvania have planned statewide referral management solutions to streamline referrals to community-based resources and can incorporate standards and expectations around interoperability through contracts with vendors that offer these services.

States agencies that coordinate or operate Medicaid funded programs are able to request Medicaid Administrative Claiming (MAC) for the administration of these programs or for

maintenance or small upgrades to data and software systems that are in some way connected with administering Medicaid services. For example, the Georgia Department of Human Services Division of Aging Services (DHS/DAS) was able to blend state and Social Services Block Grant (SSBG) funds with the OAA and braid in MAC to fund the development and ongoing operations of a new data system for the ADRC, 1915c waiver and OAA services, as well as Protective Services and Guardianship. As a result, the state is able to facilitate seamless screening and referral to the appropriate service and has full visibility into consumers receiving both OAA and Medicaid HCBS services.

In addition, states can request IT funding by submitting an Advanced Planning Document (APD) to CMS for the development of IT infrastructure. A toolkit is available to inform state plans that could be incorporated into an APD. Types of activities supported include design and development, operations and maintenance, or administrative activities.[26] For example, Missouri has leveraged Medicaid federal financial participation at a 90/10 match to procure a state-based care plan development and care coordination platform. This platform is being used in the Medicaid HCBS programs serving individuals with intellectual and developmental disabilities. The platform and its structures conform to CMS person-centered planning requirements. It is also being used within the state's behavioral and mental health programs. Building on this, Missouri is using its case management APD to support plans to implement a value-based payment arrangement to be submitted in an amendment to the state's HCBS 1915(c) waiver serving individuals with intellectual and developmental disabilities (I/DD). Importantly, the state's Division of Mental Health has led many of the discussions with the state's Health Information Exchanges, other Missouri state entities, and providers about the capture, exchange, and use of structured data pulled from the person-centered plan as a basis for the value-based payment arrangement.

## Section 2: Building State-Driven Roadmaps

The need to serve a growing population of older adults and people with disabilities in the next decade will require state health and human service leaders to change the orientation, roles, and culture of state agencies to embrace new partnerships, as well as think and act strategically to foster growth and modernization of the aging and disability networks. As part of their strategic planning, states may consider prioritizing the growth and sustainability of the aging and disability networks to meet the increasing demand for services and evolving financial oversight to maximize the net benefit to older adults and people with disabilities. Effectively addressing SDOH will require improved access to services and supports such as transportation, housing, nutrition, and assistive technology (AT), as well as a collective public and private approach to financing. State human service leaders can foster innovative thinking and form strategic partnerships across state government and the health care system to ensure services that address SDOH are provided and financed through a variety of sources. As Governors and State Medicaid Directors continue to advance health care transformation in their states, a collaborative approach to addressing SDOH will be important to address the holistic needs of complex populations and improve health outcomes while reducing costs. Such collaboration can fully bring to bear the assets from social services and health care systems, along with state and federal financing, in a way that best serves individuals in need during emergencies and everyday life in a person-centered, holistic way. For additional information on opportunities related to transportation, nutrition, housing, and AT, refer to Addendum 1.

State leaders can foster this culture shift through existing planning activities and funding opportunities to identify tactical steps that make up a state-driven roadmap on integrating health and social services and supporting new partnerships including CIHNs, within the state and beyond. State-driven roadmaps can outline policy and programmatic approaches to integrate services, evolution of financial oversight processes, as well as training opportunities for executive directors and staff of CBOs to enable change in their own organizations. More specifically, roadmaps can incorporate policy strategies to meet demand, such as changes to Medicaid managed care contracting to leverage the aging and disability networks, adding requirements for Medicare Advantage Special Needs Plans to incorporate CBOs in care coordination or SDOH service delivery, or defining a role for CBOs in Medicaid programs. States can also support implementation of care coordination tools, closed loop e-referrals, provider directories, e-quality measures, consumer tools, identity management systems, and shareable assessments that enable eligibility and enrollment, quality improvement, and more.

To inform a state-driven roadmap, states can analyze current systems and environments to identify the gaps and needs for intervention. For example:

- The New York State Office for the Aging (NYSOFA) developed a two-year business acumen training initiative for AAAs in the state. This initiative was aimed at enhancing local capacity and providing the tools necessary for the AAAs/ADRCs to understand the changing health and long-term care landscape, demonstrate the efficacy of AAA/ADRCs services, and build sustainable partnerships. In addition to strengthening the network's capacity, NYSOFA was recognized as an important resource for addressing SDOH by the New York Department of Health Medicaid Redesign Team in the Value-Based Payment

Roadmap that lays out standards and guidelines to support SDOH interventions and CBO engagement.

- The Colorado Health Institute, a non-profit organization, completed a research assessment of the LTSS functions and access points in Colorado, providing a broad overview of case management services, assessment tools, administrative functions, data system capabilities, and a perspective of the consumer's experience.
- The Georgia Department of Human Services, Division of Aging Services, partnered with University of Georgia to provide training and ongoing support to each AAA as part of the state's sustainability initiative. The state infused goals and measures to track progress throughout the State Plan on Aging. For example, one Area Plan goal that was common across all AAAs was to focus on long-term sustainability of aging services programs, and the objective was to develop and implement the AAA Sustainability Business Plan, a private-pay service within the AAA. The result of this process was that each AAA had a plan for funding and transitioning two programs for expansion into the private pay market.

## Potential Action Items for State-Driven Roadmaps

This section provides strategies, actions, tools, and resources that can help state health and human service leaders develop their own roadmaps on innovative strategies in policy, financing, and partnerships to sustain and integrate social and medical care in ways that effectively address SDOH. For additional context on these categories, refer to Addendum 1 and Addendum 2.

# Leadership and Policy Opportunities

- Arrange meetings between state aging, disability, and Medicaid leaders and other partner organizations to discuss: 1) how states and MCOs, if applicable, can leverage the talent and expertise of the aging and disability networks; and 2) how states can collaborate on Medicaid Waiver (1915 and 1115) design and implementation to ensure the existing state and federal investments in the aging and disability networks (and related capabilities) are appropriately leveraged and sustained.

- Collaborate across state aging, disability, and Medicaid programs to develop either a fee-for-service framework, or under managed care, MCO Request for Proposals and contract terms and conditions that clarify the role of the aging and disability networks with the goal of streamlined eligibility and enrollment processes, coordinated case management, and continuity of care. Contracts could include language incentivizing or encouraging the use of existing CBOs. The State may also award additional points on a RFP for effective use and role of the existing aging and disability networks.

- State aging, disability, and Medicaid program leaders can collaborate on State Medicaid Agency Contract (SMAC) or MIPPA contract requirements for D-SNPs to clarify how aging and disability networks can satisfy care coordination and Medicare-Medicaid integration requirements that must be implemented in CY 2021. States could leverage existing care transition standards such as those in NCQAs LTSS accreditation. Contracts should include language around two/three-way data sharing and include models for coordinating care across payers.

- Identify, support, and create opportunities for aging and disability networks to acquire additional business knowledge and skill sets to successfully partner with health care entities to address SDOH. This may include contracting for outside support to help develop business acumen of network professionals.

- State leaders can strengthen and leverage the NWD governance structure to foster the development of CIHNs that can cover various service areas, streamline contracting, ensure performance, and gain support and participation from payers and health care systems across the state.

- State aging and disability leaders can encourage formal agreements with AAA's, CILs, ADRCs, and/or State Units on Aging (SUAs) with local Veterans Administration Medical Centers (VAMCs) to expand the Veteran Directed Care (VDC) program. VDC supports a growing population of Veterans at risk for nursing home admission to access a self-directed model that enables Veterans to direct and design their care to best meet their needs.

- Through the NWD governance structure, ensure an adequate skilled workforce exists across aging and disability networks to deliver person-centered planning to all populations.

- Arrange meetings between state and local aging, disability, and Medicaid leaders and other partner organizations to discuss opportunities to streamline the application processes for MSPs and U.S. Department of House and Urban Development (HUD) rental assistance.[27] Enrolling in an MSP helps improve economic security for older adults and people with disabilities, reducing the risk of housing or food insecurity.

## Data Integration

- Convene leaders from the state Medicaid agency, state health IT, aging and disability programs, and CBOs to identify opportunities for advancing data systems and health IT infrastructure in support of shared goals and functions of the state's NWD System.

- Collaborate with health care and aging and disability network leaders on planning and implementing scalable IT solutions that address e-referrals to community-based

resources, intake and assessments requirements, interoperability, and dashboard visuals to demonstrate value and outcome-based data.

- Explore different funding opportunities to finance data system and health IT enhancements based on existing Medicaid matching potentials and other public or private financing opportunities. Consider a public private partnership as a means of implementing statewide electronic referral systems, informed by the approach in NC. Alternatively, consider a state procurement for a statewide solution, informed by the approach in PA.

## Transportation

State health and human service leaders are uniquely positioned to build relationships with their State Departments of Transportation to collaboratively develop transportation plans and influence state budget requests. State Departments of Transportation develop regional transportation plans. Some area agencies on aging are housed in councils of state government and/or other regional planning agencies. Where these relationships exist, aging and disability organizations share valuable data that informs regional transportation plans and transportation infrastructure development. The Federal Transit Administration (FTA) invests more than $12 billion annually to support and expand public transit. In addition to the FTA investments, CMS and state Medicaid agencies invest over $3 billion annually to fund non-emergency medical transportation (NEMT) programs. These federally funded, state administered transportation programs can be collaboratively planned and implemented to purposefully improve the availability and access to transportation services at the community level. Opportunities for state leaders include:

- Participate in the National Aging and Disability Transportation Center (NADTC) course to learn how to use ACL grant funds spent on transportation as match in FTA Section 5307 (Urban), Section 5310 (Older Adults/PWD), and/or Section 5311 (Rural/Tribal) Program grants.

- State health and human service leaders can meet with State Departments of Transportation leaders to develop a partnership around transportation and develop strategies to braid funding available through FTA Section 5307 (Urban),[28] Section 5310 (Older Adults/PWD),[29] and/or Section 5311 (Rural/Tribal)[30] program grants to increase access to transportation.

- State leaders can convene a meeting with CBOs (such as AAA's, ADRC's and CILs), local elected officials in rural areas, and local transportation providers to learn about transportation needs and share promising practices in providing transportation to people living in rural communities.

- State health and human service leaders can review their state's NEMT program and implement cost sharing strategies to maximize the use and reach of all federal and state funded transportation programs.

- State health and human service leaders can meet with State Department of Transportation (DOT) leaders to learn regional transportation planning schedules and assure that aging and disability organizations are aware and engaged in the development of regional transportation plans within their state.

- State health and human service leaders, along with the state DOT, can explore implementing mobility-on-demand transportation systems that use technology platforms to leverage all transportation assets in the community.

## Nutrition

Poor nutrition and food insecurity are increasingly recognized as key SDOH.[31] Approximately 33% of hospitalized older adults and 50% of those living in the community may be malnourished. Malnutrition can increase health care costs by 300%. HHS and U.S. Department of Agriculture (USDA) nutrition assistance programs that states administer serve close to 9.4 million older adults. Federally funded nutrition programs, which are administered at the state and locals levels, can be collaboratively planned, coordinated, and implemented to increase access to food and nutrition for older adults and people with disabilities of any age.

- Work with local CBOs to understand their challenges in meeting a growing demand for nutrition support. Review and update state policies to allow flexibility to meet community needs. Consult with the ACL Nutrition Resource Center for technical assistance.

- State health and human service leaders can assess opportunities to include screening for food insecurity and nutritional needs in primary care and subsequent referrals to CBOs who can offer assistance in eligibility and/or enrollment into one or more federally funded, state-operated nutritional assistance program.

- Assess state readiness for medically tailored needs to ensure appropriate nutritious meals are provided to older adults with health conditions that require pureed, low salt, or other types of specialized foods. Develop and implement strategies to improve the availability of medically tailored meals for older adults with health conditions.

- Assess procurement opportunities to aggregate purchasing power for meal services funded under the OAA to serve a greater number of older adults.

- State health and human service leaders can work together to align state policies on meals when Medicaid also pays for meals and nutrition services. Some approaches to consider include, recognize OAA nutrition and meal providers as meeting Medicaid requirements,

or co-create one set of nutrition and meal services standards and policies for nutrition and meal service providers to follow.

- Consult with state Medicaid leadership for guidance on Medicare Advantage Special Needs Plans and Medicare Advantage plans related to their responsibilities and the opportunities to financially support and use state and community nutrition assistance programs to ensure continuity of nutritional services over time and appropriate reimbursement for services.

- Assess opportunities to screen for and address social isolation and psychosocial needs through home delivered meal programs and congregate meal sites. Incorporate the most promising opportunities for screening, assessment, and interventions to address social isolation into State Plans for Aging.

- Work with the state Medicaid agency to determine if home delivered meals are a service funded in any of the state Medicaid authorities. If home delivered meals are a service funded in any of the state Medicaid authorities, train and educate staff in aging and disability networks and ensure that there is no duplication of services and funding opportunities are appropriately used.

- Collaborate with the state Community Services Block Grant (CSBG) Program Coordinator to explore using CSBG funding to provide meals and other programs that address HCBS needs. CSBG is a means tested program, and can complement state contracts with AAA to leverage the buying power. By better coordinating, states can potentially benefit from increased Nutrition Services Incentive Program (NSIP) reporting. NSIP provides funds to states, U.S. territories, and Indian tribal organizations to purchase food or to cover the costs of food commodities provided by the USDA for the congregate and home delivered nutrition programs.

## Housing

Accessible, affordable, stable, and supportive housing is well understood to be an essential social determinant that makes possible, and sustains, community living for older adults and people with disabilities. State health and human service leaders can provide assistance through several key mechanisms, including advocacy, comprehensive planning and coordination, and collaboration with key housing stakeholders (e.g., Public Housing Authorities and state and local housing finance agencies) to address housing supply and affordability, accessibility modifications, housing search, tenancy supports, and supportive services. Supportive services include a variety of assistance that responds to the social, functional, primary, and behavioral health needs of individuals. Aging and disability networks that are already working with health care organizations could play an intermediary role between health care organizations and federally assisted housing developments to organize onsite services and potentially contract across plans and providers to share related costs. State leadership and coordination of federal, state, and

locally funded housing programs can increase the supply of affordable, accessible housing and connections to services and supports, a fundamental basic need for vulnerable populations.

- State leaders can evolve the role of aging and disability networks to support integrated and supportive housing and proactively address housing insecurity among older adults by leveraging case management resources and federal technical assistance programs such as the Home Modifications Resource Center.

- State leaders can consider how person-centered planners across the aging and disability networks can assess and address housing insecurity and stability in collaboration with Public Housing Authorities and other housing stakeholders in the state.

- Develop partnerships between state agencies, MCOs, and aging and disability networks to provide ongoing, effective supportive services that ensure an individual with behavioral health challenges and/or other challenges can maintain their housing.

- Develop a partnership with their State Housing and Finance Agency to develop and implement solutions to housing needs in their states, such as design-build challenges for affordable and accessible housing.

- Assess opportunities to address social isolation through partnerships that enable assessments and relevant technologies (smart speakers, devices, apps)and evidence-based prevention programs (i.e., PEARLS, EnhanceFitness, and A Matter of Balance) to be offered to residents in need.

- States can be supportive of locally developed partnerships that integrate supportive services with housing. Examples include: iWISH demonstration, the Elder Services of the Merrimack Valley/Winn Properties partnership in Massachusetts, and the SASH model in Vermont. These models help older adults avoid evictions, reduces emergency room visits and unnecessary 911 calls, and improve the overall health and well-being of residents.

- States can consider public and private funding sources to expand access to affordable housing that integrates services through onsite or virtual service coordinators. Examples of private sector investments include the Funds created by United Health Group and Kaiser Permanente to address housing insecurity.

## Assistive Technology

Assistive technology can impact a person's well-being by improving their ability to see, speak, hear, walk, eat, bathe, connect with loved ones and live independently. Access to affordable and readily available assistive technology can be essential to enhancing the quality of life for individuals with disabilities and older adults to maintain inclusion, belonging, and active participation in a community. The State and Territory Assistive Technology Act Programs (AT

Programs) are a key stakeholder and partner in improving the awareness, access, and provision of AT. AT programs provide information and referral, training, device demonstration, device loan, and state financing and device reutilization activities that help older adults and people with disabilities learn about, use, and acquire the assistive technology that best meets their unique needs. AT activities improve the ability of older adults and individuals with disabilities to engage in all areas of daily life, including employment, education, and participation in the community. State leaders can improve access to assistive technology by ensuring the State AT Programs are a part of the NWD System infrastructure to better connect people to AT that enables them to live full lives in the community. Opportunities for states and partner organizations include:

- Develop a toolkit of AT and make it available across the aging and disability network to improve access to AT.
- Develop and implement a streamlined approach across CBOs to create and activate person-centered plans that addresses functional needs and incorporate AT.
- Ensure through policy and training opportunities that all stakeholders prioritize the use of technology to enhance and not supplant active community integration.
- Modify every taxonomy of service to include references to assistive technology and allow OAA funds to pay for these services.
- Train information and referral staff across AAAs, ADRCs, and CILs on assistive technology, as well as how to incorporate AT into person-centered plans.
- Train SHIP counselors on AT to ensure access to DME and other AT can be enabled through referrals to the AT program.
- Co-locate state AT program demonstration locations with AAA's and CIL's.
- Integrate the state AT program into the NWD System I&R process (website, toll-free number).
- Educate stakeholders in the NWD System about AT including employers, community groups, faith-based organizations, schools, elected officials, health care providers, health systems, and health care insurers/plans to increase awareness and access to AT.
- Incorporate ways to expand access to AT in state plans on Aging, Independent Living, and Developmental Disabilities in effort to empower older adults and people with disabilities in living full lives in the community.
- State human service leaders can implement policies and use contractual language to ensure that the aging and disabilities networks and MCOs prioritize the use of AT to support independence and ability to remain in the least restrictive setting. Potential vehicles to embed this policy include Olmstead plans, state independent living plans, state plans on aging, grants, and contracts.

# Addendum 1 - Aligning Resources to Increase Access to SDOH Services

American families view social needs as equally important to their health, with safe and stable housing and transportation being extremely important and access to food or balanced meals frequently or occasionally causing stress.[32] Effectively addressing SDOH through access to transportation, housing, nutrition assistance, and other services requires state aging and disability agencies to foster innovative thinking and form strategic partnerships for collaboration across various entities and publicly funded programs. Innovation and collaboration create opportunities for states and communities to integrated services that address SDOH as a part of health care transformation to improve health outcomes and reduce costs. Through the aging and disability networks, there are a variety of services to support the social and health needs of older adults and people with disabilities who reside at home. This section focuses on some of the most frequently identified unmet social needs including transportation, housing and nutrition. Federal and state funding for services that address these social needs is substantial and a coordinated approach by state and aging leaders can increase the state's ability to efficiently and effectively respond to these unmet needs. This section also identifies opportunities to increase access to assistive technology. Access to affordable and readily available assistive technology can be essential for some older adults and people with disabilities to access SDOH-related services and supports that address the most pressing needs. In-home services, household chores, caregiver support, behavioral health, financial security, and employment are all very important factors to consider and address, but are beyond the scope of this version of the Strategic Framework.

## Increasing Access to Transportation

State health and human service agencies are uniquely positioned to build relationships with their State Departments of Transportation to collaboratively develop transportation plans and influence state budget requests. The Federal Transit Administration (FTA) invests more than $12 billion annually to support and expand public transit. These federally funded, state administered transportation programs can be collaboratively planned and implemented to purposefully improve the availability and access to transportation services at the community level.

On October 29, 2019, the U.S. Department of Transportation announced nearly $50 million in new initiatives to expand access to transportation for people with disabilities, older adults, and individuals with low income. This includes:

- $40 million in grants to enable communities to highlight innovative business partnerships, technologies, and practices that promote independent mobility for all.
- $5 million in cash prizes available to innovators who design solutions to enable accessible automated vehicles.
- $3.5 million to fund projects that improve mobility options and access to community services for older adults, individuals with disabilities, and people with low incomes.

State Departments of Transportation use their State Management Plans and the locally developed Coordinated Public Human Services Transportation Plan[33] to determine how to allocate their funding to address transportation needs within the state. State health and human service leaders are encouraged to build strong working relationships with their State Departments of Transportation to collaborate on the development of the Coordinated Public Human Services Transportation Plan, the State Management Plan. The state plans are used to inform transportation investment strategies. The strong working relationships can also help state aging and disability agencies in the development of provisions related to transportation in the State Plan for Aging, the State Plan for Independent Living, the State Plan for Developmental Disabilities, the mental health and substance prevention and treatment block grant plans, and others. By coordinating these state plans and investments, states can strategically address the transportation needs of older adults, people with disabilities, and caregivers.

In addition, states and CBOs applying for FTA Section 5307 (Urban), Section 5310 (Older Adults/PWD), and/or Section 5311 (Rural/Tribal) Program grants may use HHS grant funds spent on transportation towards an eligible FTA grant match requirement.[34] These funds can be used for purchasing vehicles, hiring mobility managers, and implementing travel training programs. States can promote replication of successful community transportation examples:

- Kansas and Missouri created a compact between the states to enable cross-state transportation.[35]
- Wisconsin developed the Wisconsin Association of Mobility Managers, a network of mobility managers. Mobility management is the practice of using all available resources and developing new ones to improve mobility, increase efficiency, and reduce costs.[36]
- In Texas, Dallas Area Regional Transportation (DART) uses technology to improve the ability of different service providers to share trip information, enabling passengers to share trips or consolidate services, rather than providing separate services.[37]
- In Missouri, HealthTran increases transportation options and improves clients' ability to find and schedule appropriate transportation. HealthTran is an innovative mobility coordination and service program designed to address rural transportation limitations and barriers.[38]
- In Oregon, Ride Connection in Portland enhanced the quality of transportation for people needing dialysis and hired a person that uses dialysis in their Human Resources Department to provide sensitivity and awareness training for drivers.
- In Kentucky, the University of Kentucky in Lexington, a team of bus drivers and bus riders (composed of older adults and people with disabilities) developed an app that enables bus drivers and people that are non-communicative to communicate, improving the quality of the transportation for these riders and reducing bus driver frustration.
- In Pennsylvania, York County transportation providers, people with disabilities, and older adults worked together to increase ridership and improve transportation by changing hours of service and route design.

*For additional transportation resources, see Addendum 2.*

## Increasing Access to Nutrition

Poor nutrition and food insecurity are increasingly recognized as key SDOH.[39] Approximately 33% of hospitalized older adults and 50% of those living in the community may be malnourished. Malnutrition can increase health care costs by 300%.[40] HHS and USDA nutrition assistance programs that states administer serve close to 9.4 million older adults **(see Table 1)**. In addition, an estimated 4.5 million households in the SNAP have a person with a disability. While there are 5.5 million[41] older adults enrolled in SNAP, only 48% of the eligible population[42] are enrolled. Federally funded nutrition programs, which are administered at the state and local levels, can be collaboratively planned, coordinated, and implemented to increase access to food and nutrition for older adults and people with disabilities of any age.

**Table 1: Key Characteristics of Federal Nutrition Assistance Programs Serving Older Adults, by Agency**
**Dollars in Millions**
***Source: GAO November 2019***[43]

| Program | Eligible population | Type of assistance | Federal expenditures on older adults | Number of older adult participants |
|---|---|---|---|---|
| **HHS Administration for Community Living** | | | | |
| Home-Delivered Nutrition Program | Adults 60 years or older | Prepared meals delivered to homebound participants | 307.5 | 850,880 |
| Congregate Nutrition Program | Adults 60 years or older | Prepared meals provided in congregate settings, such as senior centers | 294.3 | 1,520,507 |
| **USDA Food and Nutrition Service** | | | | |
| Supplemental Nutrition Assistance Program (SNAP) | Households, including those with older adults, with low incomes | Benefits to purchase food in participating retail stores | $6,580.0 | 5,447,000 |
| Commodity Supplemental Food Program (CSFP) | Adults 60 years or older with low incomes | A monthly supplemental package of shelf-stable foods and refrigerated cheese | 230.2 | 675,926 |
| Child and Adult Care Food Program (CACFP) | Adults who are physically or mentally impaired or adults 60 years or older enrolled in an adult day care program | Prepared meals provided in nonresidential adult day care centers | 161.6 | 134,694 |
| Senior Farmers' Market Nutrition Program (SFMNP) | Households of adults 60 years or older with low incomes | Benefits to purchase locally grown fruits, vegetables, honey, and herbs from farmers' markets, roadside stands, and community supported agriculture programs | 19.1 | 834,875 |

A number of key opportunities and challenges exist for state health and human service leaders in addressing food insecurity and improving the nutritional status among older adults and people with disabilities. These include coordinating and leveraging all federally funded nutrition assistance programs, enabling access to SNAP, modernizing and innovating home delivered and/or congregate meal sites to include, but not limited to, medically tailored meals, partnering with local restaurants, and addressing wait lists for home delivered and congregate meals. Examples include:

- AgeOptions, the Area Agency on Aging of suburban Cook County, Illinois was awarded a 2018 ACL Innovations in Nutrition (INNU) grant to implement a closed-loop referral system between health care providers and nutrition programs. The goal is to increase the likelihood that older adults experiencing food insecurity and/or are at nutrition risk will receive and act upon referrals to community-based resources.
- The 2017 ACL INNU grant awarded to the Maryland Department of Aging used the epidemic of older adult malnutrition as the catalyst to introduce evidence-based practices, cost-cutting measures, innovative meal products, and efficient service delivery methods to forge new health care linkages and expand service to older adults in the community. This project created access to medically tailored, shelf-stable meal packages that were piloted in four area hospitals. Older adults with malnutrition, food insecurity, and/or high risk of readmission in these hospitals were targeted for meal distribution with the goal of reducing health care costs and readmissions.

Another opportunity to serve older adults and people with disabilities who are Medicare beneficiaries is the growing number or Medicare Advantage plans providing beneficiaries with home delivered meals. While approximately 50% of Medicare Advantage plans offer meal delivery often following a discharge, meal delivery can now be expanded under Special Supplemental Benefits for the Chronically Ill.[44] State aging, disability and Medicaid leaders can consider how to ensure nutritional needs are met over time for Medicare and dually eligible Medicare and Medicaid beneficiaries through OAA and USDA programs, as well as Medicare Advantage related benefits, including those in Special Needs Plans for dually eligible beneficiaries. These services should be coordinated with the Medicaid program, to ensure there is no duplication of services where Medicaid is funding home delivered meals.

In addition, state health and human service leaders of state aging and disability agencies have an important role to play in improving access to all appropriate nutritional assistance programs. Some states have experienced success with strategies that revolve around outreach and enrollment for SNAP. One promising strategy is cross-agency collaboration, where the SNAP outreach and application processes are coordinated with other benefit programs, such as Medicaid, MSPs, and the Home Energy Assistance Program (HEAP), or with local food banks.[45] The grantees described in the NCOA Senior SNAP Enrollment Promising Practice Brief[46] employed strategies to address barriers with SNAP enrollment, including reframing SNAP to demonstrate its value, reducing shame and stigma, and building trust. Sharing personal stories on Facebook that explain how SNAP has positively impacted older adults is another innovative strategy that has been used to improve awareness of the value of SNAP among older adults and people with disabilities.

Other promising practices addressing access to nutritious food include partnering with agencies or food banks that conduct outreach for other nutrition programs that older adults may qualify for, such as the Commodity Supplemental Food Program, the Senior Farmers Market Nutrition Program, and the Child and Adult Care Food Program. These partnerships leverage the resources among the various congregate meal programs, food banks, and meal delivery options available within communities. The 2017 ACL INNU grantee Mid-America Regional Council (MARC) used technology interventions to improve service, delivery, and cost-effectiveness of nutrition programs for older people at high risk of malnutrition. This project included in-home artificial intelligence-enabled speakers, Amazon Echo Show, that were deployed to participant homes to reduce access barriers to good nutrition. An alliance between the AAA (MARC), food delivery organization (Shepherd's Center Central and MARC), and local food pantry (Jewish Family Services) to deliver this service.

In Massachusetts, a partnership between community-based care organizations and health plans has effectively demonstrated the economic value of nutrition through a meal delivery program that offers medically tailored meals for individuals with chronic conditions. One study found that Medicare and Medicaid dual eligibles who participate in either a medically-tailored meals program or a non-tailored food program stay healthier, resulting in fewer costly emergency department visits and hospital admissions.[47] These types of value-based strategies can provide evidence to support health plans in offering medically tailored meals or other nutritional services to their members.

State health and human service leaders have an opportunity to improve access to SNAP by easing enrollment and recertification through several USDA programs:

- The Elderly Simplified Application Project is a demonstration project in 11 states that seeks to increase participation among the elderly low-income population by streamlining the application and certification process.[48]
- The Standard Medical Deduction demonstration project, currently in 23 states, allows states to establish an assumed standard medical expense to replace actual costs of medical expenses for households in which an elderly or disabled member incurs medical expenses (excluding special diets) in excess of $35 a month.
- Combined Application Projects (CAP) are in 17 states that streamline application procedures for individuals receiving Supplemental Security Income (SSI) benefits. The project is designed to strengthen access to nutrition benefits for the elderly and disabled, while improving the administration of the Supplemental Nutrition Assistance Program (SNAP).
- Waiver of the Recertification Interview for Elderly or Disabled Households with No Earned Income allows state agencies to forgo the recertification interview for households in which all adult members are elderly or disabled, and have no earned income, but meet all other recertification requirements. Typically, a state agency must conduct face-to-face or telephone interviews to recertify (renew) benefits for existing SNAP households. More information on these waivers, including which states have such a waiver, can be found on the USDA website.[49]

- The use of mobile technology enables procedural changes that streamline the enrollment process, facilitate verification and reporting requirements, and reduce "churning." Using mobile technologies, states can provide better service and more readily reach populations that lack access to a personal computer, enhancing access for those who would otherwise be limited in their ability to access information and complete the certification process.[50]

***For additional nutrition resources, see Addendum 2.***

## Increasing Access to Housing

Accessible, affordable, and supportive housing is well understood to be an essential social determinant that makes possible, and sustains, community living for older adults and people with disabilities. State health and human service leaders can provide assistance through several key mechanisms, including advocacy, comprehensive planning and coordination, and collaboration with key housing stakeholders (e.g., Public Housing Authorities and state and local housing finance agencies) to address housing supply and affordability, accessibility modifications, housing search, tenancy supports, and supportive services. Supportive services include a variety of assistance that responds to the social, functional, primary, and behavioral health needs of individuals. CBOs that are already working with health care organizations could play an intermediary role between health care organizations and federally assisted housing developments to organize onsite services and potentially contract across plans and providers to share related costs. State leadership and coordination of federal, state and locally funded housing programs can increase the supply of affordable, accessible housing and connections to services and supports, a fundamental basic need for vulnerable populations.

### Integrating Supportive Services with Housing

Over two million seniors live in affordable apartment buildings financed by HUD, Rural Housing Service, and the Low Income Housing Tax Credit. Integrating support services in federally assisted housing is a valuable intervention, particularly since older adults in HUD-assisted housing are significantly more likely to have five or more chronic conditions compared to seniors without housing assistance.[51] An example of an integrated support service approach is the HUD Integrated Wellness in Supportive Housing (IWISH) demonstration. IWISH uses federally assisted housing as a platform to coordinate and deliver supportive services to address the health and supportive service needs of older adult residents. This model, which includes the employment of an onsite full-time enhanced service coordinator and a part-time wellness nurse, could potentially delay or avoid nursing-home care for residents, while improving housing stability, well-being, health outcomes, and reducing unnecessary or avoidable health care utilization associated with high health care costs. The IWISH demonstration is similar in some ways to another supportive housing model, the Support and Services at Home (SASH) program

in Vermont. SASH connects older adults and individuals with disabilities living in affordable housing with community-based health care and support services to promote care coordination, improve health status, and slow the growth of health care costs. From July 2011 to June 2015, SASH participants had an average savings of $1,227 per-person, per-year in Medicare expenditures. Additionally, a study published in the Journal of the American Medical Association indicates that the 3,300 SASH participants with advance directives could translate into a savings of $18.4 million in end-of-life care.[52]

States can be supportive of locally developed partnerships that integrate supportive services with housing. One such initiative is led by Elder Services of the Merrimack Valley Area Agency on Aging and Winn Properties via the Alice G. Winn and Family Heritage House to create an enhanced supportive services model. This model helps older adults avoid evictions, reduces emergency room visits and unnecessary 911 calls, and improves the overall health and well-being of residents. The onsite nurse consults with residents on health care questions and issues and directs them to the most appropriate level of care. After this initial consultation, the nurse and a geriatric support services coordinator work together with each resident's case manager, protective services worker, property management and other staff, and resident's families to ensure the resident is receiving the best service. The program also offers congregate meals, protective services, family caregiver supports, money management, access to chronic disease self-management programs, and managed care options to residents.

Given the local nature of housing, where housing choice vouchers and project rental assistance is often initiated and funded at the city or county level, Centers for Independent Living (CIL), which are consumer-controlled local nonprofits funded by ACL, are particularly well-suited to serve individuals with disabilities. Among their core services are information and referral, individual and systems advocacy, and transition assistance for individuals moving into or remaining in the community when their housing becomes unstable. Many CILs have significant home modification programs to help individuals with disabilities make their homes more accessible. CILs in a number of states have taken the lead in coordinating housing search and tenant support as a part of the successful MFP demonstration. MFP grantees have partnered, and in many cases contracted, with CILs to provide MFP demonstration services and activities such as outreach, transition coordination, housing coordination, and peer support services to support individuals eligible for Medicaid funded long-term services and supports who desire to transition from medical institutions to community-based housing.

In this capacity, these CILs have acquired a record of success in helping non-elderly people with disabilities secure housing through Section 8 vouchers, Section 811 Mainstream Housing Vouchers, Section 811 Project Rental Assistance and other HUD funding streams. Area Agencies on Aging and Aging and Disability Resource Centers also provide similar services to older adults. Programs such as the 811 PRA program, 811 Mainstream HCVP program, and Non-Elderly Disabled Category II programs are administered through required partnerships with the State Medicaid agencies and state housing finance agencies.

In addition to MFP, additional opportunities to partner with the state Medicaid Agency include wrap around services, e-referrals, and data sharing. Medicaid can pay for wrap around services to

ensure stable housing, which can be provided to both the homeless population as well as an MFP recipient. E-referrals and data sharing between the Homeless Management Information System (HMIS) and the Medicaid Management Information System enables states to become aware of someone at risk of losing housing; the aging and disability networks can play a role in coordinating resources to possibly avoid or assist individuals at risk of losing housing. Louisiana is currently piloting this type of data sharing between Medicaid and HMIS.

Home Modifications

Home modifications and repairs can change the physical home environment to increase independence, safety, and optimal health. In many cases, home modifications can also help prevent falls and other accidents in the home and can make it easier for individuals to navigate through and live in their homes. Effective home modifications can also reduce the need for ongoing LTSS. States have the opportunity to expand programs to assist low-income older adults and persons with disabilities with home modifications and repairs, which may include highlighting home modifications in their state plans or HCBS waivers.

New York State produced a *Health Across All Policies/Age-Friendly Roadmap Report*. This Roadmap facilitates the creation of, livable, and sustainable communities through multi-faceted programs that engage multiple agencies and stakeholders to tackle SDOH. Informed by the principle that all policies affect health, this approach incorporates health and age-friendly considerations into state and local government activities. The approach is grounded in three overlapping frameworks: 1) New York State Prevention Agenda;[53] 2) Smart Growth Principles;[54] and 3) World Health Organization's Eight Domains of Livability.[55] New York State started this initiative by issuing Executive Order 190: Incorporating Health Across All Policies into State Agency Activities,[56] which directs all state agencies to include these frameworks in planning, policies, procedures, and procurements. To ensure effective statewide collaboration, New York also engages a steering committee and convenes state agencies.[57]

As part of this initiative, New York State announced the completion of an affordable and supportive housing development that consists of 50 new energy-efficient apartments for adults 55 and older, including 10 apartments that have support services to help individuals with intellectual and/or developmental disabilities live independently in their homes.[58] Additionally, New York State will increase good health and social cohesion by establishing a planned mixed-income community for older adults, individuals with intellectual and/or development disabilities, and families adopting a foster child, which will encourage community integration and support. This initiative will reduce risk for social isolation and increase independent living.

State health and human service leaders can forge partnerships with State Housing Finance Agencies[59] (HFAs) to impact the availability of safe and affordable housing. HFAs are state-chartered authorities established to help meet the affordable housing needs of the residents of their states. Most HFAs are independent entities that operate under the direction of a board of directors appointed by each state's governor. The HFAs administer a wide range of affordable housing and community development programs. HFAs use Housing Bonds, the Housing Credit, HOME, and other federal and state resources to design housing programs that include home ownership, rental, and all types of special needs housing.

State health and human service leaders, in partnership with HFAs, can encourage and support regional and local partnership initiatives to increase access to safe, accessible, affordable and sustainable housing. For example, the Atlanta Regional Housing Task Force was created in 2017 by the Georgia Department of Community Affairs (DCA) and Atlanta Regional Commission (ARC) in order to offer connections for local HUD grantees and stakeholders. The task force members – including cities, counties, Public Housing Agencies (PHAs), and other HUD grantees – share data, create regional policies and tools, and discuss strategies for shared regional housing outcomes. The ARC also funds a Behavioral Health Coach (BHC) that works with individuals living in 14 Atlanta Housing Authority (AHA) properties to help address behavioral health needs that to reduce lease violations or evictions, or were disruptive to the apartment community. There are many opportunities for state health and human service leaders and HFAs to join together to increase the availability of safe, accessible, affordable, and sustainable housing.

***For additional housing resources, see Addendum 2.***

## Increasing Access to Assistive Technology

The State and Territory Assistive Technology Act Programs (AT Programs) are a key stakeholder and partner in improving the provision of AT through comprehensive, statewide programs that are consumer-responsive. AT Program services address SDOH through four state-level activities: device demonstration and device loan activities that provide access to AT, while state financing and device reutilization activities provide acquisition of AT. These AT activities improve the ability of older adults and individuals with disabilities to engage in all areas of daily life, including employment, education, and participation in the community thereby augmenting and not supplanting an individual's interaction with his/her community.

The risk of individuals with disabilities and older persons being left out of society is exacerbated by the technological changes in our everyday lives. With advances in technology, the development of policies to address SDOH needs is critical. Access to affordable and readily available assistive technology can be essential to enhancing the quality of life for individuals with disabilities and older adults to maintain inclusion, belonging, and active participation in a community. Assistive technology can impact a person's well-being by improving abilities to see, speak, hear, walk, eat, bathe, and live independently. Technologies can also help address social isolation and improve quality of life by assisting people with communication, mobility, and additional daily activities thereby facilitating interaction with the broader community.

The partnership between the Georgia State ADRC/NWD System and the state AT program enabled greater awareness and access to assistive technology for older adults, people with disabilities and caregivers. In 2013, Georgia state health and human services leaders modified every taxonomy of service to include references to assistive technology which allowed OAA funds to pay for these services. Georgia state health and human service leaders partnered with the Georgia state AT program to provide training and create AT Labs. Today, AAAs and CILs have

established 11 AT Labs to cover the entire state. All 12 AAAs have Assistive Technology toolkits for public demonstrations.

In addition to Georgia, the Kansas and Oklahoma state Medicaid programs serve as examples for state leadership roles. These programs have years of experience in collaborating with their state AT Act Programs in the implementation of comprehensive AT/DME (durable medical equipment) reuse programs. In Kansas, the AT Program is Assistive Technology for Kansans. In Oklahoma, the program is Oklahoma ABLE Tech. In both of the programs, health care systems have seen tremendous cost-savings through these partnerships. The Kansas Equipment Reutilization Program, a partnership between KanCare, the state's Medicaid system, and Assistive Technology for Kansans, reclaims and refurbishes Medicaid-purchased equipment as well as other donated devices and distributes those devices free of charge to eligible citizens. Since 2002, the Kansas Program has received 12,131 DME donations worth $13,645,405 to reassign to local residents in need. Similarly, the Oklahoma Durable Medical Equipment Reuse Program collaborates with SoonerCare, Oklahoma's Medicaid program. The Oklahoma program has successfully refurbished and reassigned 5,237 DME devices since 2012, resulting in $3.5 million in health care savings and over $1 million in State Medicaid cost savings.

***For additional AT resources, see Addendum 2.***

# Addendum 2 - Additional Resources

## Transportation Technical Assistance Resource Centers

- National Aging and Disability Transportation Center (NADTC) (https://www.nadtc.org) - NADTC's mission is to promote the availability and accessibility of transportation options to address the needs of older adults, people with disabilities, caregivers, and communities.
- National Center for Applied Transit Technology (N-CATT) (https://ctaa.org/about-n-catt/) - N-CATT's mission is to translate emerging transportation technologies for states and localities and develop learning and planning resources for rural, small-urban, and tribal transportation providers and communities.
- National Rural Transit Assistance Program (RTAP) (https://nationalrtap.org/Home) - National RTAP's mission is to address the training and technical assistance needs of rural and tribal transit operators across the nation, and to support the state RTAP programs.
- National Center for Mobility Management (NCMM) (https://nationalcenterformobilitymanagement.org) - The mission of NCMM is to facilitate communities to adopt transportation strategies and mobility options that empower people to live independently and advance health, economic vitality, self-sufficiency, and community.
- Shared-Use Mobility Center (SUMC) (https://sharedusemobilitycenter.org/) - The SUMC is a public-interest organization working to foster collaboration in shared mobility (including bike sharing, car sharing, ride sourcing, and more) and help connect the growing industry with transit agencies, cities, and communities across the nation. Through piloting programs, conducting new research, and providing advice and expertise to cities and regions, SUMC hopes to extend the benefits of shared mobility for all.
- Transit Planning 4 All (www.acltoolkit.com/) - The Transit Planning 4 All resource center issues demonstration grants to communities of older adults, people with disabilities, and transportation providers to engage in inclusive planning and develop technical assistance resources to replicate successful strategies.
- ADA Participation Action Research Consortium (PARC) (https://adata.org/ada-participation-action-research-consortium-ada-parc) - PARC publishes maps that assist policy makers, community leaders, transportation developers, and state leaders in understanding transportation needs and opportunities for improvement.
- Paralysis Resource Center (PRC) (https://www.christopherreeve.org/living-with-paralysis/home-travel/traveling-with-your-wheelchair) - The PRC provides information for traveling with your wheelchair and makes grants to communities to increase access to transportation and technology.
- National Assistive Technology Act Technical Assistance and Training Center (AT3) (https://www.at3center.net/) - AT3 is a one-stop connection to information about assistive technology (AT). The AT3 site lists every state AT program. The state AT program demonstrates AT, provides training on AT, and makes short term loans of AT so people

can try the AT prior to making a purchase. There is AT available to assist people with transportation.

## Nutrition Technical Assistance Resources

- Nutrition Innovation Grants (www.acl.gov) - through nutrition innovation grants, states enhance and improve their nutrition service program. Explore these grants for innovative approaches.
- Nutrition Resource Center (NRC) (nutritionandaging.org) Nutrition Resource Center (NRC) (nutritionandaging.org) - the NRC provides technical assistance to states and local communities. Contact the NRC to learn more about medically tailored meals.

## Housing Technical Assistance Resources

- National Resource Center on Supportive Housing and Home Modification (https://homemods.org/) - housed at the University of Southern California's Leonard Davis School of Gerontology, this resource center is dedicated to promoting aging in place and independent living for persons of all ages and abilities. It offers research, training, and technical assistance opportunities for professionals who wish to respond to the increasing demand for home modification services and address fall prevention in the home environment. The resource center serves as an information clearinghouse on home modification to equip professionals and consumers with a comprehensive inventory of resources such as a National Directory of Home Modification and Repair Resources.
- National Council of State Housing Authorities (https://www.ncsha.org/about-us/) - a non-profit, nonpartisan organization created to advance, through advocacy and education, the efforts of the nation's state Housing Finance Agencies and their partners to provide affordable housing to those who need it. Resources include webinars on opportunity zones, housing credit programs, fact sheets, data, and research.
- LeadingAge LTSS Center at UMass Boston (https://www.ltsscenter.org/housing-plus-services/) - serves as a national catalyst for the development, adoption, and support of innovative affordable housing solutions that enable older adults with low and modest incomes to age safely and successfully in their homes and communities.

## Assistive Technology Technical Assistance Resources

- The National Assistive Technology Act Technical Assistance and Training Center (AT3) (https://www.at3center.net/) - AT3 is a one-stop connection to information about assistive technology (AT). The AT3 site lists every state AT program. The state AT program demonstrates AT, provides training on AT, and makes short term loans of AT so people can try the AT prior to making a purchase.

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