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August 15, 2023

Administration on Aging
Administration for Community Living
Department of Health and Human Services
330 C Street SW
Washington, DC 20201

Re: Proposed Rule "Older Americans Act: Grants to State and Community Programs on Aging; Grants to Indian Tribes for Support and Nutrition Services; Grants for Supportive and Nutritional Services to Older Hawaiian Natives; and Allotments for Vulnerable Elder Rights Protection Activities"

Thank you for the opportunity to provide comment on the 2023 Regulations to the Older Americans Act.

On behalf of the Milwaukee County Area Agency on Aging and the Milwaukee County Commission on Aging, we are supportive of updating the regulations to the Older Americans Act to find alignment with its modern reauthorizations. The Milwaukee County Area Agency on Aging provides services and programming to more than 185,000 older adults. Over the next decade, the population of older adults aged 65-85 is expected to increase by 30,000 and the population of older adults aged 85 and older is expected to double. The regulations offered by the U.S. Department of Health and Human Services largely align with the mission and vision of Milwaukee County and support the policies and practices of the Milwaukee County Area Agency on Aging.

The regulations for the Older Americans Act highlight two main goals: prioritizing those with the greatest economic and social need and providing States and Area Agencies on Aging (AAAs) with flexibility to tailor funding and programs to support their unique populations and needs. We agree that these goals should be prioritized and support updates to the regulations that help States and AAAs achieve outcomes that effectuate those goals. Our feedback includes comment on the implementation and execution of these goals.

State Agency Responsibilities
Comment was specifically requested on the clarity provided on cost-sharing versus voluntary contribution. We find that the conclusory explanation provided blurs any distinction between voluntary contributions and cost sharing.

> *Both proposed § 1321.9(c)(2)(x) and § 1321.9(c)(2)(xi) are intended to clarify that services may not be denied, even when a State has a cost sharing policy and or a voluntary contribution policy, if someone cannot or chooses not to contribute or to pay a suggested cost sharing amount. In other words, any State cost sharing and consumer contribution policies must be voluntary for OAA program participants, and States must ensure that program participants are aware that they are not required to contribute.*

The result of this interpretation is that cost sharing is really a voluntary contribution. We support the continuing availability to offer program participants the ability to make voluntary contributions to support program services. We also support ACL's affirmation of the types of programs for which cost-sharing is not allowed. Similarly, we believe that cost sharing ought not be applicable to individual participants meeting the definition of "greatest economic need" (e.g. at or below the federal poverty level), and that individual participants can self-determine whether they meet that definition. However, stating that anyone may choose not to participate in cost-sharing goes too far and reverts "cost-sharing" to "voluntary contribution."

Cost sharing is an important optional fiscal tool available to states, AAAs, and providers to supplement and extend the services offered and funded under the AAA. Congress provided States with the option to allow cost-sharing under limited circumstances. These guardrails protect the integrity of the Older Americans Act, while allowing in limited circumstances providers to expand or maintain programming with Older Americans Act funding without losing the ability to offer that programming, or the revenue that would otherwise accrue from cost sharing. Thus, we believe that ACL should define cost-sharing, when allowable under the Act, as allowable fees to cover the cost of materials or services that are incidental to the activity and that contributions can be required for participation from those who do not meet the definition of greatest economic need, even if Older Americans Act funding supports the overall scope of provider services.

An example of this form of allowable cost sharing is in order. Cost sharing is allowable with Older Americans Act Title IIIB funding if the State provides a statewide schema to do so. Socialization and recreational activities in a multipurpose senior center for the purpose of overcoming isolation and promoting the well-being of older adult participants are an allowable use of OAA IIIB funds. If a multipurpose senior center programming agency is funded with OAA IIIB funds by a AAA to provide these services, it would be allowable for that provider to require cost-sharing by participants who do not self-identify as meeting the "greatest economic need" criteria for certain of its offerings for materials incident to the class or activity. ACL should also clarify if requiring cost-sharing for one activity taints all programming offered by the agency accepting OAA funds.

For example, participants in a ceramics class could be required to contribute to the cost of the clay used by that participant in the class. Participants going on a cultural outing could be required to contribute to the cost of a third-party bus fare that the senior center agency arranged to facilitate transportation on the outing. If "cost sharing" by payment of fees for these types of purposes is strictly voluntary for all participants, the agency could find itself losing more revenue than it gained from accepting OAA funds, and unable to offer these types of creative activities for their participants who would otherwise qualify under the Older Americans Act. Similarly, with transportation services, where funding under one federal or state source for older adults allows for nominal cost-sharing in trip costs (e.g. paratransit programs), but the introduction of OAA funding under this cost sharing definition would relegate such nominal fares as strictly voluntary for all and remove an important source of supplemental revenue.

Thus, given the limited funding available under the Older Americans Act, and the broad scope of services for which it may be extended, we believe Congress was wise in both allowing cost-sharing (required not voluntary contributions) and in limiting the scope of application of cost-sharing by category of service and by category of participant, without imposing means testing on recipients. We urge ACL to adopt this clearer delineation of voluntary contribution and cost sharing.

Further, we argue for additional flexibility by AAAs in the implementation of cost sharing programming. The proposed regulations state that, if a State implements a cost-sharing program, it must be implemented in all AAAs throughout the state, with limited exceptions. If the goal of the regulation is to target those with the greatest social and economic need, while providing the most flexibility, this provision could be inhibitory in states where populations vary greatly between AAAs. For example, the population of the Milwaukee County AAA is economically and socially different than almost every other AAA in Wisconsin.

We support ACL's proposed specificity that the State plan must define greatest economic need and greatest social need, including for the following populations: *Native American persons; persons who experience cultural, social, or geographical isolation caused by racial or ethnic status; members of religious minorities; lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) persons; persons living with HIV or AIDS; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality as the State defines it.* However, we caution that undue flexibility given to States in interpreting this definition could perpetuate systemic racial inequities that are built into Intrastate Funding Formulas or the availability of programming under the Older Americans Act.

Milwaukee County's vision is that we will become the healthiest county in Wisconsin by achieving racial equity. Equity recognizes the particular social and systemic legacy of racist laws, policies, and actions that persist in social structures today and require redress so that those conditions can be overcome. Equity is not "equality" since many individuals, particularly Black residents continue to face the effects of past discrimination in denial of housing, health care, and other public goods, even though laws are now in place making such discrimination illegal. We think it is important to illustrate the way such inequities persist among older adults in minority populations and how current policies may inadvertently perpetuate these inequities in the distribution of funding and resources under the Older Americans Act.

Of note is that the Milwaukee metropolitan area is the second most racially segregated SMA in the nation. The state of Wisconsin is similarly segregated. Black residents constitute less than 1% of the population in rural areas. In Wisconsin, life expectancy from birth ranged from 69.5 years to 81.9 years across counties using data from 2018-2020. In Milwaukee County, overall life expectancy from birth was 75.9 years. However, for Black Milwaukee County residents, life expectancy from birth was only 70.0 years, the lowest life expectancy experienced out of all racial groupings. Finally, Black residents are almost three times as likely as White residents to suffer from life-shortening chronic disease.

Thus, under current conditions, Black residents in Milwaukee County are least likely to benefit from the programs available under the Older Americans Act. Disproportionately more Black residents than White residents will die before ever reaching age sixty (60) the qualifying age for OAA funding. For those that do, they will, on average enjoy the benefits of Older Americans Act

programs for eight years less than White residents. Funding formulas that do not consider these inequities that exist because of historical racist policies and practices, result in disproportionately more funding for White populaces, perpetuating these inequities. We suggest that states be allowed to consider the life expectancy of racial minorities when setting funding formulas, adjusting the "population count" of older adults to account for racial minorities who are not included in the older adult population due to early death from these health inequities.

Moreover, the specific set aside for rural populations, understandable in many jurisdictions, result in significantly less funding available to Black residents who overwhelmingly live in metropolitan areas. Again, such well-meaning policies perpetuate the inequitable distribution of public resources to White residents under the guise of equality. We argue for the flexibility of states to consider racial disproportionality when considering any required set aside for rural populations under the Older Americans Act. Finally, OAA Title IIID funding for programming most likely to redress inequities in chronic health conditions among older racial minorities is by far the least funded of all the subtitles of OAA Title III. We argue for additional flexibility to utilize IIIB funding for similar purposes, as well as flexibility in funding programming with IIID funds that addresses these health disparities.

We support the revision to the portion of the regulations that clarifies the State's advocacy responsibilities for older adults and family caregivers. It is important to ensure that the advocacy interests of older adults are promoted by the State at every opportunity, regardless of whether they have been proactively asked to make a comment.

We also support the provision that State plans include information about the use of III C-1 funds for carry-out meals. As we move toward an increased reliance on evidence-based data to inform program delivery and funding, we think this data, both from the State plan and AAA plan, will demonstrate to the U.S. Department of Health and Human Services the rate at which certain nutrition programs are used. We are hopeful that this data will inform future funding decisions by policymakers. This data will also be useful to determine what future caps on spending should be set at: is a 20 percent cap on III C-1 spending for carry-out meals reasonable or are States and AAAs requiring more funding for carry-out meals?

Area Agency Advisory Councils

We are supportive of the changes in this section that seek to promote diversity within Area Agency Advisory Councils. The provisions included—that Advisory Council membership include those that represent the greatest social and economic need, those that are service providers to Native Americans and are family caregivers, and that the Council should focus on assisting the AAA with targeting outreach to those with the greatest social and economic need—are in alignment with the priorities of the Milwaukee County AAA. We believe that our work is best shaped by those that use our services and those that directly interact with those we serve. Therefore, an Advisory Council that is representative of our service users will improve and expand upon what we are able to offer the community.

We are also supportive of changes in the regulations that better define the responsibilities of advisory councils during the development of the Area Agency Plan on Aging. Advisory councils, when composed of a diverse and representative swath of the community, are well situated to communicate about the area plan, hold listening sessions, and incorporate feedback into the final plan. Better defined expectations of advisory councils in relation to area plans are helpful for the process. The regulations do not address the ways in which advisory councils are expected to

carry out some of these responsibilities. Given the realities of a post-COVID world, and that advisory council members and community members have competing and important obligations, it is important to retain flexibility in developing the plan. This ensures that council members can work on the plan and work with the community in a way that respects their time and is tailored to the needs of their community.

The provision contained in § 1321.57 of the existing regulation (Area agency advisory council) is redesignated here as § 1321.63. Section 306 114 of the Act The proposed language describing the required composition of the advisory council, would clarify:

> *(3) that providers of the services provided pursuant to Title III of the Act, as well as Indian Tribes and older relative caregivers, should be represented in the council.*

We strongly urge ACL to reconsider the requirement that providers of services provided pursuant to Title III of the Act be represented on the AAA advisory council. Such a requirement serves to provide an advantage to current providers, presents a potential conflict of interest for open bidding requirements, and may inhibit a AAA's ability to move to a different service delivery model due to political influence by providers on the council who are invested in the current model. Current providers of services pursuant to Title III of the Act should be excluded, not included, from participation on the advisory council.

State and AAA Coordination

We are supportive of the many provisions throughout the regulations that require coordination between State plans and AAA plans. Because the goal is to reach those in the greatest economic and social need, it is important that the State plan "is based on and informed by area plans" because area agencies are often closest to clients. AAAs can help better define the population that is in the greatest economic and social need, which will inform area and state plans.

While this will require the planning process to begin earlier, including the gathering of input of multiple different community stakeholders and Advisory Councils, we think that the resulting plans will be much more comprehensive. Service delivery that arises from these plans will also be much more successful. Following the COVID-19 pandemic, there were many changes to the communities we serve, the services we provide, and what the needs are in AAAs and throughout states. It is especially important that we all coordinate now.

Legal Assistance Programs

The regulations specifically request comment on the conflict between the requirement that legal assistance programs, which are required under III-B, protect against guardianship, but also protect older adults from future diminished capacity. This is important because diminished capacity can lead to other legal problems: consumer legal issues, medical-related issues, and other legal issues that may require legal assistance. However, it is also important that older adults maintain independence and express self-determination. We support that the regulations attempt to eradicate this disparity and that protection from unwanted and unnecessary guardianship is the primary goal. We find that the proposed regulations are clear in their preference for less restrictive forms of protection for older adults and that protection from guardianship is foremost. We think the requirements that a guardian be eligible for OAA services, and that guardianship be a last resort when no other form of legal representation is available are acceptable standards for the use of legal assistance programs in the establishment of guardianship.

We support clarification in the regulations that identifies the advocacy responsibilities of legal assistance programs, especially in relation to the ombudsman program.

Family Caregiving & Caregiver Support
The rule change specifically documents that "family caregiver" is inclusive to include unmarried partners, friends, or neighbors caring for older adults. We are supportive of including individuals beyond family members as members of a caregiving team, however still using the label "family" in the formal definition presents a concern. The use of "family" in the title may deter eligible caregivers because they do not consider themselves to be "family." If the goal is to be clear and inclusive, possible alternatives could be "informal caregiver," "natural support caregiver," or "trusted personal caregiver."

We continue to seek increased support for care coordination for individuals who do not have a natural support caregiver in their lives. Caregiving services can be inaccessible for individuals who do not have a person in their lives who can identify and anticipate their needs. We support increased awareness and flexibility to support these needed services.

The rule change proposes that for a family caregiver to qualify for services, they need to be caring for an adult 60+ or an adult any age with Alzheimer Disease or related disorder who is *unable to perform at least two activities of daily living without substantial assistance including verbal reminding, physical cueing, or supervision (and at the option of the state is unable to perform at least three such activities without such assistance).* Current policy has a lower threshold for eligibility that requires inability to perform at least two activities of daily living (ADLs) OR independent activities of daily living (IADLs). Requiring that the care recipients have a need for assistance for 2 (or 3) ADLs to allow the caregiver to qualify may be a barrier for caregivers who need significant assistance with IADLs support. More flexibility in ADL/IADL eligibility allows us to support caregivers for care recipients who may not meet the eligibility criteria for other services, such as publicly funded long term care services in Wisconsin. This will allow us to support older adults who wish to continue to live in the community.

The rule change proposes that state or local public resources used to fund a program which use means testing shall not be used to meet non-federal match share. Wisconsin created the Alzheimer's Family and Caregiver Support Program (AFCSP) in 1985 in response to the growing numbers of families in Wisconsin caring for loved ones at home with irreversible dementia. The program is funded by the state of Wisconsin through general purpose revenue. To be eligible, a person must have a diagnosis of Alzheimer's disease or other irreversible dementia and must have an income of $48,000 per year or less (if the individual has a partner or spouse, they must make less than $48,000 combined). Of note, the individual or couple can subtract costs associated with Alzheimer's/irreversible dementia care when determining eligibility. The funds provided through AFCSP have been utilized as non-federal match share for Title III-E National Family Caregiver Support Program (NFCSP), which has a higher percentage of non-federal match requirement (25%) than other Older Americans Act funding. While AFCSP does have means testing, it complements the support available through OAA Title III-E and plays a critical role in supporting individuals and families with the greatest economic and social need. This is particularly critical in Milwaukee County, where the needs of caregivers outweigh the annual funding available through Title III-E. If programs are not able to use AFCSP funds as non-federal match, it could create hardship for meeting the 25% non-federal match requirement.

We are supportive of updates throughout the regulations that incorporate caregiving and family caregiver to existing rules and programs. This practice brings the regulations in alignment with updates to the Older Americans Act and ensures that caregiving is incorporated throughout all services areas, including advocacy and legal assistance.

Nutrition Programs

We agree with the flexibilities to continue to provide carry-out meals through the Congregate Nutrition IIIC-1 funding. As options expand for use of this funding, more participants access nutrition programs. It is important that our allocated funding continues to support all nutrition programs. During the COVID-19 pandemic, our carry-out meal program was a safe alternative to congregate dining, which would have put older adults at risk, and it continues to be a relevant resource for older adults. Only through COVID-19 relief funds were we able to sustain these programs. Because of the increased demand this program puts on our nutrition programs, our funding would not be able to support this method long term.

We also request clarity related to the 20 percent cap on spending for carry-out meals as a portion of IIIC-1 funding. Does this cap apply only to Federal funding, or will it apply to State funding too?

Emergency Preparedness

We commend ACL for expanding the definition of 'emergency' and 'disaster' beyond weather related occurrences and broadening the scope of preparedness that may be required of agencies for the unknown emergencies and disasters of the future. We support an all-hazards approach to emergency planning and the understanding that the older adult population is particularly vulnerable during emergencies, due to barriers in communication, technology, transportation, health, and mobility. We appreciate the stated need for increased communication and coordination in planning, response, and recovery across agencies before, during and after emergencies.

We support requirements that AAAs complete emergency planning based on risk assessments using an all-hazards approach, promoting alignment and consistency in requirements across statewide agencies, such as the continuity of operations planning required of AAAs and ADRCs. Recognizing that annual updates may place extra burden on AAAs with limited staff capacity, we recommend that guidance documents and templates be provided to agencies to assist in the process.

We appreciate the flexibilities given to state agencies in their use of funds during emergencies and the provision that the state would be required to "consult with AAAs" before redirecting up to 5% of the total OAA Title III grant award for statewide emergency purposes. However, given the value, utility, and insufficiency of these funds in general, we feel the language within this provision could be strengthened to mandate an emergency-appropriate input period for AAAs to give feedback on the expenditures before expediting the allocation.

Ombudsman Program

We are supportive of provisions within this section that strengthen protections of the independence and advocacy rights of the Ombudsman Program. These are two issues that we have encountered in our area, and we believe that they are important to incorporate. Ombudsmen should be free to operate and investigate without outside interference and without deference to the office they are housed in. Additionally, ombudsmen should advocate for older adults, as is their mandate, without consideration of the position of other stakeholders. We believe these

provisions could be strengthened by requiring that the Ombudsman Program be housed separately rather than within an established office. This would reduce the likelihood and appearance of conflicts of interest, which the regulations address extensively, and would provide ombudsmen with the ability to be truly independent and complete their advocacy responsibilities.

Thank you again for the opportunity to provide feedback on these regulations. We look forward to continuing to serve older adults in Milwaukee County and improving our services and programs with support from the Older Americans Act and through enhanced regulations.

Sincerely,

Milwaukee County Area Agency on Aging

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