




Older Americans Act: The Foundation of the Aging Services Network



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Advancing States represents the nation’s 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation and the articulation of national policies that support long-term services and supports for older adults and individuals with disabilities.

This report is an updated and expanded version of reports previously by the **National Health Policy Forum**.

- [“The Aging Services Network: Serving a Vulnerable and Growing Elderly Population in Tough Economic Times,”](#) 2011, and
- [“Older Americans Act of 1965: Programs and Funding,”](#) 2012, Carol V. O’Shaughnessy.



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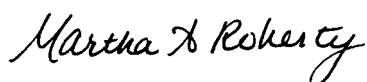
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In July 1965, when the Older Americans Act (OAA) became law, Congress and the Administration envisioned a framework of support services so that older adults would be empowered to age with dignity, health and independence for as long as possible. In the 56 years since its inception, the growth of the population over 60 has increased dramatically, the calls for more services and supports to be delivered in the home have increased, and federal, state, and local budgets have not kept up with the demand.

In response to the most recent reauthorization of the Older Americans Act, our board of directors asked us to produce this report. We could not be more pleased to have engaged with one of the foremost experts on the Older Americans Act in the nation, Carol V. O'Shaughnessy, to serve as the lead author of this report. We are also grateful to the Administration for Community Living and the Congressional Research Service for their review and feedback.

This new report will serve as an essential resource for both new and seasoned aging and disability professionals across the country as they work to manage and oversee the critical programs and services the Older Americans Act provides. We hope that you find this resource useful and that you share it with your local partners.

Sincerely,



Martha A. Roherty

Executive Director, ADvancing States

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Executive Summary

In 1965, Congress enacted the Older Americans Act (OAA) establishing a federal agency and state agencies to address the social services needs of the aging population. The mission of the OAA is broad: to help older people maintain maximum independence in their homes and communities and to promote a continuum of care for older adults. The Act is considered the major vehicle for the delivery of supportive and nutrition services to the aging population. In successive amendments, the Act created area agencies on aging (AAAs) and a host of social support programs.

The OAA established the “aging services network,” which broadly described, refers to the agencies, programs, and activities that are sponsored by the OAA. Over the last several decades, federal and state policymakers have looked to the network to administer federal and state programs that go beyond the scope of the OAA. The Act’s funding is often supplemented by other federal programs, such as Medicaid and the Social Services Block Grant (SSBG), as well as state and local funds, and over the years, states and AAAs have developed partnerships with multiple public and private agencies and organizations to improve the lives of older people.

Among the many challenges to the aging services network is its ability to keep up with demand in the face of a growing older adult population, especially those who have multiple chronic conditions, are socially isolated, have low income, live in rural areas, and/or who live in long-term care facilities and lack advocates. Research has shown that the Act’s programs serve older people, yet many more are likely to need, but do not receive, home and community-based services important to help them live in their own homes.

This report discusses the historical development, functions, and governance of the Act, its service programs, populations served, and funding.

Glossary of Terms

AAA	Area Agency on Aging	NASUAD ...	National Association of States United for Aging and Disabilities
ACL	Administration for Community Living	NFCSP	National Family Caregiver Support Program
ADLs	Activities of Daily Living	PSA	Planning and Service Area
ADRC	Aging and Disability Resource Center	P.L.	Public Law
AOA	Administration on Aging	SCSEP	Senior Community Service Employment Program (also referred to as the Community Senior Service Opportunities Act)
APS	Adult Protective Services	SHIP	State Health Insurance Assistance Program
CBO	Community-Based Organization	SLTCOP	State Long-term Care Ombudsman Program
CMS	Centers for Medicare & Medicaid Services	SSBG	Social Services Block Grant
DHHS	U.S. Department of Health and Human Services	SUA	State Unit on Aging
DOL	U.S. Department of Labor	U.S.C.	United States Code
FPL	Federal Poverty Level		
GAO	U.S Government Accountability Office		
HCBS	Home and Community-Based Services		
I&R/A	Information and Referral and Assistance		
LTSS	Long-Term Services and Supports		

Older Americans Act: Foundation of the Aging Services Network

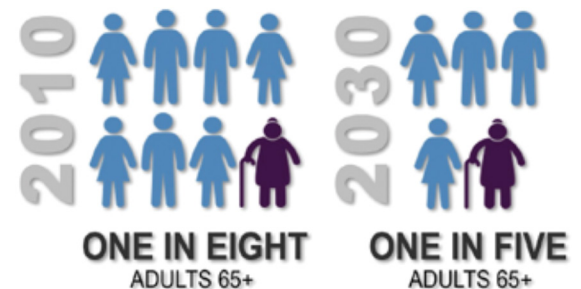
In 1965, when Medicare, Medicaid, and the OAA were enacted, people age 65 and older represented slightly more than 9 percent of the nation's population. In 2020, the number of older adults was estimated to be 56 million people and 17 percent of the U.S. population. The first wave of the baby boom generation began to turn age 65 in 2011 and by 2030 about one in five Americans is projected to be age 65 and older—a demographic milestone according to the U.S. Bureau of the Census.¹

The purpose of the OAA is to help older individuals maintain maximum independence in their homes and communities, with appropriate supportive services, and to promote a continuum of care for older Americans. The 1965 Act represented a turning point in financing and delivering community services to older people. Before then, federal and state governments played a limited role in providing social services to older people.

Although the OAA has a comprehensive mission, its reach is constrained by limited resources. The ability of the Act to fully meet its potential in the face of increasing demand by a growing older population will be influenced by policy decisions of federal, state, and local officials. Additional resources will be needed to maintain and build on the network of services created by the OAA.

The Act's reach has evolved significantly through the years. Initially, it created authority for the creation of an Administration on Aging (AoA) within the U.S. Department of Health and Human Services (HHS)² as well as creation of state agencies to be responsible for community planning for aging programs, and to serve as catalysts for improving the organization, coordination, and delivery of aging services in their states. Over the succeeding years, Congress expanded the scope, authority, and responsibilities of these agencies. The original legislation authorized general social service programs, but in successive amendments Congress authorized more targeted programs under various titles of the Act to respond to specific needs of the older population. In 1973, Congress extended the reach of the Act by creating authority for local "area agencies on aging" (AAAs) to be responsible for planning and coordination of a wide array of services for older people, as well as serving as advocates on their behalf. States with low population density or small geographic size are given the option to establish AAAs or to have the state agency perform the functions of AAAs as well as those of the state.

Figure 1. Growth of the Older Population



Source: *ADvancing States Infographic: Aging In America* <http://www.advancingstates.org/>

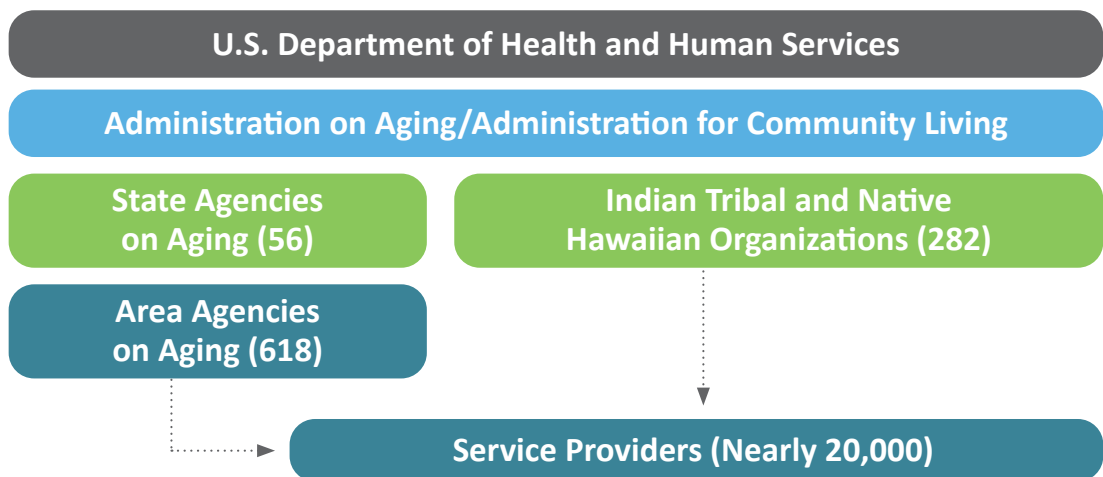
The “aging services network,” broadly described, refers to the agencies, programs, and activities that are sponsored by the Older Americans Act. Today it is comprised of 56 state agencies on aging, almost 620 AAAs, about 280 Indian Tribal and Native Hawaiian organizations, nearly 20,000 service provider organizations, and thousands of volunteers. State agencies on aging that administer the OAA are also referred to as state units on aging (SUAs). Under the Act, states and AAAs are responsible for the planning, development, coordination, and delivery of a wide array of services within each state. Organizations representing American Indians, Alaskan Natives, and Native Hawaiians are responsible for the same types of activities for their older members. Figure 2 shows the OAA infrastructure—AoA/DHHS at the federal level, state agencies on aging, Indian tribal and Native Hawaiian organizations, AAAs and service providers.

Over the last several decades, federal and state policymakers have looked to the aging services network to administer federal and state programs that go beyond the scope of the OAA. Many state agencies on aging play major roles in administering Medicaid home and community-based long-term services and supports (LTSS) programs and Medicaid managed care programs. Similarly, many AAAs deliver Medicaid-funded case management and other support services, such as home care services, to older adult participants. Some states also administer adult protective services (APS) although the APS program is not directly authorized or financed through the OAA.³

Many state agencies that administer the OAA also administer programs serving people with disabilities, including those with physical, behavioral, or intellectual disabilities. This report focuses on OAA programs, therefore programs that serve people with disabilities are outside the scope of this report

For further information on state agencies that administer both aging and disability programs, see on Damon Terzaghi and Adam Mosey, *ADvancing States State Aging and Disability Agency Profiles*, 2021. <http://www.advancingstates.org/about/state-agencies/state-aging-and-disability-profiles>

Figure 2. Major OAA Agencies



Prepared by ADvancing States

Brief Historical Context

The original 1965 law and subsequent legislation in the 1970s emphasized the planning, coordination, and needs-identification roles of state and AAAs that continue as major functions today. The functions of states and AAAs were designed to be carried out through a “bottom-up” planning process, which ensures that local communities have a role in the prioritization and implementation of services. The development of the aging services infrastructure in the early 1970s was influenced by national political trends toward decentralization of decision-making and delegation of authority to state and local governments, exemplified by the New Federalism of the Nixon administration.⁴ This philosophy, applied to aging services, emphasized that states and AAAs are in the best position to assess the needs of older adults and to plan and coordinate services within their respective jurisdictions without strict federal directives on what services to provide. While the overarching program goals are determined nationally, the program was designed to be state-administered with a great deal of state and local flexibility.

The infrastructure created by the OAA laid the foundation for the current aging services network, but the law was not intended to meet all the community service needs of older people. During the early years of implementation, Congress authorized limited dollars for OAA-funded social services and intended that federal funds were to act as catalysts, or “seed money,” to draw in state and local (that is, non-Older Americans Act) funds to benefit older adults. The resources made available under the Act are intended to leverage other federal and non-federal funding sources to serve older people. A relatively small proportion of the older population receives services directly funded by the Act. However, the infrastructure created by the Act can influence services and programs that reach a far larger proportion of the older adult population.

The Act’s decentralized planning and service model has meant that state and AAAs, working collectively within a state, are largely in control of their aging agendas and can be responsive to state and local needs, within federal guidelines and funding priorities. The flexibility given to states and AAAs has also led to wide variability in the design, implementation, and scope of aging services programs they administer, both within and outside the federally authorized OAA programs. The aging services network’s success in securing additional resources depends on political and economic circumstances and priorities in individual states and localities as well as the network’s ability to leverage other public and private sector funds.

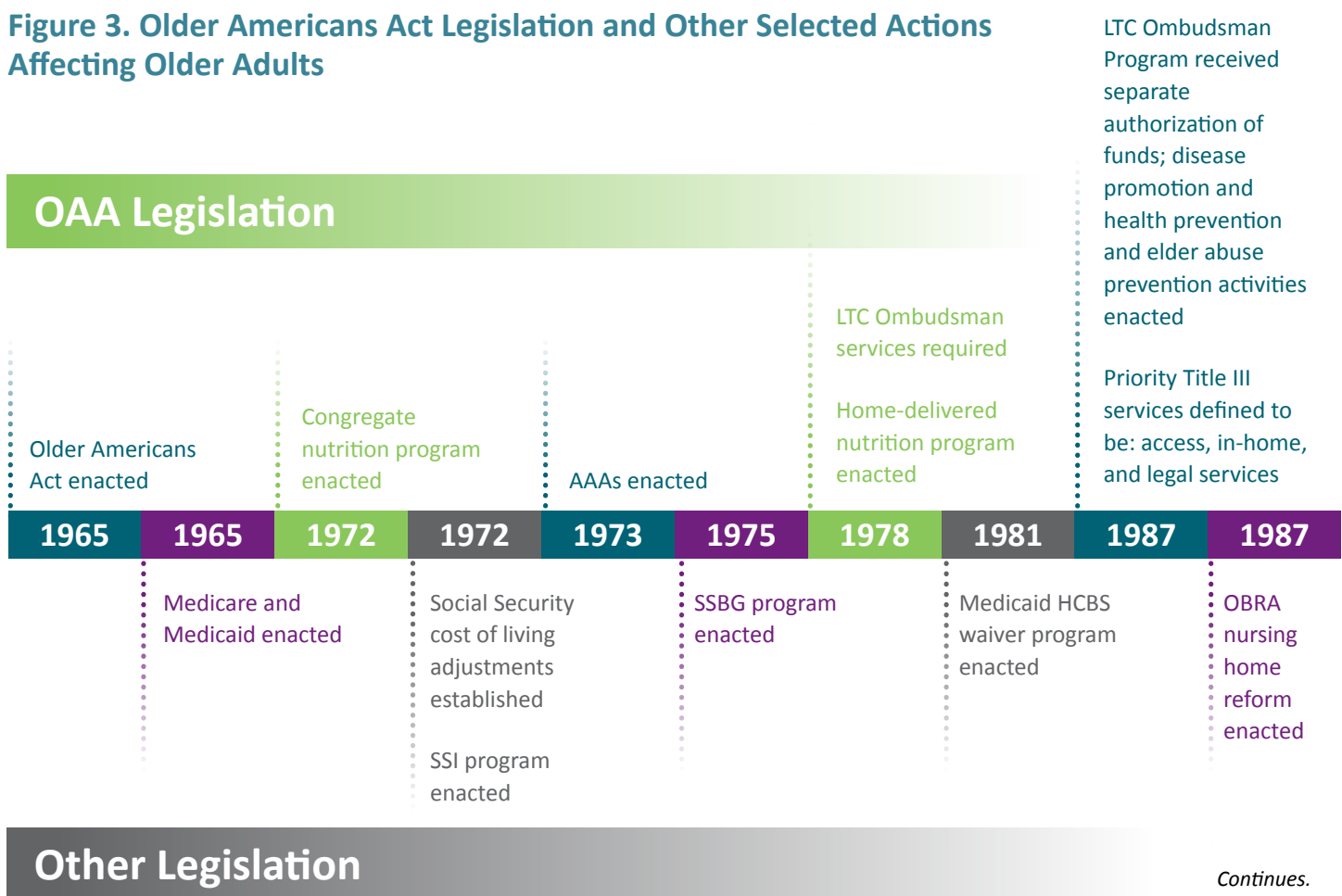
The resources made available under the Act are intended to leverage other federal and non-federal funding sources to serve older people.

As states and AAAs implemented the planning process during the 1970s and 1980s, the needs of older people became better identified, understood, and differentiated. As a result, Congress began to authorize targeted programs to respond to specific needs. Figure 3 provides a timeline of major events in the evolution of the OAA and related legislation affecting older adults.

The congregate and home-delivered nutrition services programs, created to address issues of hunger and nutritional inadequacy among older people, were added to the Act in 1972 and 1978, respectively. The state long-term care ombudsman program (SLTCOP) to address quality of care for residents in long-term care facilities was added in 1978.⁵ In 1987, Congress required states to devote a portion of Title III services funds to certain “priority” services as follows: (i) access services, defined as transportation services, outreach, information, and assistance to help older people obtain services, and case management; (ii) in-home services; and (iii) legal assistance. The disease prevention and health promotion program was also authorized in 1987 and in 2000 the family caregiver support program was enacted.

In 2006, Congress recognized the role that the aging services network can play in promoting home and community-based LTSS for people who are at risk for institutional care. These amendments required AoA to implement Aging and Disability Resource Centers (ADRCs) in all states to serve as visible and trusted sources of information on LTSS options and to coordinate and streamline consumer access to services. The Act

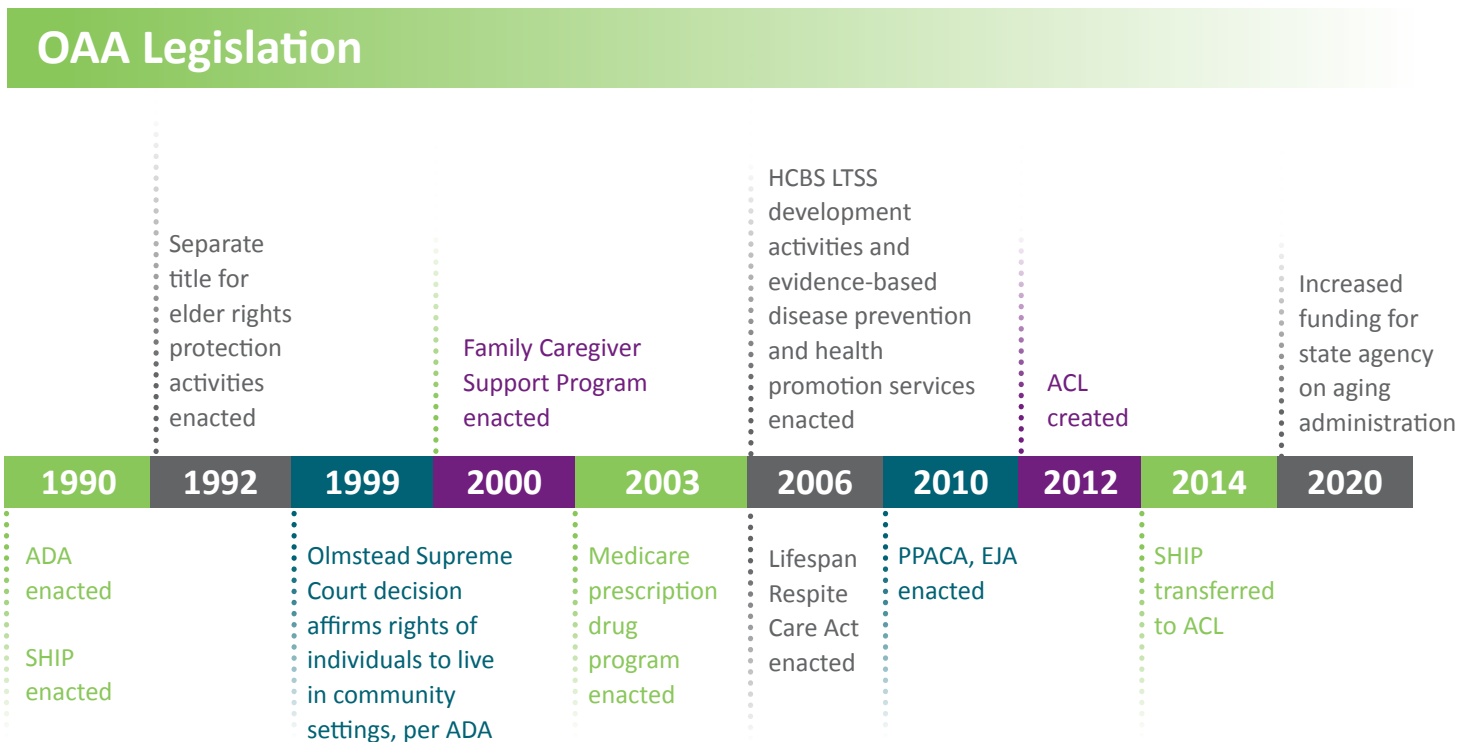
Figure 3. Older Americans Act Legislation and Other Selected Actions Affecting Older Adults



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Figure 3. Older Americans Act Legislation and Other Selected Actions Affecting Older Adults

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Other Legislation

Acronyms Defined:

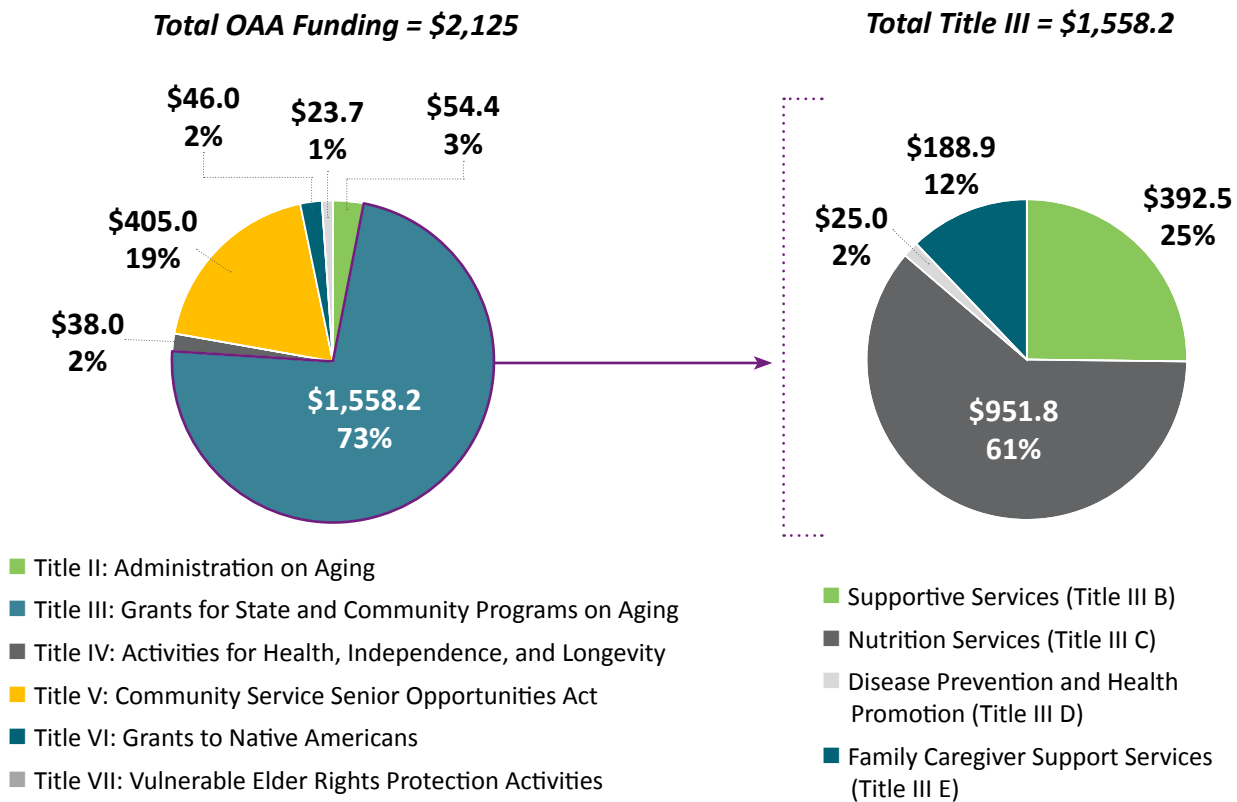
- | | |
|--|---|
| ACL Administration for Community Living | LTSS Long-Term Services and Supports |
| AoA Administration on Aging | OBRA Omnibus Budget and Reconciliation Act |
| AAA Area Agency on Aging | PPACA ... Patient Protection and Affordable Care Act |
| ADA Americans with Disabilities Act | SHIP State Health Insurance Assistance Program |
| EJA Elder Justice Act | SSBG Social Services Block Grant |
| HCBS Home and Community-Based Services | SSI Supplemental Security Income |
| LTC Long-Term Care | |

was not formally authorized between the expiration of the 2006 reauthorization in fiscal year (FY) 2012 through the next reauthorization in 2016 but continued to operate and receive congressional appropriations. The Act was not amended again until the 2016 reauthorization which formally authorized the program through FY 2019. Among the 2016 amendments were changes to the Title III funding formula that determines the distribution of federal appropriations for each state.⁶ The Act was reauthorized on March 25, 2020 through FY 2024 and made improvements and modernizations to state and community aging programs, among other things.⁷

Older Americans Act FY 2021 Funding

Figure 4 shows FY 2021 funding for all Older Americans Act programs, totaling \$2.1 billion. Most of the Act's funding, almost three-quarters, \$1.6 billion, is for Title III, Grants for State and Community Programs on Aging, primarily for nutrition programs. The Title V, Community Senior Service Opportunities Act, represents over 19 percent, or \$405 million.⁸

Figure 4. Older Americans Act Funding (in millions), FY 2021



Source: ADvancing States analysis of appropriations data.

Note: these figures reflect base appropriations for FY 2021, and do not include additional supplemental funding passed in various bills by Congress in response to the COVID-19 pandemic.

Seven Titles, Multiple Service Programs

The Act authorizes seven titles that include a series of formula-based and discretionary grants. All programs are administered at the federal level by AoA, except for the Title V Community Service Senior Opportunities Program, which is administered by the U.S. Department of Labor (DoL).

Figure 5. At a Glance: Older Americans Act Titles

Title I. Declaration of Objectives	Sets out broad social policy objectives oriented toward improving the lives of all older people.
Title II. Administration on Aging	Establishes AoA within the Department of Health and Human Services as the chief federal agency advocate for older adults and sets out responsibilities of AoA and the Assistant Secretary for Aging. Establishes aging network activities.
Title III. Grants for State and Community Programs on Aging	Authorizes activities of state and area agencies on aging and funds for supportive and nutrition services, family caregiver support, and disease prevention and health promotion activities.
Title IV. Activities for Health, Independence, and Longevity	Authorizes research, training, and demonstration projects in the field of aging.
Title V. Community Senior Service Opportunities Act	Authorizes funds to support part-time employment opportunities for unemployed low-income people age 55 and older who have poor employment prospects.
Title VI. Grants for Native Americans	Authorizes grants for supportive, nutrition services, and caregiver services for American Indians, Alaskan Natives, and Native Hawaiians.
Title VII. Vulnerable Elder Rights Protection Activities	Authorizes funds for the long-term care ombudsman program and services to prevent elder abuse, neglect, and exploitation.

Prepared by ADvancing States

Multiple service programs are authorized by Titles III, VI, and VII of the Act, as shown in Figure 6.

Figure 6. Title III, VI, and VII Primary Service Categories

Access to Services	Nutrition	Home and Community-based LTSS	Disease Prevention and Health Promotion	Family Caregiver Support	Vulnerable Elder Rights Protection
Outreach, information and assistance regarding benefits	Congregate and home-delivered meals	Home care, chore, personal care	Evidence-based health promotion	Individual counseling	Long-term care ombudsman
Case management	Nutrition counseling and education	Adult day care	Health risk assessments	Access and information and assistance	Prevention of elder abuse, neglect and exploitation
Transportation		Home modification	Routine health screening	Support groups and caregiver training	
			Physical fitness programs, among others	Respite care	

Title I. Declaration of Objectives

Title I sets out broad social policy objectives oriented toward improving the lives of all older people, including adequate income in retirement, the best possible physical and mental health, opportunity for employment, and access to comprehensive LTSS.



Title II. Establishment of the Administration on Aging

Title II establishes AoA within the U.S. Department of Health and Human Services (HHS) as the chief federal agency that advocates for older people and administers the OAA and its programs. It sets out the responsibilities of AoA and the Assistant Secretary for Aging who is appointed by the President by and with the advice and consent of the Senate. The Assistant Secretary is required to report directly to the Secretary of HHS. In 2012, the Secretary of HHS created the Administration for Community Living (ACL) where AoA is administratively located within HHS.⁹

AoA has significant responsibilities to coordinate programs for older people across agencies of the federal government, to conduct research on and evaluation of aging programs, and provide technical assistance to states and AAAs.¹⁰ Title II authorizes funds for administration, salaries, and expenses of the AoA and requires creation of various offices and responsibilities within AoA's organizational structure (see box).



The law requires AoA to create various entities, or to designate individuals, to carry out various functions, within its organizational structure, including:¹¹

- Office for American Indian, Alaskan Native and Native Hawaiian Aging
- Office of Long-Term Care Ombudsman Program and the National Ombudsman Resource Center
- Research, Demonstration and Evaluation Center for the Aging Network
- National Center on Senior Benefits Outreach and Enrollment
- National Center on Elder Abuse
- National Elder Locator Service
- National Resource Center for Women and Retirement
- National Aging Information Center
- A national resource center for services to older individuals experiencing the long-term and adverse consequences of trauma
- A national telephone hotline regarding pension benefits

AoA may elect to establish a National Center on Senior Benefits Outreach and Enrollment and to designate an officer or employee to be responsible for the administration of mental and behavioral health services authorized under this Act.

Title II of the Act. As Amended Through P.L. 116-131, Enacted March 25, 2020

In addition to these responsibilities, Title II requires AoA to establish in all states, Aging and Disability Resource Centers (ADRCs) which are entities, networks, or consortiums that provide comprehensive information and support to help individuals of all ages to access public and private LTSS; person-centered counseling; and information and referrals regarding HCBS to individuals who live in institutions or are at risk of institutionalization.

Title III. Grants for State and Community Programs on Aging

Title III formula grants create and support the activities of the 56 state and territory agencies on aging and almost 620 AAAs. These agencies act as advocates on behalf of, and coordinate social service programs for, older people. Since their inception, the major functions of states and AAAs have been to advocate for, plan, and coordinate programs that will promote “comprehensive and coordinated services systems” and “maximum independence and dignity in a home environment with appropriate support services” for older people. These agencies are also charged with developing a “continuum of care” for vulnerable older people and to help them remain as independent as possible in home and community-based settings.¹²

Title III authorizes funds, and states receive specific allotment of funds, for six major services programs: (1) supportive services, (2) congregate nutrition services, (3) home-delivered nutrition services, (4) nutrition services incentive program (NSIP), (5) disease prevention and health promotion services, and (6) family caregiver support. These programs account for \$1.6 billion, or 73 percent, of the total Older Americans Act funding of \$2.1 billion for FY 2021. (see Figure 4).

Supportive Services (Title III-B)

The supportive services program funds social services aimed at helping older people remain independent in their own homes and communities. Unlike other OAA programs that target a specific service, this program supports a wide range of services. AAAs are required to devote some funding to three categories of priority services: access services, such as case management, information and assistance, transportation, and outreach; in-home services, such as homemaker, chore, personal care assistance and respite care; and legal assistance. AAAs offer an average of 27 different services, most often provided through various service providers in their communities. These services include not only the priority services but also benefits counseling, and assessment for care planning, adult day care, and home modification and repair, among others.¹³

Unlike other OAA programs that target a specific service, Title III-B supports a wide range of services.

Due to funding constraints, the amount of services the program can provide is relatively limited. However, because OAA programs do not have income or asset tests, AAAs can provide services to support those who do not meet income eligibility requirements for other programs or to those who do not meet functional eligibility requirements for more comprehensive LTSS. AAAs also use Title III funds to supplement resources from other federal, state and community programs.

Selected services are profiled below:

Information and Referral/Assistance (I&R/A)—I&R/A is central to the mission of state agencies and AAAs. These services act as access points for aging services for older people and their families. I&R/A has been a key component of Title III state and area agency functions for decades, and in recent years its role has taken on increased significance for several reasons. These include the increasing number of older persons and the complexity of their needs, as well as the emergence of ADRCs and No Wrong Door (NWD) initiatives. These initiatives aim to provide older people and people with disabilities access to a coordinated system of information, counseling, and access to LTSS. In 2019, Title III supported about 2,400 I&R/A organizations across the country.¹⁴

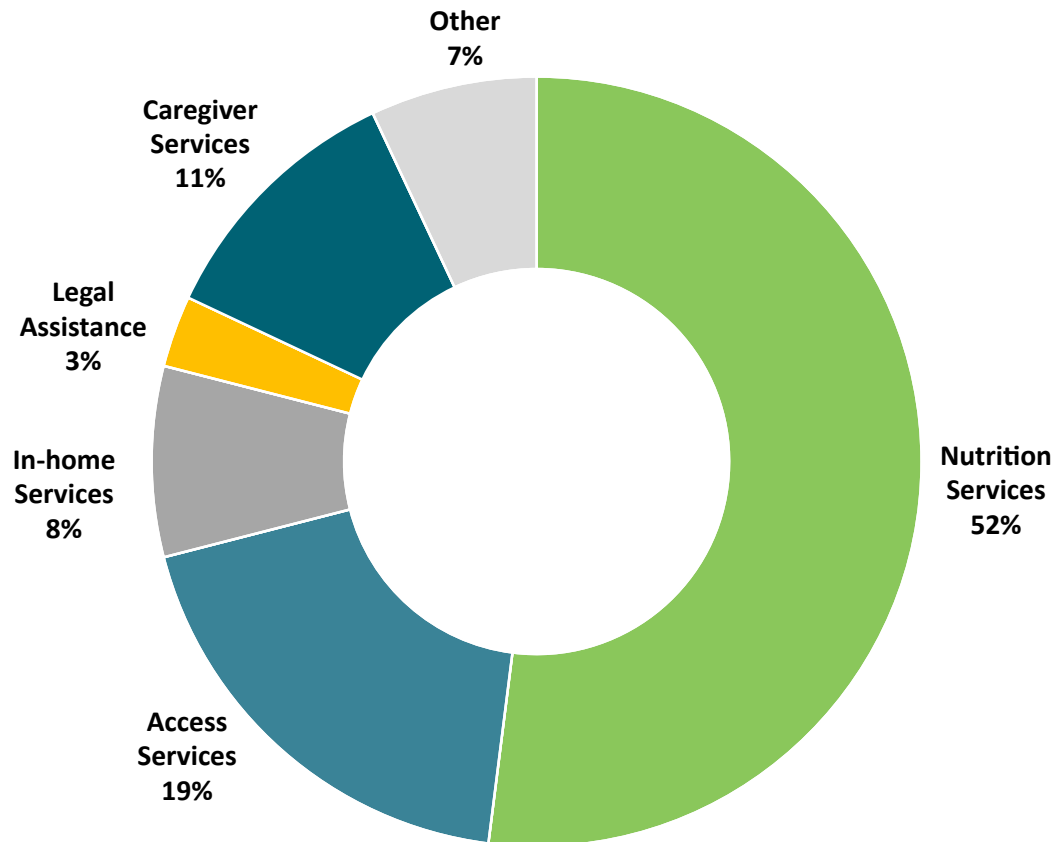
A 2018 survey of aging and disability I&R/A organizations found several challenges, including fiscal constraints and resource availability that affect capacity to address the needs of individuals and families, increasing requirements for quality and outcome measurement, and a need for additional training models. The study also identified the importance of exploring non-traditional modalities of communication, such as social media and information systems and software to improve access of information to consumers.¹⁵

Transportation Services—Transportation is one of the most frequently provided Title III services. About 83 percent of AAAs provide assisted transportation, 73 percent offer non-medical transportation, and 59 percent offer wheelchair-assisted transportation.¹⁶ Expenditures for transportation/assisted transportation services were about \$240 million in FY 2019, with Title III spending accounting for over \$70 million, or about 29 percent of the total.¹⁷

Home Care Services—AAAs are required to devote some of their Title III funds to home care services, including homemaker, chore, and personal care services. Over 330,000 people received Title III-funded personal care, homemaker, or chore services in FY 2019. Expenditures for these services were about \$894 million in FY 2019, with \$106.9 million, or 11.9 percent, expended from Title III funds.¹⁸

Figure 7 illustrates the proportion of federal Title III funding spent by major service category in FY 2019: nutrition services, in-home services, access services, caregiver services, legal assistance, and other. Nutrition services make up the bulk of the spending, accounting for 52 percent of the total.

Figure 7. Title III Service Expenditures Totaling Nearly \$1.3 billion in FY 2019



Source: ACL, AGID Data-at-a-Glance (SPR): <https://agid.acl.gov/DataGlance/SPR/>

Most of the funding for home care and other LTSS services administered by states and AAAs comes from non-Older Americans Act sources, primarily Medicaid home and community-based waiver funds. Although the amount of funding devoted to home care under Title III of the OAA is a small fraction of the amount spent under both Medicaid and Medicare, the program has the flexibility to serve people who may not otherwise be served under those programs. OAA home care and other LTSS services may be provided without the income, asset, or functional eligibility criteria under Medicaid, and without the requirement that beneficiaries need skilled care under Medicare. Many states have also developed state-only funded HCBS programs that, in many cases, often resemble services offered in either the OAA or Medicaid waiver programs but offer additional funding and/or flexibility.¹⁹

Nutrition Services (Title III-C)

The congregate and home-delivered meals programs, the oldest and perhaps most well-known OAA services, are intended to address the nutritional problems of older people. The purposes of the program are to reduce hunger, food insecurity, and malnutrition; promote socialization among older people; and delay the onset of adverse health conditions among older people resulting from poor nutritional health or sedentary behavior. The program also assists older people to access other disease prevention and health promotion services. Indirectly, the program acts as income support for many low-income older people by providing food that they would otherwise purchase (in groceries or at restaurants). The program can offer nutrition counseling and education, though access to these services is quite limited.

Meals must comply with the Department of Agriculture Dietary Guidelines for Americans and meet dietary reference intakes established by the National Academies of Science, Engineering, and Medicine.²⁰

The Act receives funding under three separate authorizations of appropriations:

- The congregate meals program. States award funds to AAAs which contract with nutrition service providers that provide meals in senior centers, congregate housing sites, adult day care programs, and other group settings.
- The home-delivered meals program. States award funds to AAAs which contract with home-delivered meals providers that deliver meals to the homes of frail older adults.
- The nutrition services incentive program (NSIP). The NSIP provides grants to states (and Title VI tribal organizations) as an incentive to provide effective and efficient delivery of meals to older adults. Grantees may choose to receive NSIP grants in cash, commodities or a combination of cash and commodities. The NSIP augments funding under the congregate and home-delivered meals programs.

Funding and meals provided. Nutrition program funding is \$951.75 million, in FY2021, 44 percent of the Act's total funding. In FY2021, funding for the congregate meals program was \$515.3 million; \$276.3 million for the home-delivered meals program; and \$160.1 million for the NSIP.

In FY2019, nearly 2.4 million people received 222 million meals; 67 percent of meals were served to frail older people living at home, and 33 percent were served in congregate settings.²¹

In recent years, the growth in the number of home-delivered meals served has outpaced congregate meals. A number of reasons account for this trend, including greater demand for home-delivered meals vis-à-vis congregate meals, state initiatives to expand services to older people living at home, and successful leveraging of non-federal funds for home-delivered meals services. In some cases, due to state or local budget reductions, home-delivered meals programs have been preserved at the expense of congregate meals programs.

States are allowed to transfer funds among their supportive and nutrition service programs (see box). The transfers states have made in recent years have tended to be from their allotments for congregate nutrition to either the home-delivered nutrition or supportive services allotments due to changing participant preferences that decreased the demand for congregate meals. In 2018, states transferred almost \$106 million from their original congregate nutrition allotments to either the home-delivered or supportive services programs.²²

Evaluation—Various evaluative studies of the nutrition program have been completed over the last few years beginning in 2015. These reports have built upon evaluations conducted in prior years.²³ The most recent reports, by Mathematica Policy Research, analyzed program structure and administration, staffing, costs of program operations,²⁴ effects on participants' food security, socialization, diet quality,²⁵ and health care utilization,²⁶ and participants' needs and services use.²⁷

Selected findings of the evaluation reports cited above are summarized as follows:^{28,29,30,31,32,33}

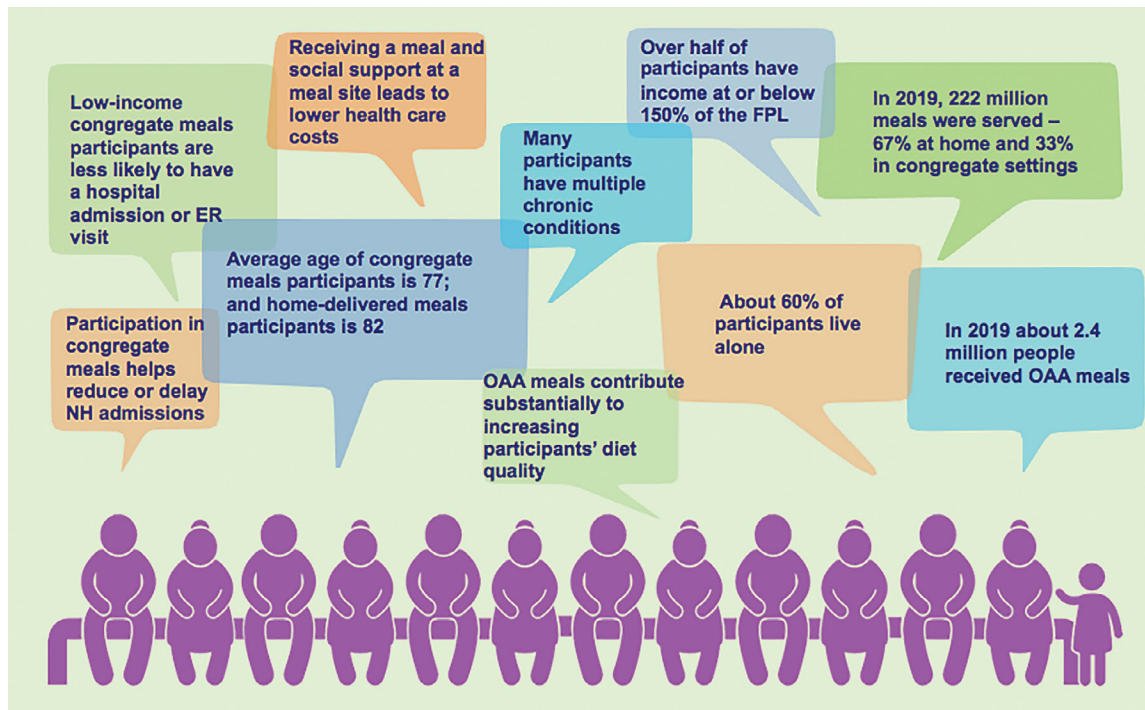
Title III Transfer Authority

States can transfer their federal allotments for supportive services, congregate nutrition services, and home-delivered nutrition services among each of these allotments. Transfers must be approved by ACL.

- States may transfer up to 40 percent of their separate allotments for congregate and home-delivered nutrition between these allotments. Under certain circumstances, states may transfer an additional amount up to 10 percent of their allotments.
- States may also transfer up to 30 percent of their allotments for supportive and nutrition services between these two allotments.

42 U.S.C. 3028 As Amended Through P.L. 116-131, Enacted March 25, 2020

Figure 8. Selected Findings from Evaluations of Nutrition Program



Sources of information included: Mathematica Policy Research, various evaluation reports of the OAA nutrition program; AGID 2019 data

Evidence-Based Disease Prevention and Health Promotion (Title III-D)

Title III-D authorizes evidence-based disease prevention and health promotion services at senior centers, and through congregate and home-delivered meals programs. ACL awards states separate allocations of Title III-D funds. In awarding funds to area agencies, states are required to give priority to areas of the state that are medically underserved, and where a large number of older people with the greatest economic need for these services resides.

The law defines disease prevention and health promotion services to include a wide range of services. These include:

- Health risk assessments;
- Routine health screening; nutritional counseling and educational services for individuals and their primary caregivers;
- Evidence-based health promotion programs, such as programs to prevent and mitigate the effects of chronic and infectious vaccine-preventable disease, and other diseases;
- Physical fitness programs, music, art, and dance movement therapy;
- Home injury control services;

- Screening for the prevention of depression and screening for suicide risk;
- Screening for fall-related traumatic brain injury and other fall-related injuries, coordination of treatment; and
- Medicine management screening, among many other services.

Although the program was enacted in 1987, in FY 2012, for the first time, Congressional appropriations legislation required that Title III-D funds be used for “evidence-based” programs. ACL requires that programs used by state agencies meet all of the following requirements: (i) have demonstration evaluation results showing they are effective in improving the health and well-being, or reducing disease, disability or injury among older people; (ii) are proven effective using experimental (randomized and control group testing) or quasi-experimental (absent use of control group testing) designs; (iii) have had research results published in a peer-reviewed journal; (iv) have been fully translated into one or more community sites;³⁴ and (v) have dissemination programs that are publicly available.³⁵

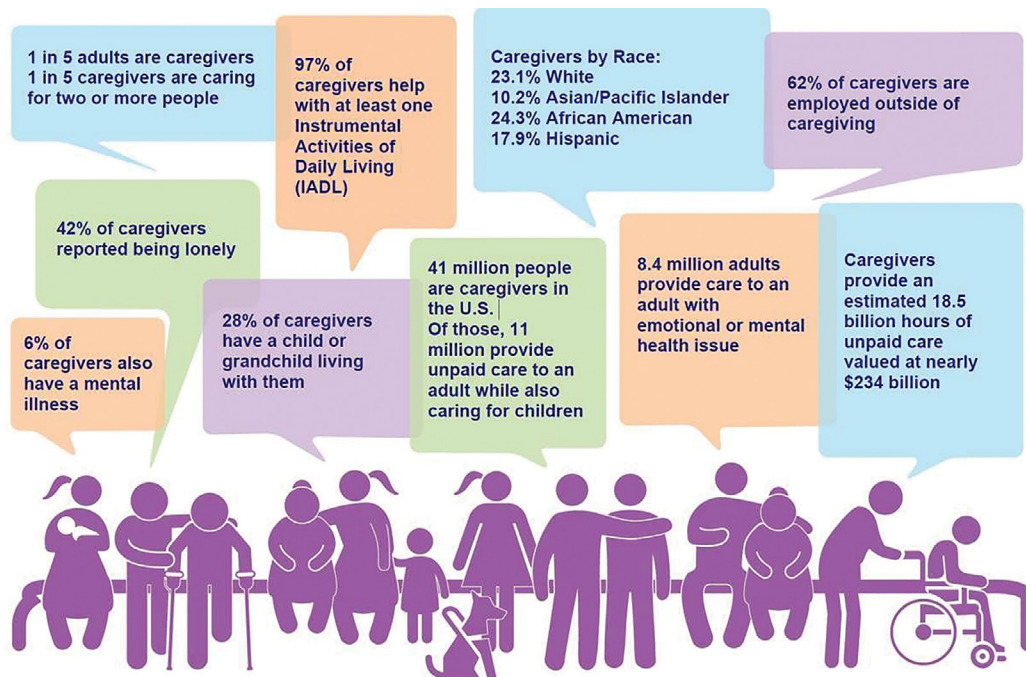
ACL and other federal agencies have published a catalogue of evidence-based programs that can be used by states. For further information, see National Council on Aging’s website: <https://www.ncoa.org/resources/ebpchart/>

Of all Title III programs, Title III-D receives the smallest amount of funding and its ability to provide the many evidence-based services authorized by the law is extremely limited. Therefore, the program is intended to provide “seed money” for these activities and expects that states and AAAs leverage other funding sources to complement Title III funds. In FY 2021, appropriations for the program were \$25 million, 1.2 percent of total OAA funding.

Family Caregiver Support (Title III-E)

The vast majority of older adults with long-term supportive care needs receive care from their families and other informal, unpaid caregivers.³⁶ Millions³⁷ of caregivers provide informal, unpaid care to older people and younger adults who need assistance due to a physical, cognitive, or mental impairment. One study found that more than 1 in 5 Americans are caregivers for an adult or child with special needs with over two-thirds providing care to people age 50 and older.³⁸ The aging of society and scarcity and expense of home care are factors that exacerbate demands on family caregivers and increase the number of families called on to provide care.³⁹ Because caregiving responsibilities often lead to physical and emotional stress, many people consider the stress of caregiving to be a public health issue of growing concern.

Figure 9. Profile of Caregivers in America



Source: *ADvancing States Profile of Caregivers in America 2020*

In response to these concerns, in 2000 Congress created the National Family Caregiver Support Program (NFCSP) under the Title III umbrella of programs.

Services—Services authorized include information and assistance, and access regarding available services, individual counseling, support groups and caregiver training, respite services to provide families temporary relief from caregiving responsibilities, and supplemental services (such as home care and home adaptations) on a limited basis to complement care provided by family and other caregivers.

Recipients—People eligible for the program are (1) adult family members or other caregivers age 18 and older providing care to individuals 60 years of age and older and individuals of any age with Alzheimer’s disease and related disorders; (2) older relatives (not parents) age 55 and older providing care to children under the age of 18; and (3) older relatives, including parents, age 55 and older providing care to adults ages 18-59 with disabilities.⁴⁰

The number of caregivers served by the program is relatively small. In 2019, roughly 762,000 caregivers were served under Title III-E, and an additional 40,000 older relative caregivers were served.⁴¹

Evaluation—In recent years ACL has conducted major evaluations of the family caregiver program. Selected findings are summarized as follows:

- *Caregiving is an almost full-time responsibility of long duration.* Caregivers surveyed had been providing care for an average of seven years and provided an average of nine hours a day of care.⁴²
- *The program helps to reduce caregiver burden and allows caregivers to continue providing care longer.* The program’s respite care benefit is especially important in reducing caregiver burden, especially for those caring for older individuals or individuals who have Alzheimer’s disease or other dementias, those who have intense caregiving responsibilities, and who live with or are spouses of care recipients. Caregivers request respite care services, in institutional settings, the home, and adult day care programs, more often than any other service.⁴³
- *States and AAAs focus priority on providing support to caregivers with the most intense caregiving responsibilities,* especially caregivers of people with Alzheimer’s disease, grandparents raising grandchildren, and other relative caregivers. To address the specific needs of these populations, both state and AAAs use targeted marketing and outreach campaigns.⁴⁴
- *About 40 percent of AAAs have waiting lists for caregiver services.* Waiting lists are often for respite care.⁴⁵

Title III Priority for Serving Older Populations

Title III services are available to all people age 60 and over who need assistance, but the law requires that services priority be given to those with the greatest economic or social need. In certain instances people under the age of 60 may also receive services.⁴⁶ In successive amendments, Congress has added specific groups of older people to receive priority including: those with low-income; members of minority or ethnic groups; older people living in rural areas; those at risk for institutional care; and those with limited English proficiency.⁴⁷

Priority for Title III Services

“Greatest social need” is defined in law as need caused by noneconomic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently.

“Greatest economic need” is defined as having an income at or below the official federal poverty level (FPL).

42 U.S.C. 3011. As amended Through P.L. 116-131, Enacted March 25, 2020.

Although the distribution of Title III funds to states is determined on the basis of age alone, states and AAAs determine how to serve the priority populations that are defined by federal law. Generally, states have established prioritization criteria for services and a variety of methods are used to target services. The Mathematica Policy Research nutrition services evaluation found that priority for congregate meals services is usually based on racial or ethnic minority status, nutrition risk assessments, economic need, and geographic isolation. Priority for home-delivered meals can be based on homebound status, the presence of activities in daily living (ADLs) impairment minimums, geographic isolation, and low-income status.⁴⁸ Some services are provided to vulnerable groups by their service definition, such as the long-term care ombudsman program and family caregiver support services.

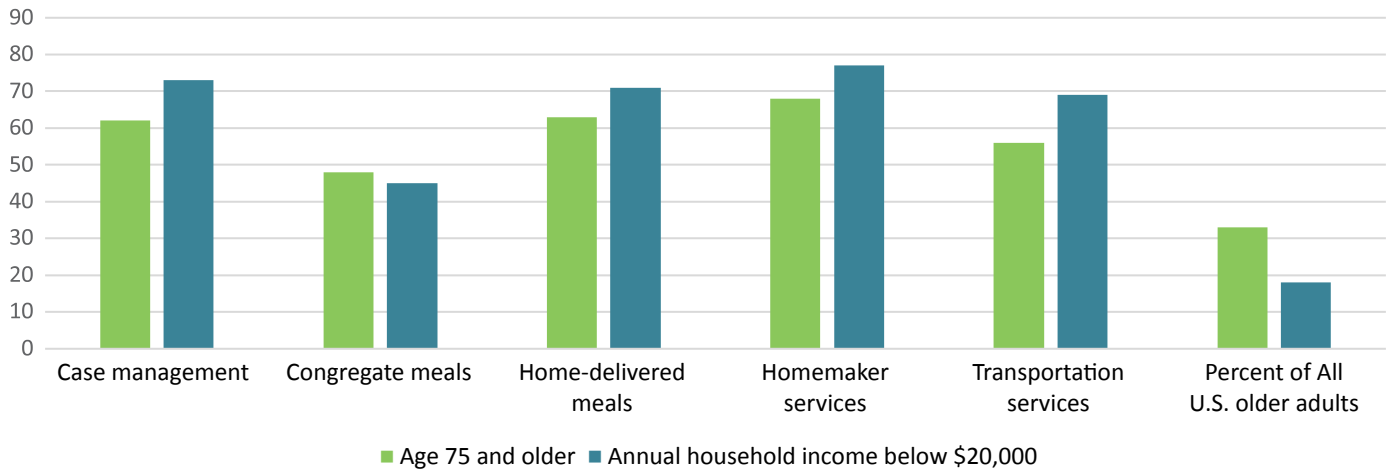
According to ACL data, in 2019, of the 73 million people aged 60 and over, about 15 percent or approximately 11 million people, received any service funded by the Act. However, a much smaller proportion of people aged 60 and older—about 4 percent or 2.7 million people—were “registered” clients, that is, they received services on a regular, or intensive basis.⁴⁹ A larger but unknown number likely benefits from the planning, coordination, and advocacy functions carried out by state and AAAs.

Although a relatively small proportion of older people receives Title III services, ACL data as well as several studies have documented that the program reaches particularly vulnerable groups. Of all Title III registered clients in 2019, one-third had income below the federal poverty level (FPL) compared to 10 percent of the U.S. population aged 60 and older. Title III services also appear to be targeted to older minority groups. About 32 percent of registered clients were members of a minority group compared to about 26 percent of the U.S. population aged 60 and over.⁵⁰

An ACL analysis of recipient data across various Title III services also shows that priority for services is given to the oldest populations and to those with lower income. About one-third of the U.S. population is 60 and older, but a higher proportion of Title III recipients of various services is age 75 and older, as shown in Figure 10. A similar pattern exists for household income. The ACL analysis also showed that Title III recipients tend to have functional limitations and chronic conditions at a higher rate than the overall population aged 60 and over. The presence of functional limitations and chronic conditions is often a predictor of nursing home admission.⁵¹ For some people, Title III services can deter or delay nursing home admission and improve their quality of life.

Figure 10. Comparison of Title III Recipients and National Population, by Age and Annual Household Income

Proportion of Low-income and Individuals Over Age 75 Served by OAA



Source: Adapted from Administration for Community Living, “Aging in Place: Do Older Americans Act Title III Services Reach Those Most Likely to Enter Nursing Homes?” December 2019, https://agid.acl.gov/Resources/DataOutputs/OAA_Brief_1_12-4-19_508.pdf

Unmet Need for Title III Nutrition and Supportive Services

A series of Government Accountability Office (GAO) reports has found unmet need for nutrition and supportive services among older people. A 2011 GAO analysis found that many older people are in need of meals and other supportive services to help them remain independent in their communities, but do not receive the help they require. About 9 percent of low-income older adults received OAA meals services, but many more were likely to need them due to financial constraints or other difficulties. About 89 percent of low-income older adults who were considered food insecure did not receive either congregate or home-delivered meals from the OAA. The report also indicated almost 90 percent of older people who were limited in two or more ADLs did not receive home-delivered meals. The analysis cited interviews with state officials who pointed to factors that contribute to unmet need, including funding constraints and older persons’ lack of knowledge about the existence of services.⁵²

Building on its 2011 analysis, GAO released a second report in 2015 that showed similar results. It found that even as the proportion of older adults who were food insecure due to financial inability to purchase food or presence of functional limitations had increased, a large proportion did not receive meals. Similarly, it found that about two-thirds of those with limitations in daily living received only limited or no in-home services.⁵³

Waiting lists for services are an indicator of unmet need. The Mathematica Policy Research study found that 41 percent of state agencies have waiting list policies for congregate meals and 57 percent have such policies for home-delivered meals. Generally, those on waiting lists have already been screened for eligibility. For AAAs that maintain waiting lists

within their planning and service areas (PSAs), an average of 51 people were waiting for congregate meals, and an average of 143 people were waiting for home-delivered meals.⁵⁴

Title III Prohibition on Means Testing: Voluntary Contributions and Cost-sharing Policies

Considering a person's income, assets, savings, or personal property as a condition of receiving Title III services is prohibited by law.⁵⁵ The law allows, and distinguishes between, voluntary contributions from older participants toward the cost of services, and cost-sharing by participants for services received. Where cost-sharing policies exist, older people may not be denied services due to failure to make voluntary contributions or cost-sharing payments (see box).

Voluntary Contributions

The law allows voluntary contributions for services from participants if the method of solicitation is non-coercive. Contributions are encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line and at contribution levels based on the actual cost of services. AAAs must consult with service providers and older individuals to determine the best method for accepting voluntary contributions.

AAAs must ensure that service providers (i) provide each recipient with an opportunity to voluntarily contribute to the cost of the service; (ii) clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary; (iii) protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution; (iv) establish appropriate procedures to safeguard and account for all contributions; and (v) use contributions to supplement (not supplant) the service for which the contributions were made.

Cost-sharing

The law allows cost-sharing policies for certain services, with the exceptions noted in Table 1.

States must meet certain requirements if they decide to establish cost-sharing policies. Among other things, they must (i) protect the privacy and confidentiality of each older individual's income; (ii) not consider assets, savings, or other property owned by an older individual in determining whether cost-sharing is permitted; (iii) not deny any service for older individuals due to their income or their failure to make a cost-sharing payment; (iv) determine the eligibility of older individuals to cost share solely by a confidential declaration of income and with no requirement for verification; and (v) widely distribute written materials describing the cost-sharing criteria for cost sharing, and the state's sliding scale, among other things.

42 USC U.S.C. 3030 Excerpts. As Amended Through P.L. 116-131, Enacted March 25, 2020

Table 1. Title III Requirements on Voluntary Contributions and Cost-sharing for Services

Voluntary Contributions Allowed	Cost-sharing Allowed	Cost-sharing Prohibited
<p>Voluntary contributions are allowed for any Title III services if the method of solicitation is non-coercive. Contributions may be solicited for congregate and home-delivered meals, transportation, and senior center services, among others.</p>	<p>Cost-sharing is allowed for certain services other than those that are specifically prohibited. These may include home care, respite care, adult day care, transportation, home repair, among others.</p>	<p>Cost-sharing is prohibited for</p> <ul style="list-style-type: none"> • Information and assistance and outreach • Congregate and home-delivered meals • Benefits counseling • Case management • Ombudsman services • Elder abuse prevention services • Legal assistance • Other consumer protection services • Any services delivered by tribal organizations

Prepared by ADvancing States



Title IV. Activities for Health, Independence, and Longevity

The purpose of Title IV of the Act is “to expand the Nation’s knowledge and understanding of the older population and the aging process; to design, test, and promote the use of innovative ideas and best practices in programs and services for older individuals; to help meet the needs for trained personnel in the field of aging; and to increase awareness of citizens of all ages of the need to assume personal responsibility for their own longevity.”⁵⁶ Since its inception, Title IV funds have been used to support a wide range of research and demonstration projects related to income, health, housing, and LTSS. Funds are awarded to a wide range of grantees, including public and private organizations, state and AAAs, institutions of higher learning, and community-based service organizations.

In each reauthorization of the Act, Congress has added new or expanded authority or requirements for the Assistant Secretary to conduct specific research and/or demonstration programs. The Act’s 2020 legislation created authority for projects that address negative health effects associated with social isolation among older people, improvements for transportation and family caregiver programs, and bringing to scale evidence-based falls prevention and chronic disease self-management programs.

Over the years, Title IV funds have been awarded to support legal assistance systems, a national Alzheimer’s disease call center, multigenerational civic engagement projects, and several national organizations serving minority older people. FY 2021 funding supports various projects to support aging network agencies including National Resource Centers on Native American Elders, National Minority Aging Organizations Technical Assistance Centers, and Holocaust Survivor’s Assistance. Title IV also funds elder rights support activities, including programs to strengthen legal assistance services and state APS programs, and programs to provide services and training to community-based organizations to assist people with Alzheimer’s disease and related dementias.⁵⁷

Funding for Title IV training, research, and demonstration was originally appropriated in 1966 and has fluctuated over the years. Funding reached a peak in 1980 at over \$54 million but has not reached that level since that time. FY 2021 funding is \$38 million, or 2.0 percent of total funding.

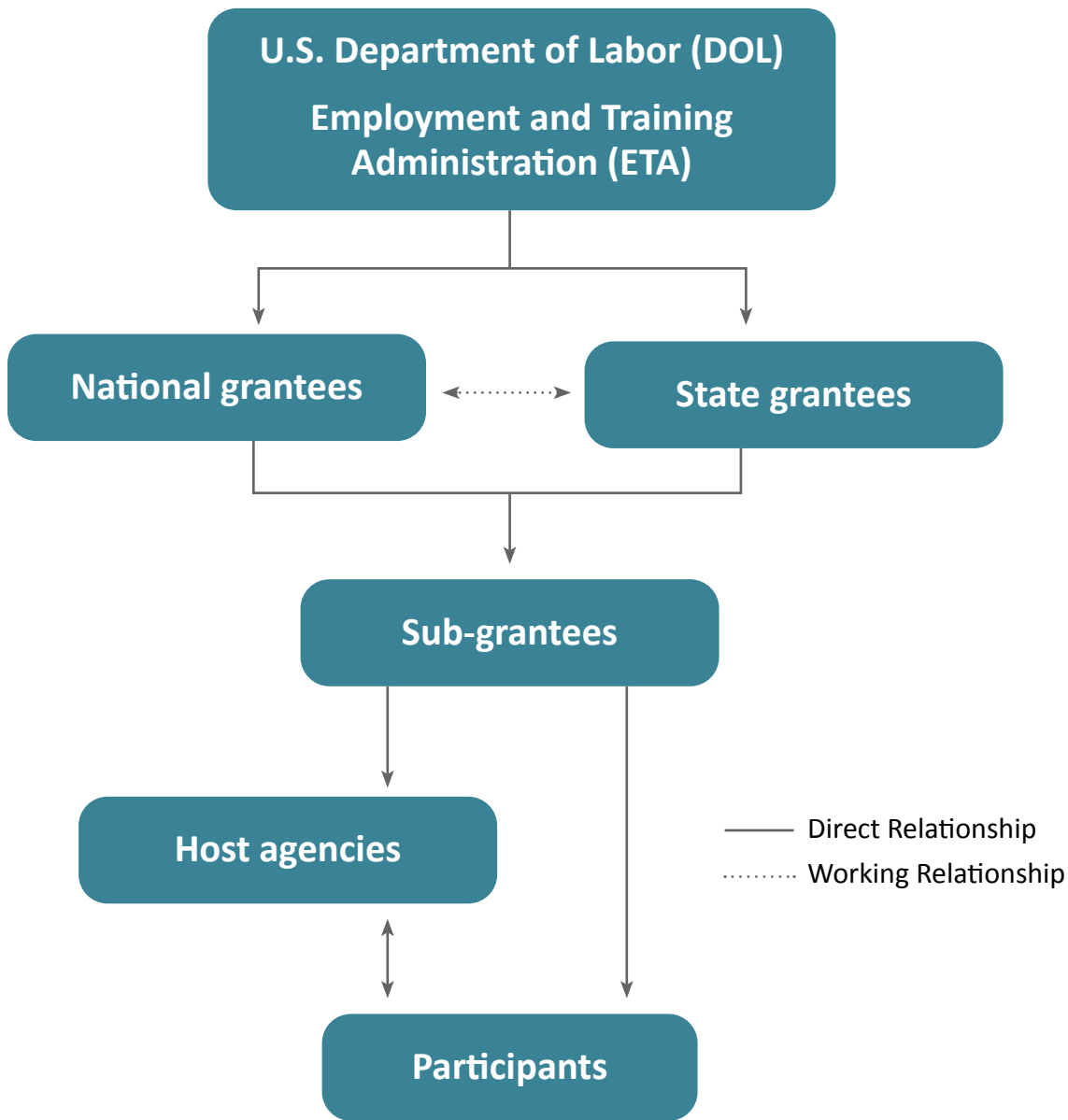
The limits on Title IV funding has constrained AoA’s ability to carry out many of the research, demonstration and training projects authorized by Congress. However, funding for research or demonstration projects of national significance has been authorized and appropriated under Title II of the Act, such as ADRCs, and various projects to advance and complement activities of the aging network.

Title V. Community Service Senior Opportunities Act

Title V, known as the Senior Community Service Employment Program (SCSEP), administered by the DoL, has as its purposes to (i) provide part-time jobs for unemployed low-income people who have poor employment prospects and (ii) help these individuals transition to unsubsidized employment in both the public and private sectors.⁵⁸ The program is intended not only to provide older individuals with employment and job training, but also to provide needed staff for community service organizations. Many SCSEP participants work for programs authorized by other parts of the Act, such as nutrition sites and senior centers, but also work in hospitals, libraries, schools, and other community services. The program subsidizes wages of participants and participation is expected to be temporary.⁵⁹

- **Participant Eligibility**—People eligible are those who are 55 years of age and older whose income does not exceed 125 percent of the federal poverty level, and who are unemployed. The law requires that grantees give preference in enrolling prospective participants who demonstrate barriers to employment, including those who are: 65 years of age or older, veterans, homeless or at risk for homelessness; or, have a disability, limited English proficiency or low literacy skills, or low employment prospects; or have been incarcerated within the last 5 years or are under supervision following release from prison, or jail within the last 5 years; or failed to find employment through the Workforce Innovation Opportunity Act; or reside in a rural area.
- **Participant Wages and Benefits**—Program participants earn the higher of the federal or state minimum wage or the prevailing wage paid by the same employer for similar occupations. Participants may also receive training and supportive services, such as transportation costs, health and medical services, special job-related or personal counseling, and work-related incidentals such as eyeglasses or work shoes. Participants work an average of 20 hours a week.
- **Grants to States and National Organizations**—The DoL contracts with states and 18 national organization grantees⁶⁰ which act as host agencies that recruit and enroll participants who are then placed in community service jobs. Grantees are expected to coordinate their activities with training and other services provided under Title I of the Workforce Innovation and Opportunity Act. See figure 11.

Figure 11. Relationships Between SCSEP Agencies



Source: *ADvancing States Primer on the Senior Community Service Employment Program*: http://www.advancingstates.org/documentation/nasvad_materials/SCSEP%20Primer.pdf

Title VI. Grants for Services for Native Americans

Title VI authorizes grants to Indian tribal organizations, Alaskan Native organizations, and nonprofit groups representing Native Hawaiians. In the authorizing legislation, Congress finds that older Indians and Native Hawaiians suffer from a higher rate of poverty and lower life expectancy than others in the population, receive less than adequate health care, and otherwise are more disadvantaged on a number of social and economic indicators than others.⁶¹ Congress has stated that services and benefits for older Alaskan Natives, and Native Hawaiians should be provided in a manner that preserves and restores their dignity, self-respect, and cultural identities.⁶²

Title VI authorizes four programs: the Indian Program (Part A), the Native Hawaiian Program (Part B), and the Native American Caregiver Support Program (Part C) and Supportive Services for Healthy Aging and Independence (Part D).⁶³ Grantees use funds for congregate and home-delivered meals, supportive services (e.g., transportation, legal assistance, homemaker service, adult day care, personal care, chore), and caregiver support services.

In order to receive funds, Indian tribal organizations must represent at least 50 older people age 60 and over. Similarly, public or nonprofit private organizations for Native Hawaiians must have the capacity to provide services to at least 50 Native Hawaiians age 60 and over. Tribal organizations are allowed to determine the age at which a member is considered an elder and thus be eligible for services.⁶⁴ According to ACL, the Title VI congregate meals program reaches 43 percent, home-delivered meals reach 19 percent, and supportive services reach 65 percent, of eligible Native American older people in grantee organizations.⁶⁵

Evaluation—Since 2016, ACL has conducted an evaluation of the Title VI program. The purpose of the evaluation is to study the barriers and facilitators to program implementation. Two reports have presented outcomes.

The first evaluation report focused on participant needs. It found that 61 percent of American Indians, Alaskan Natives, and Native Hawaiian elders were using Title VI services. The majority of elders and program staff surveyed reported that nutrition services fulfill a critical need and, for many, the program meal they receive is the only hot and nutritious meal of the day due to their inability to prepare meals because of illness. Forty-seven percent of elders reported inadequacies in their diets and 63 percent had challenges with one or more ADLs. A majority of elders reported that the nutrition program helps them prevent illness and provides social connections.

Title VI program directors reported a number of unmet needs among elders, including need for expansion of home-delivered meals, greater availability of personal care services, and improved transportation services.⁶⁶

The second evaluation report focused on the Title VI caregiver program. The majority of the evaluation grantees provide information, outreach, and assistance in accessing services to caregivers. Counseling, support groups, and training are provided less frequently. Caregivers reported that the program helped them in important ways, particularly by providing relief from the stress of caregiving and helping to improve their overall quality of life. Often, caregivers do not have training or knowledge to support them. Therefore, many struggle with caregiving tasks such as administration of medical care at home and navigating insurance issues.⁶⁷

Funding and Grantees—Total FY 2021 funding for Title VI is \$46 million (\$35.2 million for Parts A and B and \$10.8 million for Part C). In FY 2018, grants were awarded to 270 tribal organizations (representing 400 Tribes and villages), including one organization serving Native Hawaiian elders.⁶⁸



Title VII. Vulnerable Elder Rights Protection Activities

Title VII authorizes two distinct but related programs: the long-term care ombudsman program and programs to prevent elder abuse, neglect, and exploitation. Congress appropriates separate appropriations for each of these programs and ACL awards separate allotments to states to carry out the programs. Unlike Title III programs, a state agency is not required to allot Title VII funds to AAAs. A state agency may administer vulnerable elder rights protection activities either directly or through contracts or agreements with a variety of agencies, including public agencies, such as other state agencies and county governments; nonprofit private organizations; institutions of higher education; Indian tribes; or nonprofit service providers or volunteer organizations, as well as area agencies.

These two programs are funded at \$23.7 million in FY 2021, representing about 1 percent of total OAA funding.

Long-Term Care Ombudsman Program

Despite significant public and private spending for care in nursing homes and other residential care facilities, assuring quality of care and resident rights has been a serious and continuing concern of long-term care consumers and policymakers for decades. The OAA ombudsman program, authorized by law in 1978, aims to improve the quality of life and care in long-term care facilities by assisting residents to resolve complaints about services they receive and assuring their rights are protected. It is based on a consumer advocacy model intended to improve quality of care and active ombudsman representation of institutionalized people. Complaints investigated by ombudsmen may relate to action, inaction, or decisions of long-term care providers or their representatives, and other actions that adversely affect the health, safety, welfare, or rights of residents.

The program is the only OAA program that focuses solely on the needs of institutionalized persons. The law requires that ombudsmen serve residents of all long-term care settings, *regardless of age*. Settings include nursing facilities, board and care settings, and other adult care homes including assisted living, or other similar settings.⁶⁹ In addition, ombudsmen are, where feasible, to provide services to residents who are transitioning from a long-term care setting to a home care setting.⁷⁰

In 2019 ombudsmen received almost 202,000 complaints from residents, their families or other concerned people and resolved or partially resolved almost three-quarters of all complaints.⁷¹ Frequent nursing home complaints are improper eviction or inadequate discharge planning for residents; unanswered requests for assistance; and lack of respect for residents and poor staff attitudes. In other settings frequent complaints are improper eviction or inadequate discharge planning, administration and organization of medications, and quality and quantity of food.

Ombudsmen complement efforts of federal and state staff who, under Medicare and Medicaid statute and regulations, are required to review and enforce federal regulations governing nursing home quality of care. Other functions carried out by ombudsmen include representing the interests of residents before governmental agencies and seeking administrative and legal remedies to protect their rights.

In response to reports of variability in ombudsman program implementation across the states, in 2015, ACL published final rules clarifying the functions and responsibilities of the program, effective July 1, 2016. In background on the rule, ACL noted that:

“[O]mbudsman programs were designed by Congress to have several features which are uncharacteristic of other programs and services created by and funded under the Act. Among those features are independence, unusually stringent disclosure restrictions, a public policy advocacy function, and the Ombudsman responsibility to designate staff and volunteers to serve as representatives of the Office even if they do not report to the Ombudsman for personnel management purposes.”⁷²

An issue that had caused some concern was the conflict that could arise between the ombudsman and the state agency that has oversight over the program. Because in some cases, the state agency that has oversight over the ombudsman program is also the agency that regulates and enforces standards for nursing and other care facilities, ombudsmen, as resident advocates and as employees of the state agency, may encounter conflicts with other administrative units of state agencies. The regulations are intended to clarify the ombudsman role. For more information on the rule see *State Long-Term Care Ombudsman Program, 2019 Revised Primer for State Agencies*.⁷³

Despite broad recognition of its value in assisting residents and its efforts to complement federal and state oversight of long-term care settings, the program is threatened in its ability to meet its legislative mandates. Because of limited funding many analysts and practitioners believe that the program strains to meet its full potential as a robust consumer advocacy program. While ombudsmen are required to maintain a presence in all nursing homes and other residential care settings, meeting this requirement is challenging given the staffing available. In 2019, ombudsmen visited some, but not all, facilities regularly; visitation occurred in 69 percent of all nursing homes and 30 percent of all board and care, assisted living, and similar homes at least quarterly.⁷⁴

The program relies heavily on the work of certified volunteer ombudsmen who make up 63 percent of the ombudsmen workforce (See Table 2). In FY 2019, over 1,300 paid ombudsmen and nearly 6,000 certified volunteer ombudsmen were responsible for assisting residents of 16,253 nursing facilities and over 58,000 board and care and similar facilities with more than 3 million beds.⁷⁵ Because of the significant contributions of unpaid ombudsmen volunteers, the program’s effective resources are higher than its actual funding.

Table 2. Long-Term Care Ombudsman Program Staffing, FY 2019

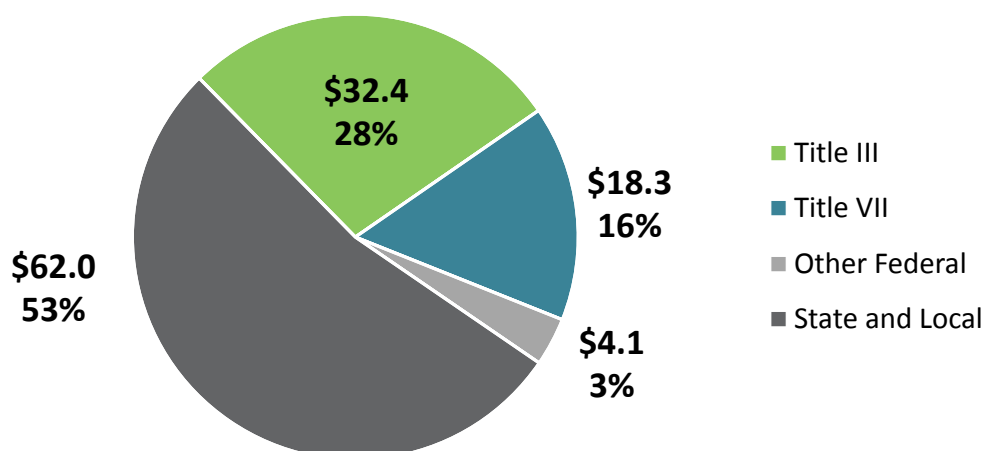
Total Staff	9,446	100%
Paid Staff	1,351	14%
Certified Ombudsman Volunteers	5,947	63%
Other Volunteers	2,148	23%

Source: Based on data in Administration for Community Living, LTC Ombudsman National and State Data, FY 2019 <https://agid.acl.gov/DataGlance/NORS/>

In FY 2021, Congress appropriated \$18 million for the State Long-term Care Ombudsman Program (SLTCOP). In addition to the specific Title VII federal appropriation, states may use some of their Title III funds, and devote significant state and local funds, for the program. Figure 10 shows total federal, state and local funding for the program for FY 2019. Federal Title III and Title VII funding, and other federal funding, for the program made up 48 percent of funding. Significant support—53 percent—came from state and local sources, well over the amount required by federal law to receive federal matching funds.⁷⁶

Figure 12. Total Funding for SLTCOP FY2019 (in millions)

Total Funding for SLTCOP = \$116.8



Source: Based on data in Administration for Community Living, LTC Ombudsman National and State Data, FY 2019 <https://agid.acl.gov/DataGlance/NORS/>

Prevention of Elder Abuse, Neglect, and Exploitation

Title VII authorizes a program for a wide range of activities intended to develop, strengthen, and carry out programs for the prevention, detection, assessment, and treatment of elder abuse, neglect, and exploitation. Under this program, states are required to carry out activities to make the public aware of ways to identify and prevent abuse, neglect, and exploitation. In addition, states are required to promote an elder abuse, neglect, and exploitation prevention system, including development of state law that will assure immunity from prosecution for persons reporting any instance of elder abuse, neglect, and exploitation.

Older Americans Act FY 2021 funding for the elder, abuse, neglect and prevention programs is \$4.8 million. Most funding for adult protective services comes from other funding sources. According to a survey of state aging and disability agencies, the vast majority of states (42 states) finance elder abuse prevention and exploitation prevention activities from state general funds; more than a third of states finance these services through the SSBG program (19 states). Older Americans Act funds and county or local government funds, Medicaid case management funds, and Victims of Crime funding are also used by states. This survey pointed out that while “elder justice services are a top priority” for state agencies, the rising number of cases and reports of elder abuse, neglect and exploitation without increased funding has constrained their ability to meet the demand.⁷⁷



Administration of the Act: Governance and Functions

Role of ACL

The original act in 1965 created the Administration on Aging in the Department of Health and Human Services (DHHS, which was then the Department of Health, Education and Welfare). Its placement in DHHS and administrative structure have changed over the years. In 2012, the Secretary of DHHS created the Administration for Community Living (ACL) to bring together the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities. This administrative move was based on the principle “...that people with disabilities or functional limitations of any type, regardless of age, have a common interest in being able to access home and community-based supports and services. And further, that these supports make the difference in ensuring that they can fully participate in all aspects of society, including the option to live at home.... [T]he creation of ACL has enhanced the ability of these programs to work collectively to advance their common objective: helping older adults and people with disabilities of all ages to live where and with whom they choose and fully participate in their communities.”⁷⁸

Major AoA Offices

The Administration on Aging includes the following components:

- Office of the Assistant Secretary for Aging
- Office of Supportive and Caregiver Services
- Office of Nutrition and Health Promotion Programs
- Office of Elder Justice and Adult Protective Services
- Office of American Indian, Alaskan Native, and Native Hawaiian Programs

Source: Administration for Community Living/Administration on Aging Organizational Chart <https://acl.gov/sites/default/files/about-acl/2019-08/ACL%20Organization%20Chart%202019.pdf>

The administrator of ACL also acts as the Assistant Secretary for Aging, serves as a visible advocate for older people, and is responsible for providing leadership on program development, planning, and other initiatives affecting older people and their caregivers across the federal government. The Assistant Secretary administers all OAA formula and discretionary grant programs (see box for major AoA organizational offices).⁷⁹

Role of State Agencies on Aging

States are responsible for designation of a state agency on aging to act as a visible advocate on behalf of older people, and for planning, coordination, policy development, priority setting, and evaluation of all state activities related to the Act's purposes. State agencies

Selected provisions of Section 307 of the Act setting out state plan on aging requirements. Among its stipulations are requirements that the plan:

- Require each area agency on aging submit to the state an area plan on aging and that the state plan be based on area plans;
- Evaluate the need for supportive and nutrition services, and multipurpose senior centers within the state and develop a process to determine the extent to which public or private programs and resources can meet these needs;
- Specify a minimum proportion of the funds that AAAs must expend on access, outreach, information and assistance, in-home services, and legal assistance;
- Conduct periodic evaluations of, and public hearings on, aging services and service effectiveness reaching individuals with greatest economic need, greatest social need, or disabilities;
- Prohibit conflict of interest for any individuals involved in the designation of the head of the state or area agency, or any representative of these agencies;
- Promote the development and implementation of a state system of comprehensive and coordinated long-term care to enable individuals to receive care in home and community-based settings, in a manner responsive to their needs and preferences;
- Assure that Title III programs will be coordinated with Title VII programs and that states make efforts to increase access to Title III services for older Native Americans.
- Assure that special efforts will be made to provide technical assistance to minority providers of services.

42 USC 3025 and 42 U.S.C. 3027 et seq. (Summary and excerpts of provisions; includes selected requirements not otherwise discussed in this report). As amended through P.L. 116-131, enacted March 25, 2020

A copy of every state plan on aging can be accessed at: <http://www.advancingstates.org/initiatives/aging-policy-and-programs/map-state-plans-aging>

are required to develop a statewide plan on aging to be submitted to the Assistant Secretary for Aging for approval and may be for a two-, three-, or four-year basis. State plans are required to demonstrate how states will assess and meet the needs of older people using OAA funds as well as other funding resources. The law stipulates a wide range of activities that states must carry out on behalf of the well-being of all older people in the state. (see box for selected requirements).

State agencies on aging are required to divide the state into planning and services areas (PSAs), and, for all PSAs, designate AAAs that develop area plans on aging. State plans are to be based on area plans. Eight state agencies operate as both the state and area agency due to their small geographic size or population density. These states are Alaska, Delaware, Nevada, New Hampshire, North Dakota, Rhode Island, South Dakota and Wyoming.

State agency staffing patterns vary considerably based on each state's older population and the type and budgets of programs they administer. About half of agencies have 150 or more full-time equivalent (FTE) staff and the rest range from under 10 to 150 FTE staff.⁸⁰

Beyond the administration of OAA funds, most state agencies have been assigned and assumed broad responsibilities for the administration of other federal and state funds that benefit older people, people with disabilities, and their caregivers. These can include Medicaid funds for home and community-based LTSS, state general funds, the Social Service Block Grant (SSBG), the State Health Insurance Assistance Program (SHIP), and state general revenue funds for a myriad of services for older people, and programs for younger people with disabilities.⁸¹

The consolidation of aging and disability programs within ACL mirrors the organization of programs for these populations that pre-existed across states before its creation. In the majority of states, one umbrella administrative agency is responsible for OAA programs as well as programs for people with physical disabilities. About half of the umbrella agencies also administer programs for people with intellectual or developmental disabilities. Almost all of these agencies manage ADRCs which serve both aging and disability programs and about half administer Medicaid home and community-based services waivers and other Medicaid authorities for these populations.⁸²

Role of Area Agencies on Aging

Like state agencies, the more than 600 AAAs across the nation are to serve as advocates on behalf of older people in their respective PSAs, and to provide planning, coordination, and evaluation of activities related to the Act's purposes. AAAs are required to develop plans on aging to be submitted to the state agency for approval on a two-, three-, or four-year basis. AAAs are required to demonstrate how they will assess and meet the needs of older people using OAA funds as well as other funding. See box for selected provisions.

Upon receipt of funds from states, AAAs use funds to develop grants or contracts with service providers in their PSAs to carry out supportive, nutrition and other aging services. In general, AAAs are prohibited from directly providing services except under certain conditions: provision is necessary to assure an adequate supply of services; services

Selected provisions of Section 306 of the Act setting out area plan requirements. Among its stipulations are requirements that the plan:

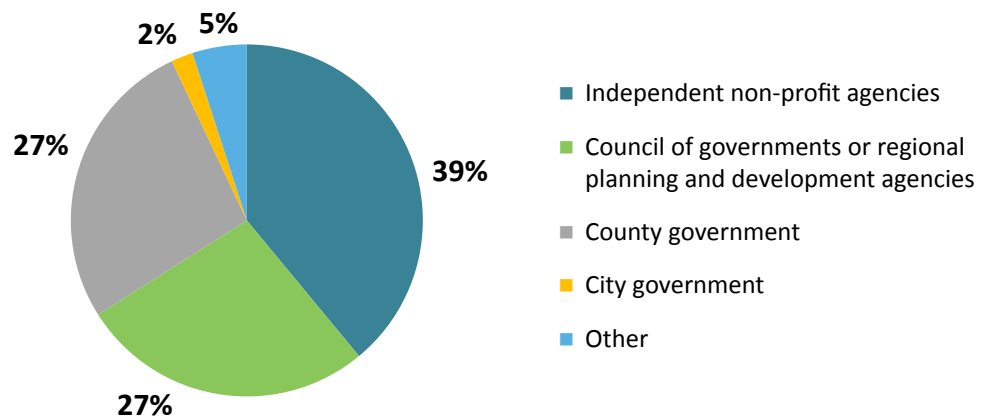
- Provide a comprehensive and coordinated system for supportive services, nutrition services, and, for the establishment, maintenance, modernization, or construction of multipurpose senior centers where appropriate;
- Determine the extent of need for supportive and nutrition services, and multipurpose senior centers;
- Evaluate the effectiveness of the use of resources in meeting the needs of older people;
- Enter into agreements with service providers to meet the needs of older people;
- Assure that an adequate proportion of supportive services funds be allocated to access services outreach, information and assistance, in-home services, and legal assistance;
- Designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers;
- Provide that the AAAs consider the views of service recipients in the development and administration of the area plan;
- Establish an advisory council to advise AAAs on the development and administration of the area plan;
- Facilitate the area-wide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals;
- Implement evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes to reduce the risk of injury, disease, and disability;
- Provide information relating to the need to plan in advance for long-term care, and available public and private long-term care options, service providers, and resources;
- Provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, in all contractual and commercial relationships.

42 U.S.C. 3026 et seq. (Summary and excerpts of provisions; includes selected requirements not otherwise discussed in this report). As amended through P.L. 116-131, enacted March 25, 2020

are directly related to state or area agency administrative functions; or services can be provided more economically, and with comparable quality, by the state or AAA. Functions considered “core” functions and generally provided directly by AAAs are information, referral, assistance, and outreach services to help older people determine their service needs and options; long-term care ombudsman programs; and family caregiver and support services. Other services generally provided by AAAs are case management, assessment, and development of care plans to assist older people get the support services they need, and benefits counseling to help older people apply for, and receive, benefits from income, health, and LTSS programs.

Governance and Staffing—Most agencies are independent non-profit agencies, located in councils of government or regional planning and development agencies; or are part of county governments (see Figure 13).

Figure 13. AAA Organizational Structure



Source: National Association of Area Agencies on Aging and Scripps Gerontology Center, Miami University, 2020 National Survey of Area Agencies on Aging Report, Meeting the Needs of Today’s Older Adults <https://www.n4a.org//Files/AAA-Survey-Report-2020%20Update-508.pdf>

AAAs employ a median number of 21 full-time staff, five part-time staff and 50 volunteers, numbers that have not changed over the last four years. Staffing can range from small staffs of just a few people, especially in rural states or rural areas within a state, to very large staffs of one-hundred or more in major metropolitan areas. In part, this reflects state policy decisions regarding geographic distribution of area agencies, the dispersion of the elderly population within a state, and funding.⁸³

AAAs administer diverse sources of funds in addition to those provided under the OAA, including state and local funds, private sector grants, and Department of Veterans Affairs funds. On average, state and local government funding represents more than 40 percent of AAA budgets. Over the past two decades, many AAAs have taken on important responsibilities for some aspects of Medicaid home and community-based services for older people and people with disabilities. Their primary responsibilities center on care management, assessment, service planning and level of care determinations for these populations. Forty-three percent of AAAs that responded to a 2020 survey reported receiving some Medicaid funds. For those receiving this funding, Medicaid represented about 28 percent of overall agency budgets.⁸⁴

Role of Service Providers

AAAs contract with, or make grants to, a wide range of community-based organizations (CBOs) that deliver services to older people. CBOs are entities (non-profit or for-profit) that provide aging or disability services, under a contract or grant from the AAA in their respective areas. CBO staff and volunteers deliver services to older people in their homes, in senior centers, through transportation providers, and adult day centers, among other sites. AAAs are responsible for the oversight, management and quality of the services provided by CBOs within their respective PSAs.

According to ACL in 2019, AAAs contracted with over almost 4,000 organizations to provide transportation or assisted transportation services; almost 4,000 and 3,500 organizations to provide congregate and home-delivered meals, respectively; and over 3,500 and 3,600 organizations to provide homemaker and personal care providers, respectively. Other CBOs provide the full range of services authorized by the Act.⁸⁵



Distribution of Federal Funds and Non-Federal Matching Requirements

Distribution of Funds to States and Other Entities

Title III and Title VII Formula Distribution Factors—ACL distributes Title III and Title VII funds to states according to population-based formulae. Except for family caregiver support services and nutrition services incentive grants, each state receives Title III allotments for services proportionate to its population age 60 and over, compared with the total U.S. population age 60 and over. Family caregiver support program funds are allotted based on states' proportionate population age 70 and over. Nutrition services incentive grants to states are based on the number of qualified meals served the preceding fiscal year (see Table 3). States receive separate allotments for each Title III and Title VII program.

Title V Allocations—Under fairly complex formula distribution requirements, the statute stipulates various provisions: (1) a hold harmless amount at grantees' 2000 level of funding; (2) a division of the remaining funds into two parts that vary according to the level of appropriations in any given year; and (3) an allotment to states based on their share of the population aged 55 and older. Generally, in recent years about 78 percent of funds have been distributed to national grantees and 22 percent to state grantees.

Title VI Grants—Organizations serving older Indians and Native Hawaiians receive grants based on applications submitted to the Assistant Secretary on Aging.

Non-federal Matching Requirements

In general, states are required to provide matching funds to draw down federal OAA services funds (See Table 3).

- For supportive and nutrition services grants, states are required to provide 15 percent of the cost of services in matching funds as a condition of receiving federal funds. One-third of the 15 percent non-federal share for supportive and nutrition services grants must be met by State only sources.

- For family caregiver service grants, states are required to provide 25 percent of the cost of services in matching funds as a condition of receiving federal funds.
- States may support long-term care ombudsman services with Title III and Title VII funds. States are not required to provide matching funds for this program under either Title III or Title VI.
- Title V grantees must contribute at least 10 percent toward the cost of a project with certain exceptions: in an emergency or disaster project; or if a project is located in an economically depressed area.
- There is no matching requirement for Title VI projects.

State and local communities often provide additional funds, above the federal requirements, to spread Older Americans Act funds more widely. Voluntary contributions from older people to pay part of the costs of some services, especially for the congregate and home-delivered nutrition programs, may augment federal, state, and local funds. Voluntary contributions may not be used to meet non-federal match requirements.

Table 3. Factors Used for Distribution of Older Americans Act Services Funds to States and Other Entities and Non-Federal Matching Requirements 1/

Title III Grants to States	Recipient	Distribution Factor	Non-Federal Matching Requirement
Supportive services	States 2/	A state's proportionate share of the U.S. population age 60 and older.	A state must contribute at least 15 percent. 3/
Congregate and home-delivered nutrition services	States 2/	A state's proportionate share of the U.S. population age 60 and older.	A state must contribute at least 15 percent.
Nutrition services incentive program	States and tribal organizations	A state's proportionate share of the qualified U.S. total number of meals served in the preceding FY. For tribal organizations, the number of meals served by the organization in the preceding FY.	None required

Continues.

Title III Grants to States	Recipient	Distribution Factor	Non-Federal Matching Requirement
Disease prevention and health promotion	States 2/	A state's proportionate share of the U.S. population age 60 and over.	None required
National family caregiver support program	States 2/	A state's proportionate share of the U.S. population age 70 and over.	A state must contribute at least 25 percent.
Title V, Community Service Senior Opportunities Act	States and 18 national organizations (see section on Title V for list of national organizations)	A state's proportionate share of the U.S. population aged 55 and older and per capita income and other factors. 4/	States and national organizations must contribute 10 percent.
Title VI, Grants for Native Americans	Indian tribal organizations and organizations providing services to Native Hawaiians	<p>Indian tribal organizations and organizations serving Native Hawaiians receive grants based on applications to the Assistant Secretary on Aging.</p> <p>A tribal organization is eligible for a grant if it represents at least 50 individuals age 60 years or older, among other things. 5/</p> <p>An organization is eligible for a grant for Native Hawaiians if it will serve at least 50 individuals age 60 or older, among other things. 5/</p>	None required

Continues.

Title III Grants to States	Recipient	Distribution Factor	Non-Federal Matching Requirement
Title VII, Vulnerable Elder Rights Protection Activities			
Long-term care ombudsman Elder abuse, neglect, and exploitation prevention programs	States 2/	A state's proportionate share of the U.S. population aged 60 and over.	None required

1/Funds are allotted to states and other recipient agencies according to a formula which takes into account the factors shown in this table as well as other stipulations in the law regarding minimum, hold harmless, reservation of funds, and/or set aside amounts. Requirements for minimum, hold harmless, reservation of funds, and set aside amounts are not shown in this table. Distribution factors for territories are not shown in this table.

2/Includes the District of Columbia and Puerto Rico.

3/States may use any amount of the III-B allotment, as it determines to be adequate, for conducting an effective ombudsman program. Match for Title III-B services is calculated after the state determines the amount of Title III-B funds that will be used for the ombudsman program.

4/Other factors include (i) a hold harmless amount at grantees' 2000 level of funding; and (ii) a division of the remaining funds into two parts that vary according to the level of appropriations in any given year, not shown in this table.

5/Organizations providing services under Title VI are allowed to serve people under age 60 at the discretion of the organization but receive no federal funds for this purpose.

Source: Sections 308(b) and 304(d)(1) of the Older Americans Act, as amended through P.L. 116-131, enacted March 25, 2020.

State Distribution of Title III Funds to Area Agencies on Aging

States allocate Title III funds to AAAs based on a state-determined formula, the intrastate funding formula (IFF). States must develop the formula in consultation with AAAs and use the best available population data. The law requires that the formula consider the geographical distribution of older individuals and the distribution of older individuals with greatest economic and social needs, with particular attention to low-income minority individuals.

Administration Funds: Title III Allowable Amounts

The law places limits on the amount of federal funds that states and AAAs may use for administration and implementation of their state and area agency programs as shown in Table 4. In general, the amount that can be used for state plan administration is related to a benchmark for the total Title III appropriation amount (\$800 million). In recent years the amount appropriated has exceeded the benchmark. Therefore, as shown in Table 4 states may use the greater of 5 percent of their allotments for supportive, home-delivered nutrition, disease prevention and family caregiver services, or \$750,000, for state agency administration.

Table 4. Allowable Amounts for State and Area Agency Administration Costs and Non-Federal Matching Requirements

OAA Title and Program	Recipient	Allowable Amount	Non-Federal Matching Requirements
Administration	States 1/	<p>States: When total appropriations for supportive, congregate and home-delivered nutrition, disease prevention and health promotion, and family caregiver services exceed \$800 million, a state may use the greater of</p> <ul style="list-style-type: none"> • 5 percent of their allotments for supportive, home-delivered nutrition, disease prevention and family caregiver services, or \$750,000, for administration. <p>When total appropriations for supportive, congregate and home-delivered nutrition, and disease prevention, health promotion, and family caregiver services is less than \$800 million, a state may use the greater of</p> <ul style="list-style-type: none"> • 5 percent of their allotments for supportive, congregate and home-delivered nutrition, disease prevention and family caregiver services, or • \$300,000, for administration. 	States must contribute a matching share of at least 25 percent of the costs for state administration.

Continues.

States may provide up to 10 percent of their allotments for services to be used for area agency administration (after the allowable amount for state administration is deducted from services allotments). AAAs must contribute a matching share of at least 25 percent of the cost of area agency administration.

OAA Title and Program	Recipient	Allowable Amount	Non-Federal Matching Requirements
Administration	Territories 2/	<p>When total appropriations for supportive, congregate and home-delivered nutrition, disease prevention and health promotion, and family caregiver services exceed \$800 million, a territory may use the greater of</p> <ul style="list-style-type: none"> • 5 percent of their allotments for supportive, congregate and home-delivered nutrition, disease prevention and family caregiver services, or • \$100,000, for administration. <p>When total appropriations for supportive, congregate and home-delivered nutrition, disease prevention and health promotion, and family caregiver services is less than \$800 million, a territory may use the greater of</p> <ul style="list-style-type: none"> • 5 percent of their allotments for supportive, congregate and home-delivered nutrition, disease prevention and family caregiver services, or • \$100,000, for administration. 	
Area Agency Administration	Area agencies	States may allow up to 10 percent of their state allotments for services to be used for area plan administration by area agencies.	Area agencies must contribute a matching share of at least 25 percent of the cost of area agency administration.

1/Includes the District of Columbia and Puerto Rico.

2/Guam, American Samoa, United States Virgin Islands, the Trust Territory of the Pacific Islands, and the Commonwealth of the Northern Mariana Islands.

Source: Section 308 and Section 305(d) of the Older Americans Act, as amended through P.L. 116-131, enacted March 25, 2020.

Broad Mission but Limited Resources

The mission of the aging services network set out by law is expansive and aimed at addressing many competing needs of older people across a wide spectrum of services. Despite its broad mandate and sweep of services, OAA resources are very limited. Funding has not kept pace with increasing demands from a growing elderly population. As a result, some programs have grown very slowly over time, or have not been brought to scale. Some programs' capacity depends heavily on volunteers, thereby masking any need for additional staff resources to carry out program functions. Moreover, the aging services network's decentralized planning and service model has led to variability in program implementation across states and communities.

Nevertheless, despite its funding constraints and variability in implementation, over the last 56 years, the OAA has encouraged development and provision of multiple and varied services for older people, significantly expanded service access and the aging workforce, and advocated for improvements in quality of care and protection of the rights of older people. State and AAAs have relationships with tens of thousands of service providers offering a wide range of services across the nation. OAA funds reach limited numbers of older people, but ACL data and other research suggest they are well targeted to vulnerable older people. The initiatives taken by state and AAAs to broaden their responsibilities and attract a diverse funding pool have allowed them to improve service delivery and respond to changing needs and resources.

Aging service providers face increasing challenges in financing and delivering services in the face of demographic trends. While use of federal OAA discretionary funds has encouraged service delivery innovation, funding for the Act's core programs has not kept pace with reports of increasing demand. Stresses on aging services network programs have been heightened by the continuing budgetary constraints faced by state and local governments.

In the future, policymakers may need to focus on actions that will enable communities to sustain services in the face of growing demand, and dramatic increases in the older population. In an environment where there is more competition for public resources, policymakers and practitioners in the field of aging will continue to develop new advocacy, planning, and sustainability models to meet the needs of older people. While these trends play out, ACL and its national partners are helping states and AAAs develop more entrepreneurial approaches to aging programming and operations. The dramatic increase in the aging population and continuation of stress on public funds may require aging network agencies to assess how to become social entrepreneurs by broadening their base of financial support while at the same time advocating for increased public funding.



Endnotes

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- ² Then the Department of Health, Education and Welfare (HEW).
- ³ The most common state-reported APS funding sources are state general fund appropriations, the Social Services Block Grant, Older Americans Act, county or local government funds, non-OAA ACL grants, Victims of Crime Act funding. <http://www.advancingstates.org/sites/nasuad/files/NASUAD%202017%20State%20of%20States%20Report.pdf>
- ⁴ Carroll L. Estes. *The Aging Enterprise: A Critical Examination of Social Policies and Services for the Aged*. San Francisco: Jossey Bass, 1979).
- ⁵ The ombudsman program began as a pilot program in the early 1970s. The 1978 law added statutory authority for the program under Title III of the Act. It was later incorporated into Title VII of the Act.
- ⁶ Kirsten J. Colello, *Older Americans Act: 2016 Reauthorization*, Congressional Research Service, May 2, 2016. <https://crsreports.congress.gov/product/pdf/R/R44485>
- ⁷ For information on the 2020 amendments see Kirsten J. Colello and Jared S. Sussman, *Older Americans Act: 2020 Reauthorization*, Congressional Research, July 1, 2020. <https://crsreports.congress.gov/product/pdf/R/R46439>

- ⁸ In addition to the regular appropriations, legislation enacted in response to the COVID-19 pandemic added significant unprecedented funding for the Older Americans Act. The Families First Coronavirus Response Act (FFCRA) provided \$250 million. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided \$870 million. The Consolidated Appropriations Act, 2021 included \$175 million. Finally, the American Rescue Plan Act of 2021 (ARPA) allocated \$1.43 billion for the OAA. In total, supplemental funding for the OAA passed during the COVID-19 pandemic stands at \$2.775 billion. For additional information relating to Older Americans Act funding, see: Kirsten J Colello and Angela Napili, Older Americans Act: Overview and Funding, Congressional Research Service, April 22, 2021. <https://crsreports.congress.gov/product/pdf/R/R43414>
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- ¹³ National Association of Area Agencies on Aging and Scripps Gerontology Center, Miami University, 2020 National Survey of Area Agencies on Aging Report, Meeting the Needs of Today's Older Adults. <https://www.n4a.org//Files/AAA-Survey-Report-2020%20Update-508.pdf>
- ¹⁴ Administration for Community Living, Data-at-a-Glance (SPR), 2019. <https://agid.acl.gov/DataGlance/SPR/>
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