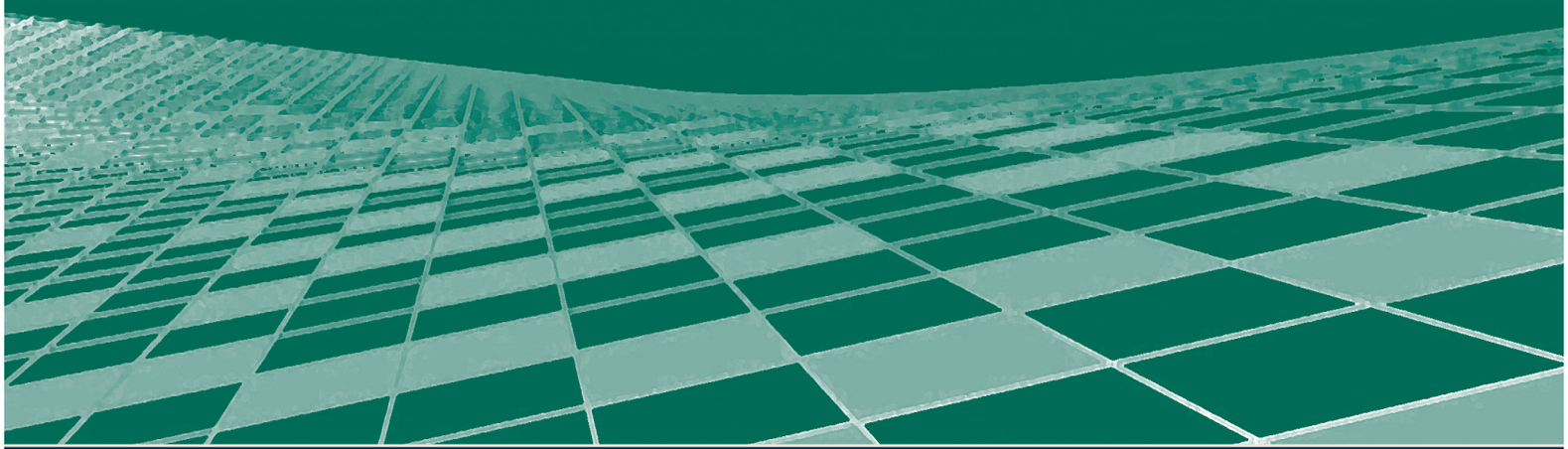
NASUA
National Association of State Units on Aging

State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices

OCTOBER 2009

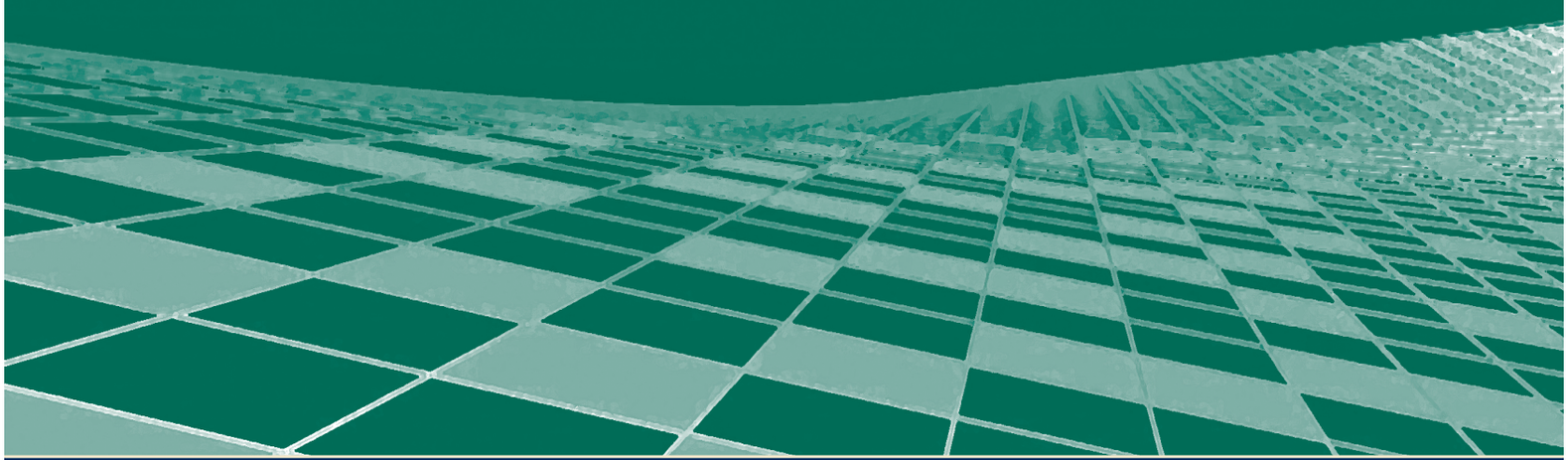


PREPARED BY THE NATIONAL ASSOCIATION OF STATE UNITS ON AGING

NASUA
National Association of State Units on Aging

NATIONAL ASSOCIATION OF STATE UNITS ON AGING

1201 15th Street, NW • Suite 350 • Washington, DC 20005



NASUA
National Association of State Units on Aging

State of Aging: 2009 State Perspectives on State Units on Aging Policies and Practices

OCTOBER 2009

PREPARED BY THE NATIONAL ASSOCIATION OF STATE UNITS ON AGING

Table of Contents

Appendix

State by State Tables

About NASUA

The National Association of State Units on Aging (NASUA), founded in 1964, represents the nation's 56 officially designated state and territorial agencies on aging. The Association's principal mission is to support visionary state leadership, advance state systems innovation and articulate a national policy on elder rights and home and community based services for older adults and individuals with disabilities and their families.

NASUA is the articulating force at the national level through which the state agencies on aging join together to promote social policy in the public and private sectors responsive to the challenges and opportunities of an increasingly diverse aging America.

NASUA works to:

- Inform policy makers on current and future needs and preferences of older persons, adults with disabilities, and their families and caregivers—and on the status and operations of federal and state programs that serve them.
- Serve as the vehicle for membership to collectively develop and promote policy recommendations with the public and private sectors.
- Maintain mutually beneficial relationships with other national organizations, as well as with the private sector.
- Analyze federal legislative, regulatory, and administrative actions affecting state policies and programs.
- Facilitate exchange of information, ideas, and experience on effective and efficient state and local policy options, program models, service delivery strategies, and management practices.
- Provide general and specialized information, consultation, training, technical assistance, and professional development support on the full range of policy, program and management issues of concern to the states.

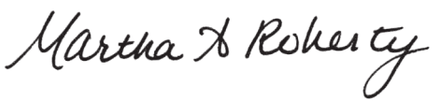
Acknowledgements

This survey represents the culmination of a yearlong project by the National Association of State Units on Aging and is conducted in honor of the 45th anniversary of the association. Roughly every five years the association conducts a survey that examines the state of the state units on aging. The results allow members to take a pulse of the dynamic, national landscape of aging in America, changing roles and responsibilities of state departments, and to analyze how states compare with one another.

We would like to thank the State Units on Aging for completing the detailed survey and for responding to our repeated inquiries checking the results. We recognize the difficult fiscal conditions that many states currently face and the extraordinary effort put forth by state staff to help us complete this effort.

The NASUA Board of Directors Executive Committee, under the leadership of President Patricia Polansky, provided essential direction in this anniversary effort and we would like to extend a special thank you for their guidance. Catherine Rudd served as the senior policy advisor on this project and was ably assisted by Jessica Barker and Bernice Hutchinson.

With appreciation,



Martha A. Roherty
Executive Director
National Association of State Units on Aging

NASUA Board of Directors

2009–2011

Officers:

President:

Irene Collins, Commissioner
Alabama Department of Senior Services
Montgomery, AL

1st Vice President:

James Toews, Assistant Director
Oregon Seniors & People with Disabilities
Salem, OR

2nd Vice President:

Carol Sala, Administrator
Nevada Aging and Disability Services Division
Department of Health and Human Services
Carson City, NV

Secretary:

Maria Greene, Director
Georgia Division for Aging Services
Atlanta, GA

Treasurer:

Charles D. Johnson, Director
Illinois Department of Aging
Springfield, IL

Immediate Past President:

Patricia A. Polansky, Assistant Commissioner
New Jersey Division of Aging & Community Services
Trenton, NJ

Past President:

Kathy Leitch, Assistant Secretary
Washington Aging & Disability Services
Olympia, WA

Regional Representatives:

Region I

Pamela Giannini, Director
Connecticut Bureau of Aging, Community and Social Work Services
Alternate Representative: Diana Scully, Director, Maine Office of Elder Services
(Representing Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont)

Region II

Michael Burgess, Director
New York State Office for the Aging
Alternate Representative: Rossana Lopez Leon, Executive Director, Puerto Rico Governor's Office for Elderly Affairs
(Representing New York, New Jersey, Puerto Rico, Virgin Islands)

Region III

Linda Nablo, Commissioner
Virginia Department for the Aging
Alternate Representative: Gloria Lawlah, Secretary
Maryland Department of Aging
(Representing Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia)

Region IV

Dennis Streets, Director
North Carolina Division of Aging and Adult Services
Alternate Representative: Doug Beach, Secretary
Florida Department of Elder Affairs
(Representing Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee)

Region V

Jean K. Wood, Division Director
Minnesota Aging and Adult Services
Alternate Representative: Sharon Gire,
Executive Director, Michigan Office of Services to the Aging
(Representing Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin)

Region VI

Gary Jessee, Assistant Commissioner for Access and Intake
Texas Department of Aging and Disability Services
Alternate Representative: Lance Robertson,
Director, Oklahoma Aging Services Division
(Representing Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Region VII

Brenda Campbell, Division Director
Missouri Division of Senior and Disability Services
Alternate Representative: Sarah Briggs, Director
Nebraska Health & Human Services, State Unit on Aging
(Representing Iowa, Kansas, Missouri, Nebraska)

Regional VIII

Todd Coffey, Director
Colorado Division of Aging and Adult Services
Alternate Representative: Charles Rehbein, Aging Services Bureau Chief
Montana Office on Aging
(Representing Colorado, Montana, North Dakota, South Dakota, Wyoming)

Region IX

Lynn Daucher, Director
California Department of Aging
Alternate Representative: Noemi Pendleton,
Director, Hawaii Executive Office on Aging
(Representing Arizona, California, Hawaii, Nevada, Guam, Trust Territory of the Pacific Islands, American Samoa)

Region X

Kim Toryanski, Administrator
Idaho Commission on Aging
Alternate Representative: Kathy Leitch,
Assistant Secretary, Washington Aging & Disability Services
(Representing Alaska, Idaho, Oregon, Washington)

KEY FINDINGS

1. The responsibilities and structures of the state units on aging vary widely.
2. The characteristics of the population served by the SUAs continue to diversify, with nearly two-thirds of states serving both the elderly and physically disabled populations regardless of age.
3. Funding from the U.S. Administration on Aging continues to be a less significant source of the State Unit on Aging's total funding.
4. States continue to face extraordinary pressure due to the economic decline.
5. States are preparing for the aging baby boom generation by developing a comprehensive strategy of services for long-term services and supports.
6. States are invested in strengthening the core services of the Older Americans Act and are expanding their own efforts to mirror the federal legislative proposal, *Project* 2020.
7. States are enhancing evidence-based health promotion and disease prevention programs that allow seniors and individuals with disabilities to remain in their homes and communities.
8. States are encouraging community living through the use of various grant initiatives and state funded only programs.
9. States view information and referral as an important core component of the Older Americans Act and continue to expand person centered access to information systems, building on the foundation of the existing information and referral systems.
10. States are expanding their use of technology to improve planning outcomes in their programs.

Executive Summary

The National Association of State Units on Aging (NASUA) has analyzed and reported on the state role in the evolution of home and community based services and support for 45 years. This report continues that strong tradition and builds upon the association's research foundation.

From February through April 2009, NASUA surveyed its members to obtain a snapshot of their work and the current challenges they face. The results provide that snapshot as well as the states' perspective on the evolution of the aging network as it works to redesign the long-term care delivery system. There were 10 themes that emerged from the survey questions asked of the states.

The first finding was that states continue to demonstrate the age old adage that if you have seen one state system, then you have seen one state system. Each of the state structures for delivering home and community based services and supports has been designed to support the needs of that state. The second finding concluded that the role of the state unit on aging continues to evolve to cover additional populations and not just those individuals over 60 years of age. The majority of states now report serving a more diverse clientele of seniors and individuals with physical disabilities. The third finding is that the U.S. Administration on Aging funding designed to support and sustain the aging services program activities continues to diminish in comparison to the growth of the population and other funding sources that create the total funding for the states' efforts. In fact, the AoA funding is supporting less than 30 percent of the overall efforts in the states. The fourth finding is that states across the nation continue to face mounting pressure as the economy continues to decline. Most analysts believe that this tightening within the state budgets will continue for at least two more years, causing additional significant administrative and programmatic cuts. The fifth finding is that states are preparing for the aging baby boom generation by developing a comprehensive strategy of services for long-term services and supports. This compelling imperative is driving change in planning and systems development to embrace a more complex and diverse population that states will serve. The sixth finding is that delivering core services of the Older Americans Act continues to be a central mission for state units on aging. While Older Americans Act funding has not kept pace with the demands, the core service package remains relevant to meeting the needs of older Americans. The seventh finding is that states are enhancing evidence-based health promotion and disease prevention programs that allow seniors and individuals with disabilities to remain in their homes and communities. The survey results indicate in our eighth finding that states continue to encourage community living though the use of various grant initiatives and state funded only programs. The ninth finding is that states continue to expand their person centered access to information systems, building on the foundation of existing information and referral systems. Finally, states continue to expand their use of technology to improve planning outcomes in their programs.

This report is based on 52 responses received from the states, the District of Columbia and a partial response received from the Northern Mariana Islands.[1]

[1] Pennsylvania and Alaska provided partial responses to the survey. American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands did not respond to the survey.

Policy Context

The Older Americans Act of 1965 (OAA) provides the framework and authority for the establishment of the national network of federal, state, and local agencies that plan for and provide services to older adults (those at least 60 years of age).[2] The partners that make up the National Aging Services Network are the U.S. Administration on Aging (AoA), the 56 State Units on Aging (SUAs), the 629 Area Agencies on Aging (AAAs), the 244 tribal organizations, 29,000 service providers, and a multitude of volunteers in communities throughout the nation. These network partners support the desire of the populations served to live with dignity and independence in their homes and communities. Since 1965, the demographics of the country have changed dramatically. The baby boomer population is aging and there is a trend of lower death rates at older ages.[3] By 2020, almost one in six individuals will be age 65 and older.

Over time, while funding for aging services has increased, so have expenditures and the eligible populations to be served. Total expenditures[4] for services provided increased by 63 percent between 2000 and 2008, from $2.097 billion to $3.428 billion. At the same time, the numbers of service units increased for some services (personal care and case management, and, following an eight year decline, home delivered meals), while decreasing for others (congregate meals and transportation). One explanation for the decrease in transportation units is the substitution of the purchase of bus passes for the direct provision of transportation. Transportation per unit cost nearly doubled, reflecting the increasing costs of fuel and the need to find other cost effective alternatives for providing this necessary service. Costs per unit for other services increased as well (personal care, case management, information and assistance).[5] Some of these increased costs per unit can be explained by inflation. However, in many instances, the type of services referenced here have become more complex, reflecting the intricate needs and expectations of clients aging in place as well as the more sophisticated and detailed services now offered. In contrast, when measured in calendar year 2000 dollars, the per unit cost of a home delivered meal increased only by fifty cents.[6]

In 2000, the national average cost to provide a home delivered meal was $3.71, a remarkable achievement in light of the importance of nutrition in the lives of older adults and the number of people being served. In 2008, the national average cost of providing home deliv-

---

2. The OAA defines "older individual" as one who is 60 years of age or older. See Section 102(a)(40) of the OAA.

3. An Aging World: 2008 *http://www.census.gov/prod/2009pubs/p95-09-1.pdf*

4. Includes federal appropriation, state shared and other funding sources as reported by individual states through annual State Program Reports filed with the U.S. Administration on Aging.

5. See Aging Integrated Database (AGID), State Program Reports, *www.aoa.gov* and summary tables found in appendix of this report.

6. CPI Inflation Calculator, Bureau of Labor Statistics, U.S. Department of Labor, *http://www.bls.gov/data/inflation_calculator.htm*

ered meals was $5.14, an even more remarkable feat, factoring in inflation, reduced resources of aging programs and the number of meals delivered.

Many challenges and opportunities face the network as increasing numbers of new clients seek long-term services and supports in the community, rather than in institutions. The aging network itself is in a period of transition as it moves away from the focus on institutional care and implements innovative systems that will provide real options for home and community based services for older adults and, increasingly, individuals with disabilities.

Finding 1: The responsibilities and structures of the state units on aging vary widely.

State Units on Aging are agencies of the 56 state and territorial governments officially designated by governors and state legislatures to administer, manage, design and advocate for benefits, programs and services for the elderly and their families and, in many states, for adults with physical disabilities.

State Units on Aging vary greatly in their organizational structure, leadership, staffing, budgets, and services. Just over 70 percent of state units are located within a larger umbrella administrative agency within state government.[7] For example, many SUAs are located within human services agencies, state health departments or the welfare department. Nearly 25 percent of the states function as an independent agency within the state government and four percent of the state unit on aging departments are within a board or commission.

For the state units on aging that function within a larger umbrella agency, 65 percent of the units are located within the human services department, followed by 23 percent of the units being located within state health departments. (See Appendix, Table 1 for state specific information.)

Due to the important role that the aging constituency plays in elections, it has become increasingly common to have a political appointee directing state aging programs. Half of the state unit directors are appointed directly by the governor to their leadership role and nearly 40 percent more are appointed by the umbrella agency head, who is appointed by the governor. This direct connection to the governor makes the position of state unit on aging director more visible and political than some of the other human service agency departments.

Despite being appointed by the governors, a surprisingly high number of state aging heads report to umbrella agency leadership rather than directly to their governor. Only 32 percent of the state unit on aging directors report directly to the governors. One state indicated that it reports to a board or commission on aging. (See Appendix, Table 2 for state specific information.)

---

7. The term "umbrella agency" is a descriptive term intended to capture those organizational structures where an administrative agency is made up of or includes a number of agencies. These agencies usually have some relationship to one another in the work that they do. For example, the state Medicaid agency and the state unit on aging may be separate agencies, but structurally, in some states, they may be part of the same, larger agency.

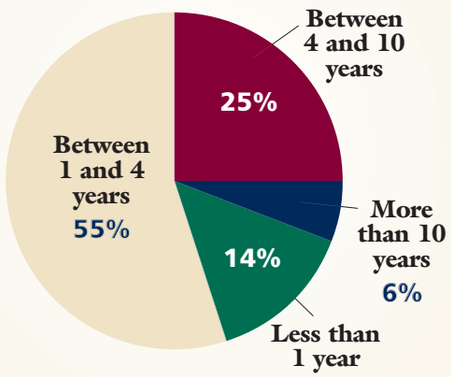
The titles of the leaders of the state units also vary greatly. The most common title that states use for their aging leader is Director of the State Unit. The second most common title for leadership is Commissioner on Aging which is used in 17 percent of the states. Other titles used in the states include executive director, secretary, administrator, assistant director, bureau chief, manager, and assistant secretary.

Because many of the state aging unit leads are appointed by governors and have direct political connections, their tenure is shorter and tends to correspond with the election cycle. Nearly 70 percent of state unit directors report serving in their position for less than four years and only six percent of the states have an agency head with more than 10 years of experience.

Providing leadership within the state on aging issues is viewed as the major job responsibility for many of the state aging directors. State unit directors indicate their primary functions include:

- Providing state leadership
- Managing relationships (with aging network partners, state legislators, and other state agencies)
- Setting the state's aging agenda
- Leading statewide strategic planning efforts
- Internal state unit management

How long has the SUA official served in this position?



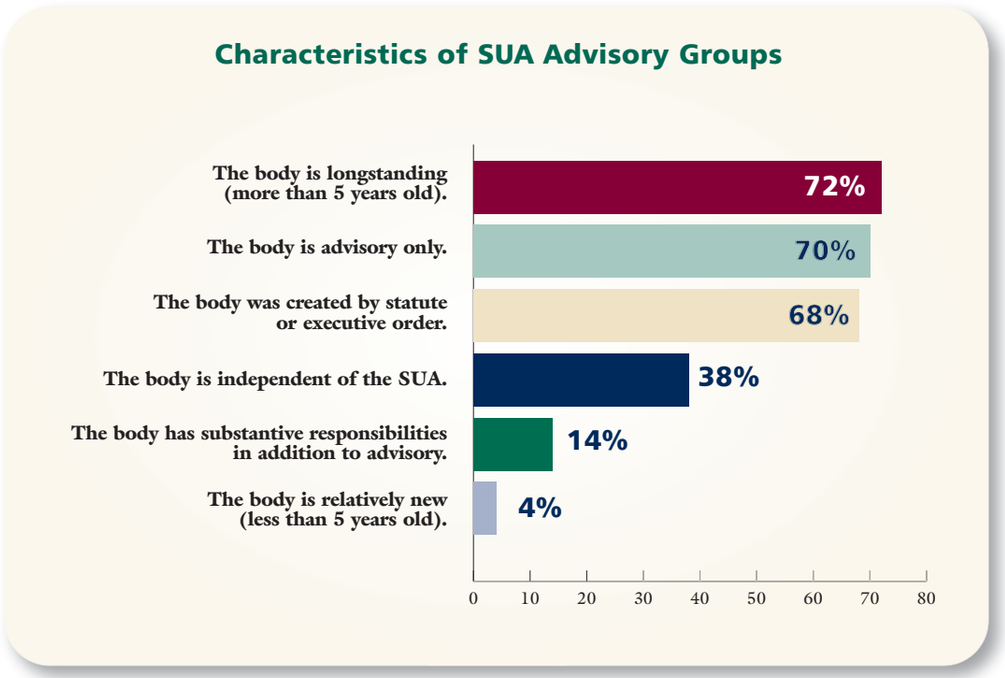
Advising the State Unit

Nearly every state reported that it has an advisory panel, council, or other body that assists the state unit in developing policies that inform state leaders about aging policy.

The majority of states report that the use of the advisory boards has been a long standing policy within their units, with 70 percent of states reporting that the boards have been in place for more than five years. An equal number of states indicated that the boards were officially created either by executive order or statute.

The role of the advisory councils varies across the states. Nearly 40 percent of the states indicated that the advisory board is independent of the state unit on aging and 70 percent of the states reported that the board acts in an advisory capacity only. Just over 10 percent of the states indicated that the advisory board has more substantive responsibilities. For example, in Arizona, the Governor's Advisory Council on Aging (GACA) monitors and develops program

policies that affect older adults. The GACA also holds at least one major event each year, such as the Governor's Conference on Aging or Senior Action Day with the Legislature.[8] In Michigan, the Commission on Services to the Aging not only advises the governor and the legislature on state policy for services to older adults, but also participates in the preparation and approval of the state plan, as well as the budget required by the Older Americans Act. The Michigan Commission also has authority to enter into contracts necessary to perform its duties.[9] In Tennessee, the Commission on Aging and Disability is the designated state agency on aging. In Minnesota, the Board of Aging administers and makes policy relating to all aspects of the Older Americans Act.[10]



Staffing the State Unit

Just as the role of the state unit on aging varies greatly across the nation, the size of the state units on aging also varies from the very small agency staff of less than 10 employees to very large offices of more than 100 employees. Nearly half of state units report having staff sizes larger than 75 employees.

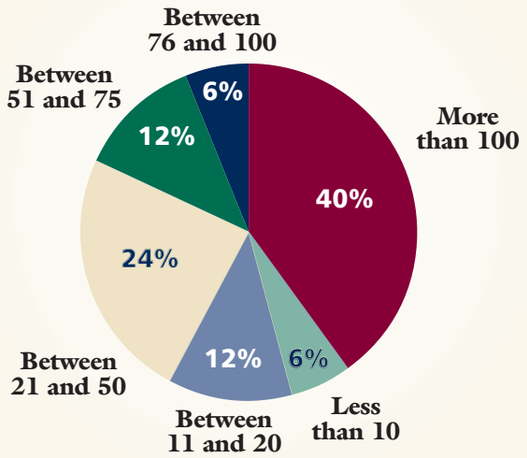
---

8. See *http://www.azgovernor.gov/gaca/* accessed July 28, 2009.

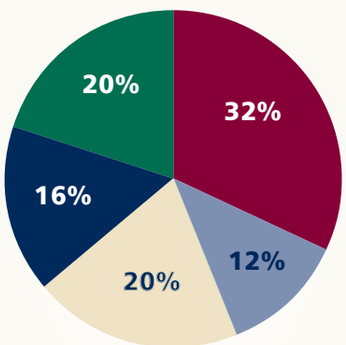
9. See Older Michiganians Act Section 400.584 *http://www.legislature.mi.gov/(S(zxhurhewdlallo55xtydlo45))/documents/mcl/pdf/mcl-Act-180-of-1981.pdf* accessed July 28, 2009.

10. See 2008 Minnesota Statutes section 256.975 *https://www.revisor.leg.state.mn.us/statutes/?id=256.975&year=2008&keyword_type=all&keyword=minnesota+board+on+aging*

Size of the State Unit on Aging Staff



What percentage of your state unit staff is eligible for retirement within the next five years?



- Less than 5%
- Between 6% and 10%
- Between 11% and 15%
- Between 16% and 25%
- More than 25%

Nearly half of all state unit employees have been with the state for between four and ten years, and nearly 50 percent of all state unit staff have been with the state units for over 10 years. As a result of the increasing tenure of the state staff, many of the state staff are eligible, or will soon be eligible, for retirement from the state. According to over 30 percent of survey respondents, more than a quarter of their staff will be eligible to retire from state government within the next five years. When survey respondents with 25 percent or more of staff eligible for retirement in the next five years were asked whether they had a succession plan in place to replace the workforce, slightly more than half of the states indicated that they had a plan to deal with the aging state workforce. Another 20 percent of states not anticipating a large number of retirees within the next 5 years also have succession plans in place.

Staff Training

Training for staff is seen as key for nearly all of the state unit directors. Training is provided to state employees in a variety of ways, including formal classroom training, on-the-job

training, job shadowing, annual skills training, and relevant conference attendance. Web-based training is also available in the areas of compliance, employee orientation, health and safety, IT/desktop, and supervisory skills in many states. Some states reported that there is one state agency that has the responsibility for providing training for all state employees on a wide range of subjects. Several states reported that the staff is trained internally in the state unit while others indicated that they seek out opportunities for a broader national training for their staff. States are taking advantages of various opportunities and locales for training. States indicated that training can be provided on-site within the state agency, in a sister state agency, or on-line. In addition to training opportunities provided by organizations such as NASUA, several states indicated that they pursued training opportunities with local universities. Many states provide training to their staff at their statewide aging conferences.

Training for state staff includes a wide range of operational topics such as grants management, personnel management, facilitation skills, systems analysis, management training, conflict management, as well as leadership training and development. States are also providing direct service training to staff in programs including Medicaid waivers, elder abuse prevention, Health Insurance Portability and Accountability Act of 1996 (HIPAA), universal precautions, identifying potential suicide, caregiver training, case management, cultural competency, training on advance directives, and guardianship programs.

States also indicated recognition of the importance of providing opportunities for staff with professional licensures to maintain those credentials and seek programs that will provide those services in fields such as social work, law, and nursing.

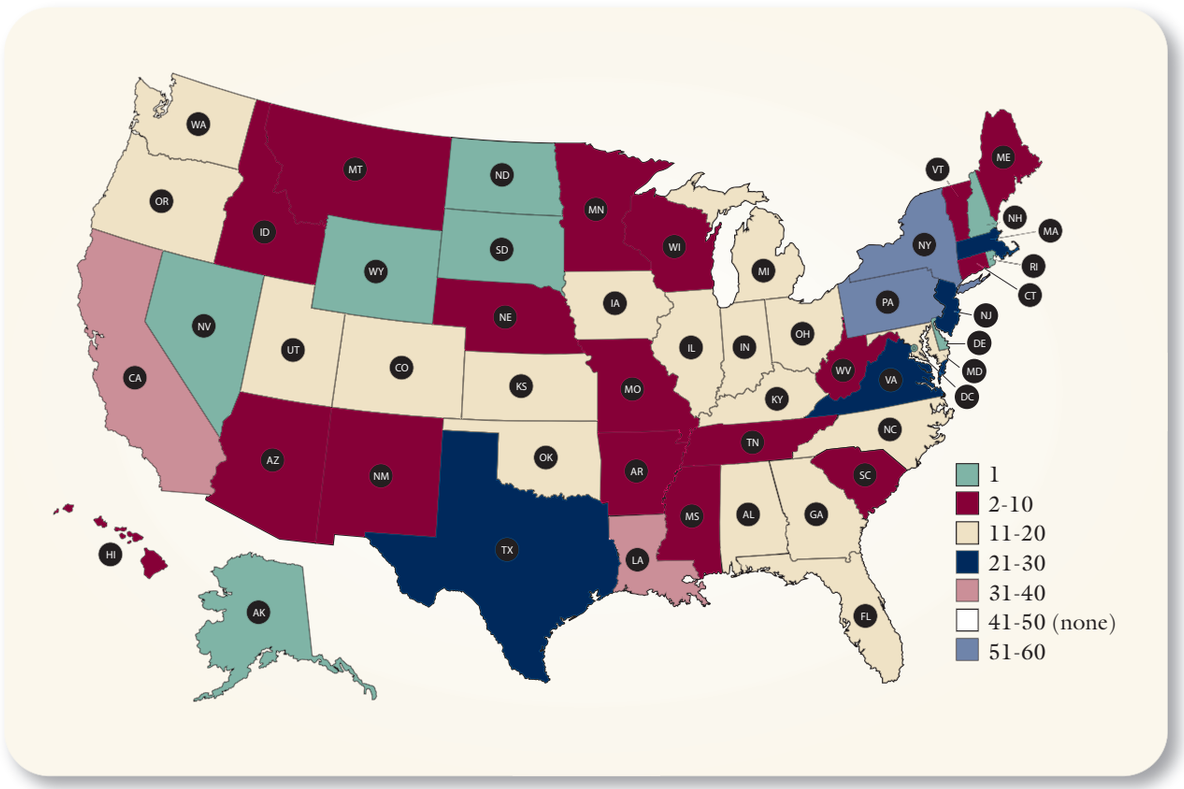
Administering the Programs

The survey asked how the state unit administers it programs. There are three basic program administration models: multiple-sub state planning and services areas, statewide, and county based. For purposes of administering human services, a planning and service area is designated by the state after considering a number of factors, including geographical distribution of older individuals within the state, the incidence of the need for supportive services, nutrition services, multipurpose senior centers, legal assistance, the distribution of older individuals who have greatest economic and social need residing in such areas, the distribution of resources available to provide services, boundaries of existing areas within the state which were drawn for purposes of planning and administering supportive services, the location of units of general purpose local government within the state, and any other relevant factors.[11] The majority of states administer their programs through multiple sub-state planning and service areas.

The map on page 8 (Map 1: Number of Planning and Services Agencies in Each State) shows a delineation of the number of planning and service areas within the states.

[11] See Section 305(a)(1)(E) of the Older Americans Act.

Map 1: Number of Planning and Services Agencies in Each State



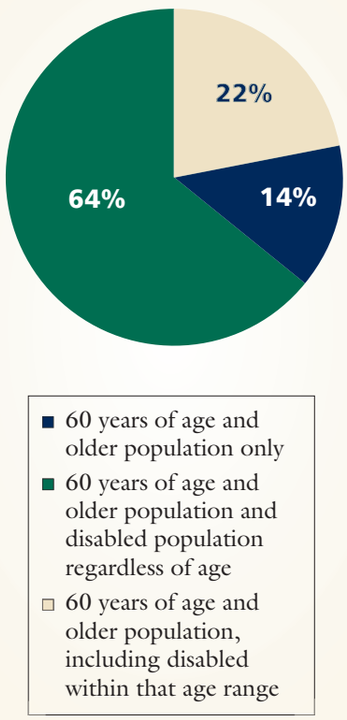
Finding 2: The characteristics of the population served by the SUAs continue to diversify, with nearly two-thirds of states serving both the elderly and physically disabled populations regardless of age.

According to 2008 State Program Reports (the most recent year for which data are available), nearly 10 million clients were served by OAA Title III social and nutrition services.[12] This figure does not include the clients receiving services through non-OAA programs administered through the state agency.

For the OAA programs, approximately 3 million people received registered services during FY 2007.[13] This represents six percent of the eligible population (60 years of age and older) of 52 million. However, almost 20 percent of the eligible population received some service supported by Title III of the OAA.[14] In addition to registered services, other services available under Title III include transportation, legal assistance, nutrition education, information and assistance, and outreach.

In addition to the traditional Older Americans Act programs, state units are increasingly expanding the populations they serve beyond those traditionally eligible for OAA services. Nearly 65 percent of the states are serving not only individuals 60 years of age and older, but also adults with disabilities regardless of age. Several states indicated that in addition to adults with physical disabilities, they are now serving clients with mental retardation/developmental disabilities. Just 14 percent of states indicated that they are limited to serving only older adult clients.

Characteristics of population served



12. U.S. Administration on Aging, 2008 State Program Reports *http://www.data.aoa.gov/*

13. Registered services under Title III of the OAA are personal care, homemaker, chore, home delivered and congregate meals, adult day care/health services, case management, nutrition counseling and assisted transportation. See the U.S. Administration on Aging, Aging Integrated Database (AGID) website at *http://198.136.163.234/default.asp?keep=0*

14. Numbers of those served and definition of registered services are from the U.S. Administration on Aging, Aging Integrated Database (AGID) website at *http://198.136.163.234/default.asp?keep=0.* 2007 population figures were obtained from *http://www.aoa.gov/AoARoot/Aging_Statistics/Census_Population/Population/2007/2007-Natl-Pop-Est.html.*

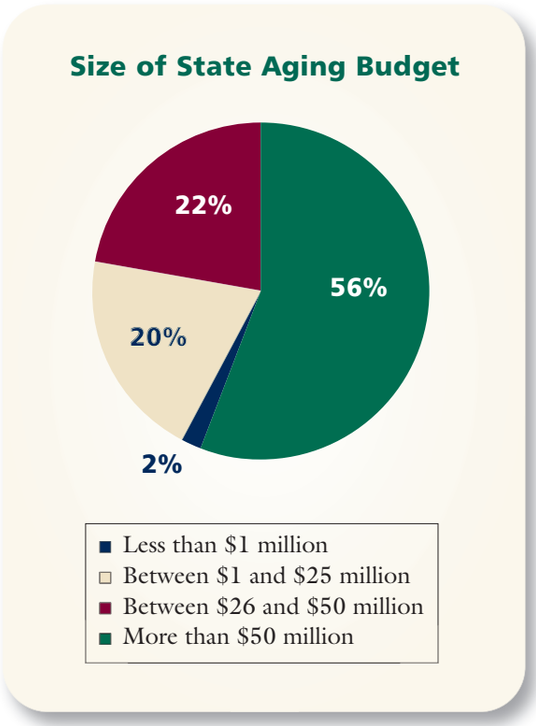
Several programs stand out for serving clients younger than 60 years old: the Caregiving Program, the Foster Grandparent Program, Program of All Inclusive Care for the Elderly (PACE), Lifespan Respite, Alzeheimer's Disease Initiative, and Title V employment programs which require services to be provided to eligible recipients 55 and older. States with strong single entry point systems, such as aging and disability resource centers, provide information about long-term services and supports to anyone who inquires. Several other states indicated that they manage the adult protective service program which serves all adults over the age of 18.

States with large tribal populations indicated that tribal programs serve all individuals 55 and older. States administering funds through the Social Services Block Grant program reported that they are required to serve citizens of any age.

Finding 3: Funding from the U.S. Administration on Aging continues to be a less significant source of the state unit on aging's total funding.

Over 50 percent of states have state budgets that are larger than $50 million. The state budgets of the state unit on aging programs include many programs outside of the Older Americans Act funding. In fact, for some states, the OAA is increasingly becoming a less significant source of the SUA's total funding. On average, 30 percent of the SUA budget comes from the OAA.[15] A quarter of the states report that OAA funding is 10 percent or less of their budget. Nearly three-quarters of the SUAs report that Medicaid funding is part of their budget, with 20 percent reporting that it is the source of funding for more than half of their budget.

There are many other sources of funding for state units on aging in addition to the OAA and Medicaid. Those other sources include state appropriations, Social Services Block Grant funding, and foundation or private grant funding. In addition, several states indicated that



[15] This finding is the same as when the states were surveyed five years ago. See "40 Years of Leadership: The Dynamic Role of State Units on Aging", NASUA, September 2004.

they have earmarked revenue sources from income tax check-offs, licensing fees, or the state lottery that support all or part of the aging programs in their states. (See Appendix, Table 3 for state specific information).

Cost Sharing and Voluntary Contributions

Another potential source of revenue is cost sharing from those clients that can afford to pay for services.[16] The OAA has strict prohibitions on cost sharing for services it funds. Cost sharing is prohibited for information and referral/assistance, outreach, benefits counseling, care coordination, ombudsman, elder abuse prevention, legal assistance, other consumer protection services and congregate as well as home delivered meals.[17] Further, a state must have a cost sharing plan in place whose detailed requirements are intended to ensure that cost sharing does not decrease participation in services. A minority of states, less than one quarter, currently have a cost sharing plan for OAA services. Those states that have not implemented cost sharing report various reasons for not having done so. After simply not having developed a plan, the most common reason is that the administrative burden associated with compliance is expected to exceed the amount states anticipate collecting. In contrast, nearly half the states impose cost sharing for non-OAA services. Solicitation of voluntary contributions for OAA services is fairly common. Only three states report that they do not solicit voluntary contributions for any services. (See Appendix, Tables 8 and 9 for state specific information.)

Finding 4: States continue to face extraordinary pressure due to the economic decline.

The current economic crisis continues to force many state aging directors to grapple with difficult decisions on budget cuts and reductions in services. Not since the late eighties has the economy looked as sluggish. The most challenging times in the economy increase demand for state planning, budgeting, and monitoring for services that are delivered at the community level on everything from providing assistance with heating bills to providing home delivered meals as well as all types of home health supports.

The National Association of State Units on Aging (NASUA) surveyed its members four times between June 2008 and June 2009 to gauge the impact of the economic downturn on aging services. Over 50 percent of states responding to the NASUA survey report a budget shortfall for FY09. Forty percent of the states indicated that their budgets will be balanced for FY09, while just one state is reporting that it will have a surplus for FY09. Conditions for FY10 appear to be on a similar course with just slight variations in the number of states reporting that they will have budget shortfalls.

---

16. Private paying consumers represent the majority of the U.S. population and are a potential revenue source. See NASUA Issue Brief, *Supporting the Information Needs of Private Paying Consumers: Examining the Capacity of Aging Network Consumer Information Programs,* June 2009.

17. See Section 315(a)(2) of the Older Americans Act.

Nearly 60 percent of the states reported that they are being asked to reduce their agency's budget for both FY09 and FY10. Nearly 12 percent of the states indicated that while they have finalized their adjustments for FY09, they are not yet sure what type of adjustments will be necessary for the FY10 budget.

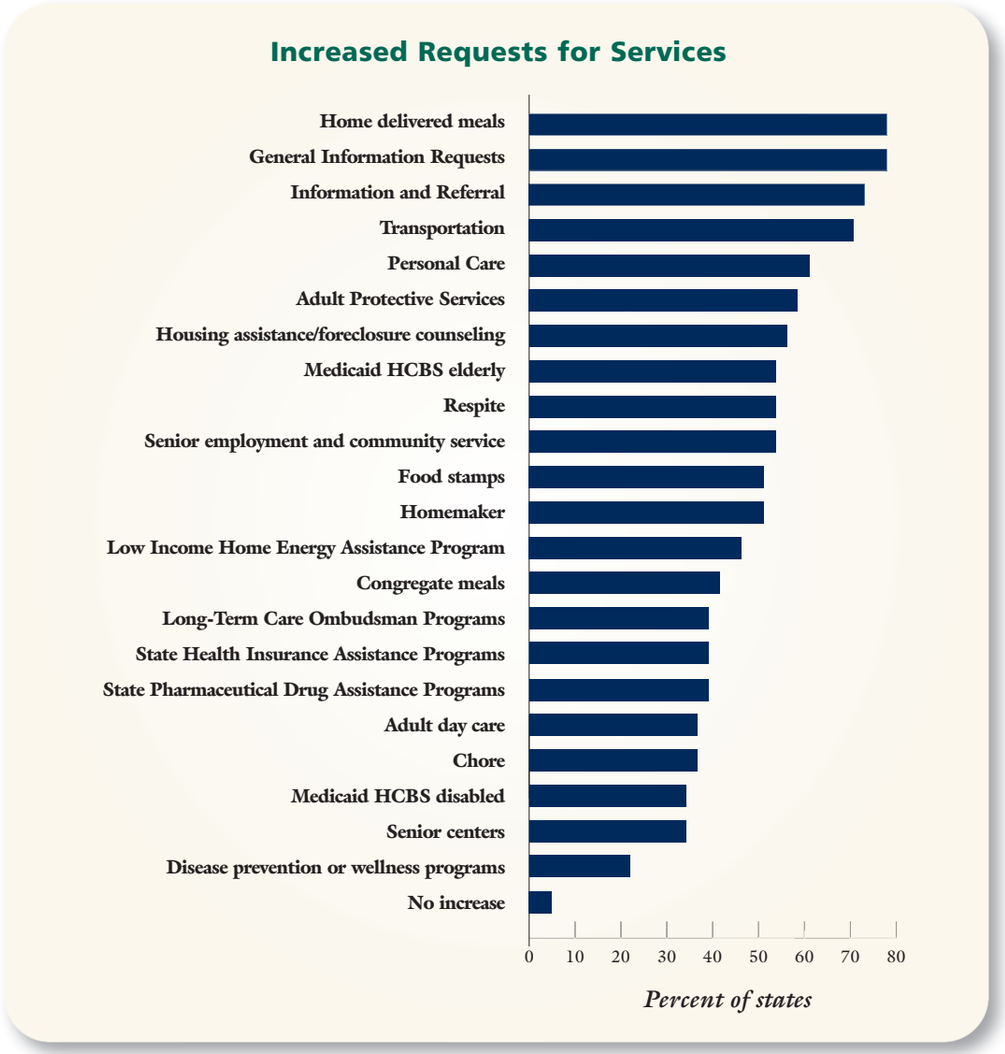
Survey respondents were asked to list the extent of the budget cuts that they were being asked to make for FY10. At the point that the survey was taken, 50 percent of the states believed that they would be asked to make adjustments to their state budgets of less than 5 percent. It is important to remember however, that even this relatively minor adjustment of 5 percent can be difficult to manage given the number of consecutive years that the states have been asked to make similar downward adjustments.[18] A relatively large number of states are already reporting larger cuts will be necessary in order to balance the FY10 budgets, with over 30 percent indicating cuts of between 6-10 percent, and nearly 12 percent indicating that they will have to make cuts of between 11-15 percent for FY10.

As in past surveys, the governors and state unit on aging directors are trying to focus the vast majority of their cutting efforts on areas that will not affect direct services. In FY10, 81 percent of the states that will cut their budgets are reporting that they will cut back on administration. The second largest area for cutting for the state units on aging programs are state funded programs for older adults. Nearly 65 percent of states indicated that they will cut their state funded programs in this area as a way to balance their FY10 budgets. Nearly 30 percent of the states reported that they will perform across the board cuts to all programs in an effort to spread the burden. An equal number of states indicated that they will cut state only funding for individuals with disabilties. Older Americans Act programs will not be spared from budget cuts, as 30 percent of the states are already reporting that they will cut OAA funded programs for FY10.

One way that states continue to manage the budget crisis is to have waiting lists for certain services. Services with waiting lists continue to grow as the economic climate worsens. Over 80 percent of the states reported that they are projecting that waiting lists will continue to grow for services in FY10. Nearly 80 percent of the states indicate that they now have waiting lists for home delivered meals. Over 50 percent of the states report having waiting lists for personal care, homemaker services, and respite care. States continue to report increasing numbers of requests for many types of services.

---

[18] Some states reported they were in their fourth consecutive year of budget cuts. See *The Economic Crisis and Its Impact on State Aging Programs,* NASUA, December 2008.



Finding 5: States are preparing for the aging baby boom generation by developing a comprehensive strategy of services for long-term services and supports.

SUAs administer a variety of programs and services for older persons and persons with disabilities. Title III of the OAA provides grants for four service programs: supportive services and senior centers; nutrition (home delivered and congregate meals); disease prevention and health promotion services; and family caregiver support. Title V of the OAA creates the Senior Community Service Employment Program (SCSEP). Title VII addresses elder rights protection activities by authorizing an ombudsman program; programs for the prevention of elder abuse, neglect, and exploitation; and state legal assistance development programs.

In addition to these services, more than half of the SUAs have the responsibility for administering Medicaid home and community based services (HCBS) waivers. The Social Security Act authorizes the Secretary of Health and Human Services to "waive" certain requirements of the Medicaid program in order to allow states flexibility to test policy innovations (Section 1115), implement managed care systems that limit freedom of choice (Section 1915(b)), and offer long-term care services in community settings rather than in institutions (Section 1915(c)).[19] The SUAs typically operate 1915(c) waivers, although some offer combined Section 1915(c) and (b) waivers. In addition, at least one state provides its Medicaid home and

[19] See "Medicaid State Waiver Program Demonstration Projects—General Information" Overview *http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp*

community based services program under Section 1115 authority. The provisions of the Social Security Act that may be waived under a Section 1915(c) waiver are:

- Statewideness (Section 1902(a)(1)). This allows a state to target particular geographic areas where the need is greatest, or where providers are available.
- Comparability of Services (Section 1902(a)(10)(B)). This permits targeting certain individuals, such as those most at risk of institutionalization. With this requirement waived, states are not required to make waiver services available to all individuals eligible for Medicaid.
- Income and Resource Rules (Section 1902(a)(10)(C)(i)(III)). Allows waiver services to be offered to individuals who would otherwise be eligible only for institutional services often due to excess income and resources.[20]

The most commonly offered services under the Medicaid HCBS waivers are personal assistance and case management. Three-quarters of the states also operate state funded programs offering community based long-term services and supports. Case management and respite are the services most often offered by the states in their non-Medicaid HCBS programs. Tables 4 and 5 identify which states operate Medicaid HCBS waivers, the types of Medicaid HCBS waivers they operate, and which states operate state funded HCBS programs. Tables 11 and 12 identify, by state, specific HCBS services offered through the Medicaid and state funded HCBS programs.

An important priority for the SUAs is designing their delivery systems for long-term services and supports to develop a more robust community based services model, rather than traditional institutional care. More than three-quarters of the states report that they have either redesigned their long-term services delivery systems or that they are in the process of making changes to achieve a more community based focus. Nearly 90 percent of the SUAs are responsible for planning and development of long-term care policy in their states. (See Table 6 of the Appendix for detail by state of the long-term care resources managed by the SUA.) States are relying on a number of mechanisms to achieve a redesign, including Medicaid HCBS waivers, Money Follows the Person grants, Medicaid Transformation Grants and state funded initiatives.

The Deficit Reduction Act of 2005 (Public Law 109-171) made two significant changes to the Medicaid Act to encourage redesign. The first was that states were given the option to establish a home and community based services program for the elderly and disabled under the state plan rather than a waiver (Section 1915(i)). The second permits states to offer a self-directed personal assistance services option, again, without a waiver (Section 1915(j)). To date, three states (Nevada, Colorado and Iowa) have received approval for amendments to their state plans under Section 1915(i). Seven states (Alabama, Arkansas, California, Florida, New Jersey, Oregon and Texas) offer self-directed personal assistance services under Section 1915(j).

---

[20] Id. HCBS Waivers—1915(c).

Two other significant features that apply to waivers that do not apply to state plan amendments are that waivers are time limited (initial three year approval, with subsequent five year renewals for Section 1915(c)) and states must demonstrate that waivers are cost-effective (expenditures for waiver participants can be no more than they would have been without the waiver).[21] These provisions do not apply to state plan amendments.

Beginning in 1992, OAA Title IV Alzheimer's demonstration grants were released to states to develop innovative program models and approaches to serving individuals with Alzheimer's disease and their families. The primary focus of these grants was in the areas of program development, service delivery, and information dissemination. The program has evolved into the Alzheimer's Disease Supportive Services Program (ADSSP) and now provides competitive awards to states to expand the availability of community-level supportive services for persons with Alzheimer's Disease and related disorders (ADRD) and their caregivers. Currently, 9 states have evidence-based grants under which they will demonstrate how existing evidence-based interventions can be translated into effective supportive service programs. Nineteen states received grants through which they will explore approaches to improving delivery of supportive services at the community level to those with Alzheimer's disease and their caregivers.[22]

Consumer direction in OAA programs reflects SUA efforts to enhance consumer choice through services provided under the Older Americans Act. Consumer direction describes programs that offer maximum choice and control for people who need help with daily activities and includes a range of approaches that permit consumers to decide what services they will use, when and how services will be provided, and who will provide the services (which may include neighbors, friends and family members). Consumer directed services include, but are not limited to, "cash and counseling" programs that offer cash or a voucher to the consumer.

A total of 16 SUAs offer consumer direction options in one or more of their OAA programs. The most common way in which consumer direction is offered through the Older Americans Act is in providing respite care or family caregiver support, but home care/homemaker services, transportation, nutrition and adult day services are also consumer directed in a few states. Over half of the states offer consumer direction in state-funded and Medicaid HCBS programs. State specific information is in Table 7 of the Appendix.

One of the issues for implementing self-direction faced by states is how to offer financial management services (FMS). FMS is a critical support for managing payroll, applicable tax withholding and the purchase of individual goods and supports. There are four recognized models for FMS. More than half of the states are using the vendor/fiscal employer agent model, which is typically operated by an outside vendor. All of the models are subject to specific IRS rules. State specific information about the models selected by those states offering self-direction is in Table 13 of the Appendix.

---

21. The state chooses whether to calculate cost effectiveness at the individual service plan level or in the aggregate for all individuals on the waiver.

22. See *http://www.aoa.gov/AoARoot/AoA_Programs/HCLTC/Alz_Grants/index.aspx*

Finding 6: States are invested in strengthening the core services of the Older Americans Act and are expanding their own efforts to mirror the federal legislative proposal, *Project* 2020.

By 2020, almost one in six individuals will be age 65 and older. The fastest growing segment of the aging population is individuals over 85, the most vulnerable older adults who tend to need long-term care and whose numbers are expected to double by 2020. These demographic trends make the country's current strategy for financing long-term care costs through the Medicaid and Medicare programs unsustainable.

Project 2020 is an incremental, coordinated national long-term care strategy that will generate savings in Medicaid and Medicare at both the federal and state levels while enabling older adults and individuals with disabilities to get the support they need to successfully age in their own home and community. This initiative has been developed by NASUA and the National Association of Area Agencies on Aging (n4a) and builds on the historic role of State Units on Aging (SUAs), Area Agencies on Aging (AAAs) and Title VI Native American aging programs (Title VIs). It is a comprehensive and integrated approach to enabling the elderly and individuals with disabilities to make their own decisions, to take steps to manage their own health risks, and to receive the care they choose in order to remain in their own homes and communities for as long as possible, avoiding unnecessary and unwanted institutionalization.

The strategy consists of a three-pronged approach that will allow communities to provide services to this growing population at a lower cost to consumers and to Medicaid and Medicare. Funding would be administered by AoA through performance-based grants to the aging network to implement consumer-centered long-term care strategies authorized in the 2006 reauthorization of the Older Americans Act. The three components are:

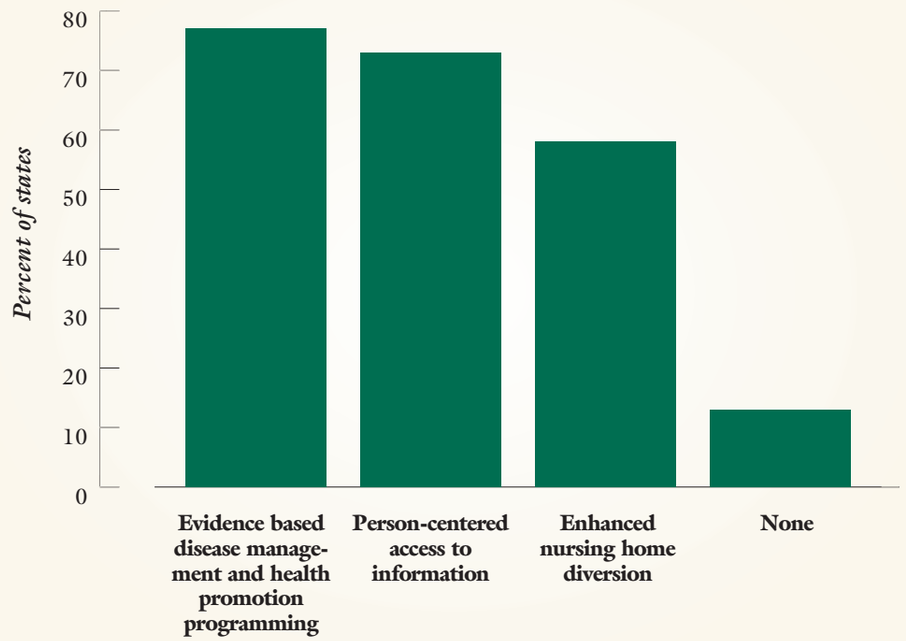
- **Person-centered access to information about long-term services and supports—**The lack of quality information about privately and publicly funded community based long-term care services is a significant factor in the over utilization of institutional services. Through the use of a single entry point system, such as the Aging and Disability Resource Centers (ADRCs) developed by the AoA and CMS, the Aging Services Network can provide individuals and their families with streamlined, comprehensive and reliable information that will help consumers make informed decisions about their long-term care. This component builds on the current nationwide network of SUAs and AAAs.
- **Cost-effective and proven evidence-based disease management and health promotion activities—**Health and behavioral science has developed significant interventions for evidence-based disease prevention and health promotion that result in improved health and well-being of elderly participants, and do not require application through expensive medical and health care settings. Through this program component

delivered at the community level, the Aging Services Network can assist individuals with interventions such as falls prevention, physical activities, nutrition counseling, chronic disease self-management and medication management.

- **Enhanced nursing home diversion services—**Eligible individuals participating in this program component will be pre-screened and receive intense case management through the single point of entry system to help coordinate personalized services and supports that will allow them to remain in their homes. This needs-based portion of the program will provide home and community based services such as home-delivered meals, homemaker services, personal care, medical transportation, home modification, assistive technology and adult day care. These traditional services provided by the Aging Services Network, when coupled with case management and the flexibility of consumer-directed models of care, provide an excellent alternative to nursing home care.

These components have been tested and refined through demonstration projects funded by AoA, the Centers for Medicare and Medicaid Services, and HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE). In cooperation with SUAs and AAAs, best practices in community based long-term care have been developed and demonstrated to reduce the need for more expensive institutional care and prevent "spend down" to Medicaid for people of all ages with disabilities.

State Implementation of *Project* 2020 Components



The *Project* 2020 components are already being implemented in the states. Nearly 80 percent indicated that they currently administer evidence-based disease management and health promotion activities. (See Table 10 in the appendix for state specific information on which evidence based programs have been implemented in which states.) Just over 70 percent of the states also indicate that they administer person-centered access to information programs, while just under 60 percent of the respondents indicate that they offer the enhanced nursing home diversion program. The respondents were not asked if they were receiving AoA grants to administer these programs, but rather if they were administering the programs in any fashion. Many of the states are administering the programs with the use of grant dollars or with foundation grants.

Finding 7: States are enhancing evidence-based health promotion and disease prevention programs that allow seniors and individuals with disabilities to remain in their homes and communities.

Nearly 80 percent of the states indicated that they are administering evidence-based disease management and health promotion activities. Evidence-based programs are interventions based on evidence that is generated by scientific studies published in peer-reviewed journals. Table 10 provides a detailed state by state list of the programs that are in use by the SUAs. The two most common programs that the states are using include the falls prevention program, *A Matter of Balance,* and the chronic disease program, *Chronic Disease Self Management Program*. Other programs that states are providing include programs on nutrition, depression, and substance abuse prevention.

Individuals will be assisted in interventions at the community level on programs such as falls prevention, physical activities, nutrition, chronic disease management, and medication management. This component of *Project* 2020 will build on the current Healthy Aging program. Under *Project* 2020, states would have the flexibility to choose among chronic disease self-management programs, falls prevention, and other programs.

Chronic Disease Self-Management Programs (CDSMP)—CDSMP programs are patient education courses led by specially trained leaders. The programs concentrate on patients' self-defined needs and self-management options for common problems and symptoms. Patients learn skills that help them to maximize their functioning and ability to carry out normal daily activities. The cost associated with this program is estimated to be $197 per person in 2009 based on current AoA funded initiatives.

Falls Prevention Programs—Programs such as *Matter of Balance* provide individuals with a plan that is designed to help minimize elders' fears of falling. More than one third of elders over 65 fall each year, and in half of the cases the falls are recurrent.[23] The cost associated with this program averages $87 per participant based on the costs of the *Matter of Balance* program currently in operation.

States report savings for the evidence-based prevention and health promotion programs on reduced hospital admissions, emergency room visits, and other medical cost savings associated with injury.

Finding 8: States are encouraging community living through the use of various grant initiatives and state funded only programs.

States reported using a variety of ways to assist those seniors and individuals with disabilities who are most at risk of nursing home placement and eventual spend down into the Medicaid program and to encourage community living. Medicaid spend down occurs when medical expenses, both acute and long-term care, cause an individual to spend their financial assets down to Medicaid eligibility ($2,000 for singles and between $3,000 and $95,100 for couples where the spouse in the community of someone in a nursing home [and in some states, the community] may retain half of their assets up to the larger amount, plus another $2,000 for the spouse in the nursing home).

Spend down happens relatively quickly in the nursing home with between one-quarter and 36 percent of residents spending down during the first three months of a nursing home stay, and one-half to three-quarters within the first year. It appears to take somewhat longer in the community with 38 percent of individuals spending down in the first year. For those that start out in the community and subsequently spend down, spend down frequently results from a nursing home admission.[24]

There are a variety of federal and state initiatives aimed at this vulnerable population. Over 60 percent of the states indicated that they have programs aimed at this special population. Some of the examples of state funded programs for home and community based programs include case management, respite programs, personal assistance, transportation services, habilitation services, foster care, behavioral supports, home modifications, purchasing of supplies and equipment, home delivered meals, and homemaker services. For a comprehensive list of all programs see Table 12.

---

[23] Tinetti ME, Speechley M, ginter SF, Risk factors for falls among elderly persons living in the community, *New England Journal of Medicine*, 1988, 319:1701-7.

[24] *Project* 2020: Potential Cost Offsets, The Lewin Group, April 2009.

The Community Living Incentives grant program funded by AoA is another pilot project that several states are involved in. The program is targeted at private pay individuals and is designed to provide an incentive for certain individuals at high functional risk of nursing home placement to stay in the community. The program is intended to support individuals as they arrange for ongoing support structure and funding, particularly those in a crisis or a near crisis situation as a result of change in health status, caregiver situation or an acute health care episode. The individual may receive a limited number of services that encourage community living. Supports include housing transition, assistive technology, home modifications, etc. Individuals would also be eligible and encouraged to participate in a consumer directed program. There are 14 states currently participating in the AoA initiative. (Arkansas, Connecticut, Florida, Georgia, Louisiana, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Texas, Virginia, and Washington.)

Finding 9: States view information and referral as an important component of the Older Americans Act and continue to expand person centered access to information systems, building on the foundation of the existing information and referral systems.

Aging and Disability Resource Centers (ADRC) provide states with an unprecedented opportunity to modernize existing systems of information access to include person centered approaches while integrating new efforts to offer long-term care services and supports planning for older adults and individuals with disabilities.

The ADRC evolution is well underway and gaining momentum. As of September 29, there are 49 states that receive federal grant dollars under the ADRC program administered through the U.S. Administration on Aging. Two additional states are receiving grant funding for the program through the Centers for Medicare and Medicaid Services.[25] With 49 states reporting some type of ADRC program, only 27 percent report that their program is statewide.

Nearly all states indicated that a primary function of their Aging and Disability Resource Center is to provide information and referral services. Many of the states indicated that the information and referral (I&R) program was being performed primarily outside of the ADRC, especially in area agencies on aging where the full services and scope of an ADRC are not available.

---

[25] For the most recent grant awards see: *http://www.aoa.gov/aoaroot/AoAPrograms/HCLTC/ADRC/docs/2009/ADRCFundingTable.pdf*

Information and Referral Services

Since its inception more than 40 years ago, the federally funded aging network has been a critical provider of essential services and supports for older adults and individuals with disabilities in states and communities across the nation. Connecting to these services and supports has been accomplished through an infrastructure of consumer information programs. Across the nation, information and referral, information and assistance, no wrong door, single point of entry, and aging and disability resource center are the monikers used to identify efforts to provide information, referral, follow-up, advocacy, and options counseling to support consumer choice.

In recent years, the Administration on Aging and Centers for Medicare and Medicaid Services have piloted ADRCs as a new, modernized approach to reaching aged and disabled consumers of all incomes, integrating disparate benefits applications processes, and providing counseling and decision support. This opportunity to build on traditional information and referral approaches requires sufficient funding for all states and uniform approaches to the national ADRC vision so that consumers receive consistent, high quality experiences no matter where they live. This report addresses ADRCs that are funded with AoA grant dollars as well as those that are not. Modernized approaches to consumer information programs require strong, core information and referral components that seek to provide information, referral, follow up and advocacy for a significant element of the consumer calling market. This component can empower independent information seekers and create more opportunities for options counseling and decision support that may require more time and research.

Operating in a complex world of national, state and local information resources, aging I&Rs demonstrate strong presence and leadership responding to Eldercare Locator driven calls, coordinating with statewide and local 2-1-1s, and providing a foundation upon which to build dynamic ADRCs that provide options counseling for people of all ages and abilities seeking long-term care planning and supports.

Looking forward, aging I&R systems across the nation are mounting new efforts to modernize approaches to person centered access to information, including implementing the single point of entry concept and new ways to assist a growing and increasingly diverse group of consumers in making informed decisions. The aging I&R system becomes the foundation to building ADRC programs. With the added ADRC dimension, the aging network continues to transform and distinguish itself as the pre-eminent gateway supporting older Americans, persons with disabilities and caregivers in an ever-changing marketplace of services and information resources.

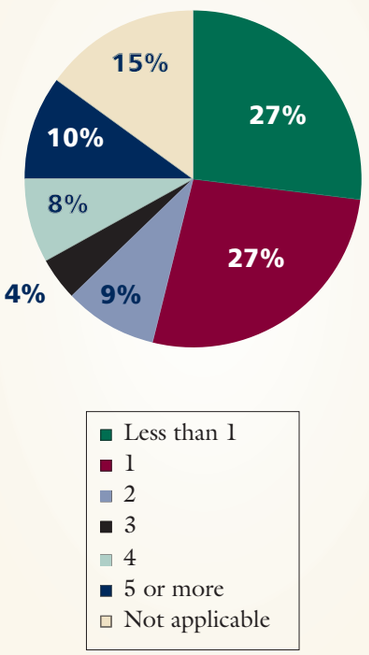
State staffing for I&R services has traditionally been low. Over one half of the states indicate that they currently have one or fewer full time staff working at the state level on information and referral. The state role for information and referral generally involves develop-

ing policies, collecting and analyzing statewide data, selecting database systems, monitoring local I&R programs, providing training and technical support activities. The majority of the staffing and direct service work takes place at the AAA level where over half of the states reported that their AAAs have five or more total full time staff working on information and referral. While in the minority, some states continue to operate fully functioning I&R programs at the state level, designed to provide direct support to consumers who call or walk into their state offices.[26]

The majority of surveyed states recognize and value the need for developing statewide, web-based I&R databases. At the same time, rapid technological change creates challenges. Many of these databases are evolving with limited resources. According to a NASUA survey in 2006, 33 states had a web-based database; 27 states had a statewide database and 11 states indicated being in the planning & development process for a database. Search capability, service directories, and mapping are commonplace features of most statewide databases.

Today, databases for statewide information and referral programs reflect a range of use of new technologies as well as ideas about populating these databases. The national family caregiver support program, Medicaid Home and Community Based Services Waiver programs, the Low Income Home Energy Assistance Program (LIHEAP), the Supplemental Nutrition Assistance Program (SNAP, formally known as food stamps), State Health Insurance Assistance Programs (SHIP), adult protective services, the long-term care ombudsman program, and general outreach and assistance rank high among programs receiving the most linkages. These programs typically have highly specialized, topic specific expertise and/or skilled advocates who provide a level of support to consumers who need it. They often share a unique partnership with I&R programs, typically illustrated by cross training, co-location and shared databases.

What is your total full time equivalent paid I&R staff at the state level?



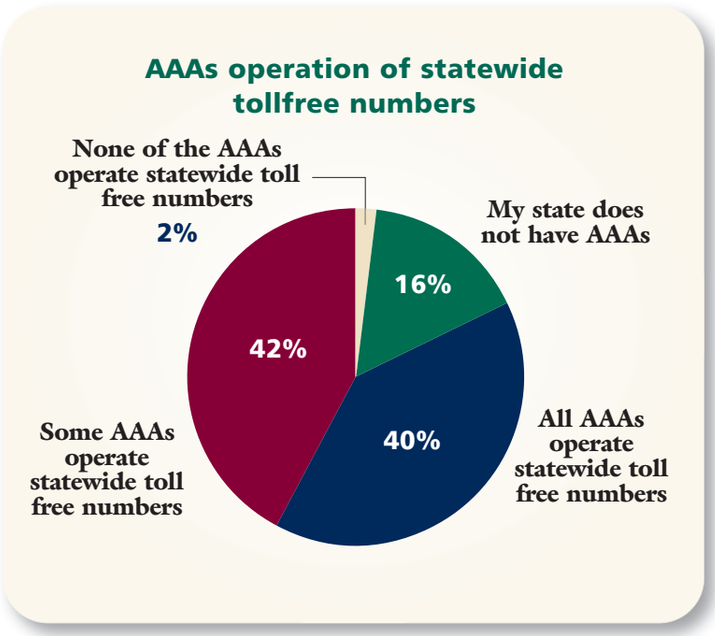
Many of the states also indicated that their database includes information on any organization or agency, both public and private, which provides services to older consumers or persons with disabilities. According to a recent NASUA issue brief, *Supporting the Information Needs of Private Paying Consumers,* when

[26] Of the 13 states operating a fully functioning I&R program at the state level, eight do not have AAAs.

asked about the level of contact with private paying consumers over the past year, the results were revealing. While 36 percent said the level of contact the organization had with private paying consumers stayed the same over the last year, more than one-third indicated the level of contact had *probably increased*. Close to a fifth of respondents thought the contact *increased noticeably*. When the *probably increased* and *stayed the same* categories are combined, the numbers reveal that a significant amount of contact with private paying consumers already exists.[27]

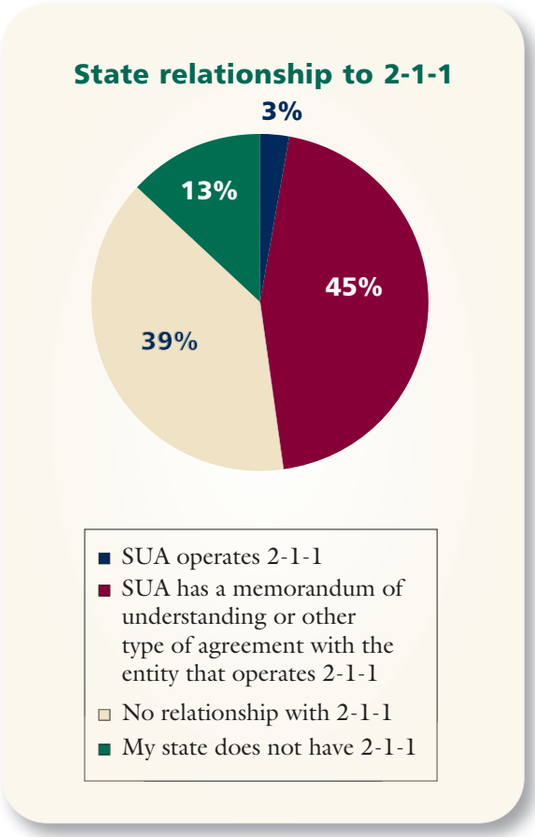
State Relationship to 2-1-1

The 2-1-1 number was officially designated by the Federal Communications Commission on July 21, 2000 as a simple, easy number to call to get connected to health and human services and I&R programs. The 2-1-1 evolution is a national partnership of the Alliance of Information and Referral Systems and the United Way, who have provided ongoing leadership to support implementation and sustainability of a national 2-1-1 system. As of April 2009, 2-1-1 has a presence in 46 states, the District of Columbia and Puerto Rico. States are in various stages of planning, implementation, and development. In most states, 2-1-1 is a portal that provides easy access to comprehensive I&R (serving all age groups and many generic information requests) and specialized I&R (serving aging, disabled, military and other populations that have existing information access systems in place). There is no age restriction for individuals calling into the 2-1-1 system.



The relationship between SUAs and the 2-1-1 program varies across the states. In 45 percent of the states there is a formal relationship with the 2-1-1 system to provide the exchange of information as it relates to supporting older adults and persons with disabilities. Nearly an equal number of states report that they have no relationship with the 2-1-1 system in their state.

[27] *http://nasua.org/documents/PrivatePayIssueBrief.pdf*, NASUA June 2009



Some of the reasons cited for the limited relationship between the two programs are that 2-1-1s are not available in the state or are available only in limited areas of the state. Several states reported that the state does not have a formal relationship with the 2-1-1 program, but the local area agencies on aging do have relationships with local 2-1-1 programs. A few of the states indicated that they were trying to re-establish a relationship with the 2-1-1 program following the breakdown in communication.

Examples of collaboration between SUAs and 2-1-1 include the following: partnering on advisory boards, 2-1-1 has formal relationships with the states' new Aging and Disability Referral System program, shared databases, 2-1-1 operating as the after hours switchboard for aging I&R calls, SUAs serving as the prime referral point for the 2-1-1 system as it relates to supporting older americans and persons with disabilities. Many states have memoranda of understanding with 2-1-1s, formally designating the aging I&R program as the recipient of calls that come from 2-1-1 with requests for aging services, calls requiring detailed assessment and older consumers needing advocacy supports.

The state's ability to provide information and referral to clients with diverse backgrounds varies greatly. The majority of states reported that at the state level they have a similar ability to serve clients who are non-English speaking as well as those with disabilities. However, the states report that the ability of the AAAs to serve clients with disabilities is not as widespread as their ability to serve those who are non-English speaking. Several states indicated that their AAAs have Memoranda of Understanding with the local Centers for Independent Living Centers (CILs) to provide information and referral for clients with disabilities.

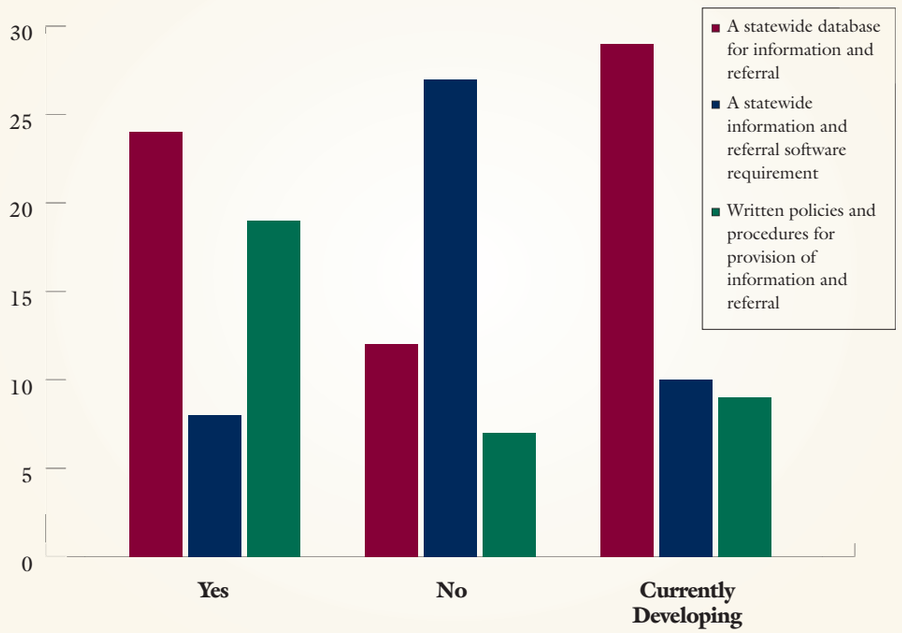
Over 90 percent of the states indicated that their information and referral programs serve all clients over the age of 18. Many of the respondents also indicated that in addition to serving clients who are elderly or physically disabled, they are initiating programs to help clients with developmental disabilities through the maze of service options. In at least four states, pilot programs are underway with this special population.

States recognize the need for formalizing the information and referral process and have begun training programs and developing processes to improve the quality of the service and supports that clients receive. States are moving towards developing formal written policies and procedures for the provision of information and referral, developing statewide information referral software, and statewide databases for information and referral.

In addition, nearly 65 percent of the states reported that they adopted the Alliance of Information and Referral Systems (AIRS) standards as guidelines for information and referral functions. Of the states that have not done so, the most often cited reason was the lack of funding for training and travel.

A majority of states report that they do not have a formal policy for information and referral staff certification. In states with a policy for certification, most reported they expect their information and referral staff to be trained and meet certain standards. Some states provide flexibility for employees so that they are certified within a set timeframe of hire. Others report that the policy is developed and enforced at the AAA level. At least one state imposes a requirement that at least one, usually the lead, information and referral worker be AIRS certified.

Formalizing the Information and Referral Process



Finding 10: States are expanding their use of technology to improve planning outcomes in their programs.

The use of technology to improve planning and coordination of services for aging programs has increased in recent years. A quarter of the states indicated that they are using geographic information system (GIS) technology to support their business decisions and as a planning tool. GIS technology allows policy makers to understand and use data in many ways that reveal patterns and trends. Maps created using GIS can be used to communicate in a quick and precise way that may leave a more lasting impression than a narrative. In combination with census data, GIS can assist in identifying the location of clusters of seniors and individuals with disabilities.

Those SUAs currently using GIS report using it primarily to identify where clients live and areas of unmet need. Some states are also using maps to support budget requests to their state legislatures. GIS technology can effectively be used to illustrate the number of residents meeting a particular profile who live in an elected representative's district and are in need of services. While the technology can be a useful tool for advocacy, acquiring it may be difficult. About half of the states reporting that they are using GIS technology purchased the software. The remainder of the SUAs leveraged relationships with other state agencies or universities to gain access to the technology.

A number of states are using Medicaid Transformation Grants to support infrastructure changes for permanent changes in long-term services and support systems. For example, seven states report using the grant funding to create or expand one-stop access to information about services, or ADRCs. Two states report that they are using the funding for information technology services that will support access to long-term care services.

Social networking is also an area of interest for some states as an avenue for networking and sharing information. These "new media," such as YouTube and Facebook, may present opportunities to market to new consumer audiences and promote visibility of services and supports. While not in heavy use in the states, there is a strong interest in learning more about social networking and how it can benefit the aging network.[28]

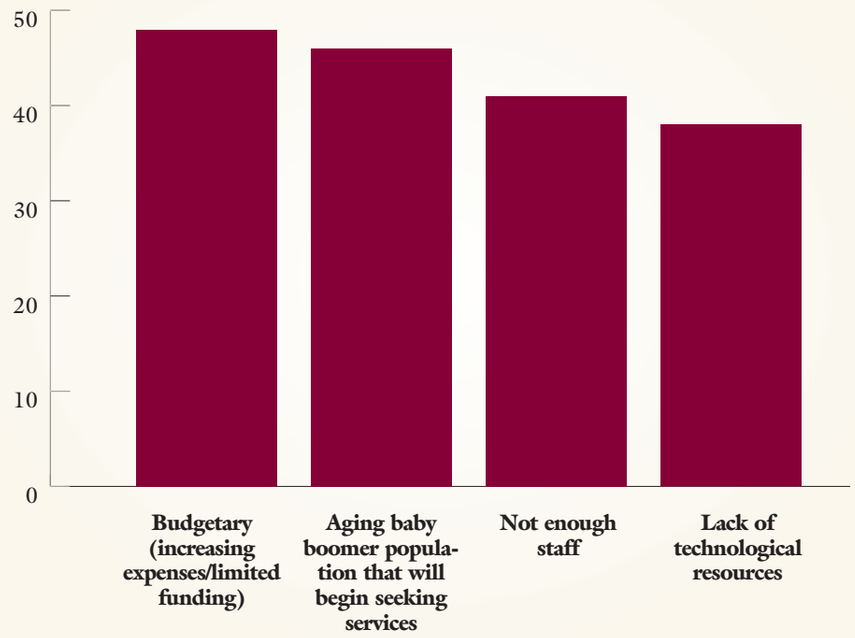
[28] Preliminary results of unpublished NASUA survey of State Information & Referral liaisons, August 2009.

Emerging Issues and Concerns

This report provides a detailed snapshot of the view from the states in 2009. Even as the year progressed, some of the information in the report evolved as states responded to a worsening economic crisis and impending cuts to their programs. With the country experiencing the worst economic downturn in many years, both the short and long-term impact on services for the most vulnerable populations is a major concern of the SUAs. The demand for state services increases just as states must tighten their budgets. In addition, states typically experience the greatest impact on their budgets in the year after a recession ends because their recovery typically lags any national recovery.[29]

Major Challenges for SUA

Percent of states that agree or strongly agree with the following statements



[29] *The Fiscal Survey of States* June 2009, National Governors Association and National Association of State Budget Officers *http://www.nasbo.org/Publications/PDFs/FSSpring2009.pdf*

Surveys of the SUA directors since the recession began have consistently shown that they continue to manage their budgets so that any reduction on direct services to consumers is minimized, but often the best they can hope for is to simply maintain existing levels of services. However, the economic crisis is not discouraging states from continuing to push for system redesign and continued development and expansion of home and community based services and supports. The proven cost-effectiveness and consumer satisfaction of non-institutional care in homes and communities has provided states with a solid basis to formulate arguments for savings as well as a higher quality of life for those served.

Even with the challenges faced by the states, they are taking steps to continue moving towards, or at least maintain, development of HCBS and rebalancing their long-term care systems. This is difficult during a recession and is a tribute to their visionary leadership and creativity.

If the economic decline continues or worsens, the ability of the states to continue to deliver necessary supports will be further challenged. There is already concern being expressed by state directors that the infusion of funding received as part of the American Recovery and Reinvestment Act of 2009 potentially sets up a cliff effect for the state programs when the funding expires—especially in the supplemental funding for Medicaid and the AoA congregate and home delivered meals program.

It is unclear at this point what the outcome will be of the much debated national health reform effort. Little is known about what will be included in a final package, including what the impact will be on cash-strapped state budgets, whether a long-term services and supports initiative such as *Project* 2020 will be included in the reform effort, and what the role of the aging network will be in health reform.

APPENDIX

Table 1: Structure of State Units on Aging

State	Independent Administrative Agency	Part of Umbrella Agency				Board or Commission	Other
		Human Services	Health	Medicaid	Welfare		
Alabama	✔						
Alaska							Health and social services
Arizona		✔					
Arkansas		✔					
California							Health and human services
Colorado		✔					
Connecticut		✔		✔			
Delaware							Health and social services
District of Columbia	✔						
Florida	✔						
Georgia		✔					
Hawaii			✔				
Idaho						✔	Governor's office
Illinois	✔						
Indiana		✔					
Iowa	✔						
Kansas	✔						
Kentucky							Health and family services
Louisiana							Governor's office
Maine		✔	✔				
Mariana Islands							Community and Cultural Affairs
Maryland	✔						
Massachusetts		✔					
Michigan	✔					✔	
Minnesota							✔[1]

Continues

[1] In Minnesota, the Board is administratively placed at Department of Human Services

State	Independent Administrative Agency	Part of Umbrella Agency				Board or Commission	Other
		Human Services	Health	Medicaid	Welfare		
Mississippi		✔					
Missouri			✔				
Montana		✔	✔				
Nebraska				✔			
Nevada		✔					
New Hampshire		✔	✔				
New Jersey			✔				
New Mexico	✔						
New York	✔						
North Carolina							Health and human services
North Dakota		✔					
Ohio	✔						
Oklahoma		✔					
Oregon		✔					
Pennsylvania	✔						
Rhode Island	✔	✔		✔			
South Carolina							Lt. Gov.
South Dakota					✔		
Tennessee						✔	
Texas		✔					
Utah		✔					
Vermont		✔					
Virginia	✔						
Washington		✔		✔	✔		
West Virginia	✔						
Wisconsin		✔					
Wyoming			✔				

APPENDIX

Table 2: Appointment of State Unit Directors

State	Director Appointed By				Director Reports To		
	Governor	Umbrella Agency Head	Board or Commission	Merit or Civil Service Selection	Governor	Umbrella Agency Head or Deputy	Board or Commission
Alabama	✔				✔		
Alaska	✔				✔		
Arizona		✔				✔	
Arkansas		✔				✔	
California	✔					✔	
Colorado				✔		✔	
Connecticut				✔		✔	
Delaware	✔					✔	
District of Columbia[1]							
Florida	✔				✔		
Georgia		✔				✔	
Hawaii	✔					✔	
Idaho	✔[2]				✔		
Illinois	✔				✔		
Indiana		✔				✔	
Iowa	✔				✔		
Kansas	✔				✔		
Kentucky	✔					✔	
Louisiana	✔				✔		
Maine		✔					
Mariana Islands		✔				✔	
Maryland	✔				✔		
Massachusetts	✔					✔	
Michigan	✔				✔		
Minnesota		✔				✔	✔
Mississippi		✔				✔	
Missouri		✔				✔	
Montana				✔		✔	
Nebraska				✔		[3]	
Nevada		✔				✔	

Continues

[1] Appointed by mayor with commission recommendation. Reports to city administrator and mayor.
[2] Also requires confirmation by state senate.
[3] Reports to Medicaid Long-Term Care Section Head.

State	Director Appointed By				Director Reports To		
	Governor	Umbrella Agency Head	Board or Commission	Merit or Civil Service Selection	Governor	Umbrella Agency Head or Deputy	Board or Commission
New Hampshire		✔				✔	
New Jersey		✔				✔	
New Mexico	✔[4]				✔		
New York	✔				✔		
North Carolina	✔					✔	
North Dakota				✔		✔	
Ohio	✔				✔		
Oklahoma		✔				✔	
Oregon		✔				✔	
Pennsylvania	✔[5]				✔		
Rhode Island	✔				✔	✔	
South Carolina		✔[6]					
South Dakota		✔				✔	
Tennessee			✔				✔
Texas		✔				✔	
Utah		✔				✔	
Vermont	✔					✔	
Virginia		✔				✔	
Washington	✔					✔	
West Virginia	✔					✔	
Wisconsin				✔		✔[7]	
Wyoming		✔				✔	

[4] Requires confirmation by state legislature.

[5] Requires confirmation by state senate.

[6] Reports to Lt. Governor's chief of staff.

[7] Reports to Division of Long-Term Care Administrator.

APPENDIX

Table 3: Sources of Funding for SUAs

State	OAA*	Medicaid*	State Appropriation	Targeted Tax**	State Lottery	Foundation/ Private Grants	Other Federal Funding
Alabama	30%	65%	✔				
Alaska	✔	✔	✔			✔	✔
Arizona	50%		✔			✔	✔
Arkansas	31%	12%	✔	✔		✔	✔
California	75%	✔	✔			✔	✔
Colorado	60%		✔			✔	
Connecticut	60%		✔				✔
Delaware	29%	14%	✔				✔
District of Columbia	31%	26%				✔	
Florida	12%	✔	✔	✔			
Georgia	25%	50%	✔	✔			
Hawaii	42%		✔			✔	✔
Idaho	54%		✔				✔
Illinois	10%	✔	✔				
Indiana	<3%	93%	✔				
Iowa	48%		✔			✔	✔
Kansas	2.8%	91%	✔	✔		✔	✔
Kentucky	35%	✔	✔				
Louisiana	50%		✔				
Maine	35%	10%	✔			✔	
Mariana Islands	50%					✔	
Maryland	35%	✔	✔			✔	
Massachusetts	10%	✔	✔			✔	✔
Michigan	50-75%		✔	✔		✔	
Minnesota[1]	5%	✔	✔			✔	
Mississippi	50%		✔				✔
Missouri	5%	90%	✔	✔		✔	✔
Montana	70%		✔				

Continues

* Percentage of total SUA budget, if specified in response.

** Targeted tax may include a tobacco tax, income tax check-off, or other tax assessment specifically designated for services administered by the SUA.

[1] OAA funding and related state funds administered by SUA. The remainder is administered by the Department of Human Services.

State	OAA*	Medicaid*	State Appropriation	Targeted Tax**	State Lottery	Foundation/ Private Grants	Other Federal Funding
Nebraska	55%		✔				✔[2]
Nevada	21%	31%	✔				✔[2]
New Hampshire	5%	67%	✔			✔	
New Jersey	✔	✔	✔		✔	✔	
New Mexico	11%	6%	✔			✔	✔
New York	41.43%		✔				✔
North Carolina	41.5%	0.8%	✔			✔	✔
North Dakota	86%	<1%	✔	✔			
Ohio	10.5%	82%	✔				
Oklahoma	35%	65%	✔				
Oregon	7.5%	60%	✔			✔	
Pennsylvania	14.81%	31.1%	✔		✔		✔[2]
Rhode Island	49.6	34%	✔	✔			✔
South Carolina	50%	1%	✔	✔			✔
South Dakota	3%	53.6%	✔				✔
Tennessee	✔	✔	✔				✔
Texas	1%	95%	✔				
Utah	4%	<5%	✔				
Vermont	3%	75%	✔				✔
Virginia	57%	<0.5%	✔	✔		✔	
Washington	1.4%	✔	✔			✔	
West Virginia	12%	45%	✔		✔[3]		
Wisconsin	25%	25%	✔				✔
Wyoming	60%		✔				

* Percentage of total SUA budget, if specified in response.

** Targeted tax may include a tobacco tax, income tax check-off, or other tax assessment specifically designated for services administered by the SUA.

[2] Tobacco settlement funds.

[3] In addition to state lottery funds, West Virginia receives funding from licensing fees for table gaming.

APPENDIX

Table 4: Home and Community Based Programs Administered by SUAs

State	Operating Agency for at least one Medicaid HCBS Waiver	Operates State Funded HCBS Program
Alabama	Yes	No
Alaska	Yes	Yes
Arizona	No	Yes
Arkansas	Yes	No
California	Yes	No (as of 10/09)
Colorado	No	Yes
Connecticut	No	Yes
Delaware	Yes	Yes
District of Columbia	No	Yes
Florida	Yes	Yes
Georgia	Yes	Yes
Hawaii	No	Yes
Idaho	No	No
Illinois	Yes	Yes
Indiana	Yes	Yes
Iowa	No	Yes
Kansas	Yes	Yes
Kentucky	Yes	Yes
Louisiana	No	Yes
Maine	Yes	Yes
Mariana Islands	No	NR
Maryland	Yes	Yes
Massachusetts	Yes	Yes
Michigan	No	No
Minnesota[1]	Yes	Yes
Mississippi	No	Yes
Missouri	Yes	Yes
Montana	No	No

Continues

[1] Operated by Department of Human Services.

State	Operating Agency for at least one Medicaid HCBS Waiver	Operates State Funded HCBS Program
Nebraska	No	Yes
Nevada	Yes	Yes
New Hampshire	Yes	No
New Jersey	Yes	Yes
New Mexico	Yes	No
New York	No	Yes
North Carolina	No	Yes
North Dakota	No	No
Ohio	Yes	No
Oklahoma	Yes	Yes
Oregon	Yes	Yes
Pennsylvania	Yes	Yes
Rhode Island	Yes	Yes
South Carolina	No	Yes
South Dakota	Yes	Yes
Tennessee	No[2]	Yes
Texas	Yes	Yes
Utah	Yes	Yes
Vermont[3]	Yes	Yes
Virginia	No	Yes
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin	No	No
Wyoming	No[4]	Yes

[2] Tennessee was the operating agency for Medicaid HCBS waivers until July 1, 2009.

[3] Vermont operates two Section 1115 waivers, one for all long-term care (nursing facilities, enhanced residential care homes and home and community settings); and another known as Global Commitment (includes developmental services, traumatic brain injury, and other services).

[4] Wyoming was the operating agency for Medicaid HVBS waivers until July 1, 2009.

APPENDIX

Table 5: Types of Medicaid Home and Community Based Services Waivers Operated by SUAs

State	Traumatic or Acquired Brain Injury	Autism	Adult Foster Care	Aged (60+)	Assisted Living	Medically Fragile Children	Physically Disabled	Developmentally Disabled
Alabama				✔			✔	
Alaska				✔		✔	✔	✔
Arizona*								
Arkansas				✔	✔		✔	
California				✔				
Colorado*								
Connecticut*								
Delaware	✔			✔	✔		✔	
District of Columbia*								
Florida				✔	✔			
Georgia				✔			✔	
Hawaii *								
Idaho*								
Illinois				✔				
Indiana	✔			✔			✔	
Iowa*								
Kansas				✔[1]				
Kentucky				✔			✔	✔
Louisiana*								
Maine				✔			✔	
Mariana Islands*								
Maryland				✔				
Massachusetts				✔				
Michigan*								
Minnesota[2]				✔				
Mississippi*								
Missouri				✔[3]	✔		✔	
Montana*								

Continues

*SUA does not operate any Medicaid HCBS waivers.

[1] Kansas also operates a waiver for frail elderly for those 65 and older.

[2] Operated by Department of Human Services.

[3] Missouri also operates an aged & disabled waiver for those 63 and older.

State	Traumatic or Acquired Brain Injury	Autism	Adult Foster Care	Aged (60+)	Assisted Living	Medically Fragile Children	Physically Disabled	Developmentally Disabled
Nebraska*								
Nevada			✔	✔	✔			
New Hampshire				✔			✔	
New Jersey				✔	✔		✔	
New Mexico	✔			✔			✔	
New York*								
North Carolina*								
North Dakota*								
Ohio				✔	✔			
Oklahoma	✔		✔	✔	✔		✔	
Oregon	✔			✔			✔	✔
Pennsylvania	✔		✔	✔			✔	
Rhode Island				✔	✔		✔	
South Carolina*								
South Dakota				✔			18+	
Tennessee*[4]								
Texas				✔		✔	✔	✔
Utah				✔				
Vermont[5]	✔	✔		✔	✔	✔	✔	✔
Virginia*								
Washington				✔			✔	✔
West Virginia				✔			✔	
Wisconsin*								
Wyoming[6]								

*SUA does not operate any Medicaid HCBS waivers.

4 Tennessee operated Medicaid HCBS waivers for aged (60+) and physically disabled (22+) until July 1, 2009.

5 Vermont provides "HCBS" under its Section 1115 Global Commitment Waiver or its Section 1115 Long-Term Care Waiver. The state serves older adults (60+), individuals with physical disabilities, individuals with developmental disabilities and individuals with traumatic brain injury.

6 Wyoming operated Medicaid HCBS waivers for adult foster care, aged (60+), and assisted living until July 1, 2009.

APPENDIX

Table 6: Long-Term Care Resources Managed by SUAs

State	Planning and Development of Policy	Financing	Quality for Institutional Services	Quality HCBS	Regulation of HCBS Providers	Eligibility Determination
Alabama	✔			✔[1]		
Alaska	✔	✔	✔	✔	✔	✔
Arizona	✔	✔			✔	✔
Arkansas	✔			✔	✔	
California	✔	✔		✔	✔	
Colorado			✔	✔		
Connecticut	✔					✔[2]
Delaware	✔	✔	✔	✔	✔	✔
District of Columbia	✔			✔		✔
Florida	✔	✔[3]		✔		✔[4]
Georgia				✔		
Hawaii	✔	✔	✔	✔[5]		✔[6]
Idaho	✔					
Illinois				✔	✔	✔
Indiana	✔	✔	✔	✔	✔	
Iowa	✔					
Kansas	✔	✔	✔		✔	✔
Kentucky	✔	✔	✔	✔	✔	✔
Louisiana	✔		✔	✔		
Maine	✔			✔		✔
Maryland	✔	✔	✔	✔		
Massachusetts[7]	✔	✔		✔	✔	✔
Michigan						
Minnesota	✔	✔		✔		
Mississippi				✔		
Missouri	✔	✔		✔	✔	✔
Montana	✔					
Nebraska						✔

Continues

1 Alabama has quality oversight for the HCBS waivers administered by the SUA.
2 Connecticut does eligibility determinations for OAA programs, some CMS funded programs and Title V.
3 Effective July 2009.
4 Florida has responsibility for the functional component of the eligibility determination.
5 Hawaii monitors quality for state and federally-funded (non-Medicaid) HCBS.
6 Hawaii manages eligibility determinations for HCBS.
7 Massachusetts HCBS resource management is limited to services for elders, eligibility determination is limited to clinical eligibility.

State	Planning and Development of Policy	Financing	Quality for Institutional Services	Quality HCBS	Regulation of HCBS Providers	Eligibility Determination
Nevada	✔		✔	✔		✔
New Hampshire	✔	✔		✔	✔	✔
New Jersey	✔	✔		✔		✔
New Mexico	✔			✔		
New York						
North Carolina	✔	✔	✔	✔	✔	✔[8]
North Dakota						
Ohio	✔			✔		✔
Oklahoma	✔	✔		✔	✔	✔
Oregon	✔	✔	✔	✔	✔	✔
Pennsylvania	✔	✔	✔[9]	✔	✔	✔[10]
Rhode Island	✔		✔	✔	✔	✔
South Carolina	✔		✔			
South Dakota	✔	✔		✔		
Tennessee	✔			✔		
Texas	✔	✔	✔	✔	✔	✔
Utah	✔		✔	✔		✔
Vermont	✔	✔	✔	✔	✔	✔[11]
Virginia	✔					
Washington	✔	✔	✔	✔	✔	✔
West Virginia	✔	✔	✔	✔	✔	
Wisconsin	✔					
Wyoming	✔					

[8] North Carolina is responsible for financial and clinical eligibility determination policy. Eligibility is determined at local departments of social services.

[9] Pennsylvania handles nursing facility certification (sister agency conducts surveys) and MDS quality review.

[10] Pennsylvania determines clinical eligibility. Financial eligibility is determined in a sister agency.

[11] Vermont determines clinical eligibility for its Section 1115 Long-Term Care waiver. Financial eligibility is determined in a sister agency.

APPENDIX

Table 7: SUAs Offering Consumer Direction

State	OAA Programs						Medicaid HCBS	Medicaid SPA 1915(j)	State Funded HCBS
	Family Caregiver Support	Respite	Home Care Homemaker	Transportation	Nutrition	Adult Day Services			
Alabama								✔	
Alaska*									
Arizona							✔		
Arkansas							✔	✔	
California							✔		✔[1]
Colorado	✔	✔	✔	✔			✔		✔
Connecticut	✔	✔							✔
Delaware									✔
District of Columbia*									
Florida							✔	✔	
Georgia	✔						✔		✔
Hawaii									
Idaho									
Illinois[2]									✔
Indiana							✔		✔
Iowa	✔	✔	✔	✔	✔	✔	✔		✔
Kansas							✔		✔
Kentucky	✔	✔	✔				✔		✔
Louisiana[3]							✔		✔
Maine	✔			✔	✔		✔		✔
Maryland									✔
Massachusetts			✔				✔		✔
Michigan							✔		✔
Minnesota		✔			✔		✔		✔
Mississippi*									
Missouri	✔	✔	✔				✔		✔
Montana*									
Nebraska	✔		✔				✔		✔
Nevada							✔		✔

Continues

*SUA does not offer consumer direction.

[1] Cut October 2009

[2] Illinois operates a small cash and counseling demonstration.

[3] Louisiana is working on developing consumer direction at all levels.

State	OAA Programs						Medicaid HCBS	Medicaid SPA 1915(j)	State Funded HCBS
	Family Caregiver Support	Respite	Home Care Homemaker	Transportation	Nutrition	Adult Day Services			
New Hampshire	✔						✔		
New Jersey							✔	✔	✔
New Mexico	✔	✔	✔				✔		
New York[4]									
North Carolina	✔	✔	✔			✔			✔
North Dakota	✔	✔							
Ohio							✔		
Oklahoma	✔	✔	✔	✔			✔		✔
Oregon	✔	✔	✔	✔	✔	✔	✔	✔	✔
Pennsylvania	✔					✔	✔		✔
Rhode Island	✔	✔	✔		✔	✔	✔		✔
South Carolina*									
South Dakota*									
Tennessee									✔
Texas	✔	✔	✔	✔			✔	✔	
Utah							✔		✔
Vermont		✔					✔		✔
Virginia[5]									
Washington							✔		✔
West Virginia							✔		✔
Wisconsin*									
Wyoming*									

*SUA does not offer consumer direction.

[4] New York will offer consumer direction in its nursing home diversion modernization grant in 3 demonstration AAAs starting in June 2009, including in the grant's Veteran's Administration option.

[5] Virginia is offering consumer direction through its AoA funded community living program grant.

APPENDIX

Table 8: SUAs that Permit Solicitation of Voluntary Contributions for Services

State	OAA Services	State Funded Services	No contributions for any services
Alabama	✔		
Alaska	✔	✔	
Arizona	✔		
Arkansas	✔		
California	✔		
Colorado	✔	✔	
Connecticut	✔	✔	
Delaware	✔	✔	
District of Columbia	✔	✔	
Florida	✔		
Georgia	✔	✔	
Hawaii	✔	✔	
Idaho	✔	✔	
Illinois	✔	✔	
Indiana	✔		
Iowa	✔		
Kansas	✔		
Kentucky	✔	✔	
Louisiana	✔	✔	
Maine	✔	✔	
Maryland	✔		
Massachusetts	✔	✔	
Michigan	✔	✔	
Minnesota	✔		
Mississippi	✔		
Missouri	✔		
Montana	✔	✔	
Nebraska	✔	✔	
Nevada	✔		
New Hampshire	✔	✔	
New Jersey	✔	✔	

Continues

State	OAA Services	State Funded Services	No contributions for any services
New Mexico	✔	✔	
New York	✔	✔	
North Carolina	✔	✔	
North Dakota	✔	✔	
Ohio	✔	✔	
Oklahoma	✔	✔	
Oregon	✔	✔	
Pennsylvania	✔	✔	
Rhode Island	✔	✔	
South Carolina	✔	✔	
South Dakota	✔		
Tennessee	✔	✔	
Texas	✔		
Utah	✔	✔	
Vermont	✔	✔	
Virginia	✔	✔	
Washington	✔		
West Virginia	✔	✔	
Wisconsin	✔	✔	
Wyoming	✔	✔	

APPENDIX

Table 9: Use of Cost Sharing, by Service

State	State has Cost Sharing Plan	AAAs with Cost Sharing Plans	OAA Services Subject to Cost Sharing							Non-OAA Services Cost Sharing
			Personal Care	Homemaker	Chore	Adult Day Care	Assisted Transportation	Disease Prevention Health Promotion	Respite	
Alabama	No	All								
Alaska	No	N/A								
Arizona	No	Some								No
Arkansas	No	None								No
California	No	None								No
Colorado	No	None								No
Connecticut	No	None								No
Delaware	No	N/A								Yes
District of Columbia	Yes	N/A	✔	✔	✔	✔	✔	✔	✔	Yes
Florida	No	None								Yes
Georgia	Yes	All	✔	✔		✔		✔	✔	Yes
Hawaii	No	None								No
Idaho	Yes	Some								No
Illinois	Yes	None								No
Indiana	Yes	All								Yes
Iowa	No	None								Yes
Kansas	No	None								Yes
Kentucky	No	None								Yes
Louisiana	No	Some								No
Maine	No	None								Yes
Maryland	No	None								Yes
Massachusetts	No	None								Yes
Michigan	No	Some								
Minnesota	Yes	All							✔	Yes
Mississippi	No	None								No
Missouri	No	None								No
Montana	Yes	Some							✔	No
Nebraska	Yes	Some	✔	✔	✔		✔	✔		Yes
Nevada	Yes	N/A								Yes
New Hampshire	Yes	N/A		✔		✔	✔			No
New Jersey	No	None								Yes
New Mexico	Yes	Some	✔	✔	✔	✔	✔	✔	✔	No

Continues

State	State has Cost Sharing Plan	AAAs with Cost Sharing Plans	OAA Services Subject to Cost Sharing							Non-OAA Services Cost Sharing
			Personal Care	Homemaker	Chore	Adult Day Care	Assisted Transportation	Disease Prevention Health Promotion	Respite	
New York	No	None								Yes
North Carolina	Yes	All	✔	✔	✔	✔	✔	✔	✔	Yes
North Dakota	No	N/A								No
Ohio	Yes	All	✔	✔	✔	✔			✔	No
Oklahoma	No	None								No
Oregon	No	None								Yes
Pennsylvania	Yes	All	✔	✔	✔	✔	✔		✔	Yes
Rhode Island	Yes	N/A		✔		✔	✔		✔	Yes
South Carolina	Yes	Some	✔	✔	✔	✔		✔	✔	No
South Dakota	No	N/A								Yes
Tennessee	Yes	All	✔	✔	✔				✔	Yes
Texas	No	None								No
Utah	No	None								No
Vermont	No	None								Yes
Virginia	Yes	All	✔	✔	✔	✔	✔		✔	Yes
Washington	Yes	None							✔	Yes
West Virginia	No	None								Yes
Wisconsin	No	None								Yes
Wyoming	Yes	N/A					✔	✔	✔	Yes

APPENDIX

Table 10: Evidence-Based Programs Implemented by SUAs

State	A Matter of Balance	Chronic Disease Self Management	Enhance Fitness	Enhance Wellness	Healthy IDEAS or PEARLS	Medication Management Improvement System	Other
Alabama							Wellness Program
Alaska							
Arizona		✔					[1]
Arkansas		✔					Active Living Everyday
California	✔	✔					
Colorado	✔	✔					[2]
Connecticut		✔					[3]
Delaware							[4]
District of Columbia			✔	✔			
Florida	✔	✔					
Georgia*							
Hawaii		✔	✔				[5]
Idaho							Fit and Fallproof
Illinois		✔					
Indiana	✔	✔	✔				
Iowa	✔	✔	✔	✔			
Kansas			✔				
Kentucky	✔	✔				✔	
Louisiana	✔		✔	✔			
Maine	✔	✔	✔	✔	✔		
Maryland	✔	✔	✔		✔		
Massachusetts	✔	✔					
Michigan	✔	✔	✔				

Continues

*State has not implemented any evidence-based disease management or health promotion programming.

[1] Arizona is creating a falls prevention coalition focused on a variety of evidence-based falls prevention programs.

[2] Colorado also has Diabetes Self Management, Powerful Tools for Caregiving, Healthy Moves for Aging Well, Tomando Control (Spanish CDSMP).

[3] Connecticut has Step By Step, a falls prevention program developed by Yale University.

[4] Delaware has implemented Mobile Diabetes Wellness Initiative, Medication Risk Screening & Medication Management Counseling, Healthy For Life Program, Senior Aquatic Fall Prevention Project, Delaware's Mental Fitness Initiative, Walk Delaware Senior Fitness Challenge.

[5] Hawaii is also implementing the Arthritis Self Management Program (ASMP) and Diabetes Self Management Program (DSMP).

State	A Matter of Balance	Chronic Disease Self Management	Enhance Fitness	Enhance Wellness	Healthy IDEAS or PEARLS	Medication Management Improvement System	Other
Minnesota	✔	✔					
Mississippi*							
Missouri		✔					Chronic Care Improvement
Montana*							
Nebraska		✔					[6]
Nevada*							
New Hampshire		✔				✔	Powerful Tools for Caregivers
New Jersey	✔	✔			✔		
New Mexico	✔		✔				
New York	✔	✔	✔	✔	✔	✔	
North Carolina	✔	✔			✔		Fit & Strong 3 Arthritis Foundation Programs
North Dakota*							
Ohio	✔	✔			✔		
Oklahoma		✔	✔				
Oregon		✔	✔				[7]
Pennsylvania	✔	✔					
Rhode Island		✔					
South Carolina	✔	✔					2 Arthritis Foundation Programs
South Dakota*							
Tennessee	✔						
Texas	✔		✔		✔		
Utah*							
Vermont	✔	✔			✔		
Virginia							
Washington	✔	✔	✔	✔	✔		
West Virginia		✔					Chronic Care Management
Wisconsin	✔	✔					Sure Step, Stepping on Fall Prevention
Wyoming*							

*State has not implemented any evidence-based disease management or health promotion programming.

[6] Nebraska has implemented Arthritis-PACE, Diabetic Retinopathy Screening, You Can (diet and walking program), and Feet Can Last A Lifetime (foot screening).

[7] Oregon has implemented Tai Chi, Arthritis Foundation programs, StrongWoman, and Strong for Life.

APPENDIX

Table 11: Medicaid HCBS Services Offered by States and Administered by SUAs

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**
Alabama[1]	✔	✔												✔		✔						
Alaska[2]	✔	✔	✔	✔		✔		✔		✔	✔	✔	✔	✔			✔		✔			
Arizona[3]***	✔	✔	✔	✔	✔	✔								✔		✔						
Arkansas[4]	✔	✔	✔		✔		✔	✔		✔				✔		✔					✔	
California	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔
Colorado***	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔			✔	✔					✔
Connecticut[5]***	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔		✔	✔					✔
Delaware	✔	✔	✔		✔	✔		✔	✔			✔										
District of Columbia***	✔		✔	✔	✔							✔				✔						✔
Florida	✔	✔	✔	✔	✔			✔		✔		✔		✔		✔		✔	✔	✔	✔	
Georgia	✔	✔	✔	✔		✔						✔		✔		✔	✔					
Hawaii	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	
Idaho***	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔		✔	✔		✔			
Illinois	✔															✔						
Indiana	✔	✔	✔	✔	✔		✔	✔		✔		✔		✔		✔						✔
Iowa***	✔	✔	✔	✔	✔			✔	✔		✔	✔	✔	✔		✔				✔	✔	
Kansas[6]			✔		✔	✔				✔		✔				✔						
Kentucky	✔	✔	✔			✔			✔	✔		✔	✔		✔	✔	✔			✔	✔	
Louisiana***	✔	✔	✔		✔					✔												

Continues

* Personal Emergency Response Systems
** One-time expenses associated with move from an institution to the community, e.g., security deposits, moving expenses.
*** SUA does not operate Medicaid HCBS waivers, but, in some instances, provided information about services offered in the state.
1 Alabama also offers personal care and adult day care.
2 Alaska also offers adult day care and chore services.
3 Arizona's waiver is authorized under Section 1115.
4 Arkansas also offers chore, adult day health care, adult companion, and counseling support management services.
5 Connecticut also offers chore, adult day care, and mental health counseling.
6 Kansas also offers dental wellness, monitoring medication assistance, nursing evaluation, sleep cycle support, and comprehensive support.

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**
Maine	✔	✔	✔	✔	✔					✔						✔		✔		✔	✔	
Mariana Islands***																						
Maryland[7]	✔	✔	✔	✔	✔			✔	✔	✔		✔		✔								✔
Massachusetts	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Michigan***	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔	✔	✔	✔	✔						✔
Minnesota	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Mississippi***	✔	✔	✔	✔	✔	✔		✔				✔		✔		✔						
Missouri		✔	✔					✔		✔		✔		✔		✔						✔
Montana***	✔	✔	✔	✔				✔	✔	✔	✔	✔		✔		✔		✔			✔	
Nebraska***	✔	✔	✔	✔	✔	✔		✔	✔	✔		✔		✔	✔	✔	✔					
Nevada	✔	✔	✔		✔		✔	✔								✔						
New Hampshire	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
New Jersey	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
New Mexico	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔		✔	✔	✔	✔		✔	✔	✔
New York***																						
North Carolina***																						
North Dakota ***[8]	✔	✔	✔	✔	✔		✔			✔	✔	✔		✔		✔	✔					
Ohio[9]	✔		✔	✔	✔			✔		✔		✔		✔		✔						✔
Oklahoma	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔
Oregon	✔		✔	✔	✔		✔	✔						✔		✔						✔
Pennsylvania	✔	✔	✔	✔	✔	✔	✔			✔		✔	✔	✔	✔	✔						✔
Rhode Island	✔	✔	✔	✔	✔			✔		✔		✔		✔	✔	✔	✔	✔		✔	✔	✔
South Carolina***	✔	✔	✔	✔	✔	✔				✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
South Dakota[10]		✔			✔							✔		✔	✔	✔						

Continues

* Personal Emergency Response Systems

** One-time expenses associated with move from an institution to the community, e.g., security deposits, moving expenses.

*** SUA does not operate Medicaid HCBS waivers, but, in some instances, provided information about services offered in the state.

7 Maryland also offers family or consumer training, dietician/nutrition training, senior center plus.

8 North Dakota also offers family personal care and chore service.

9 Ohio also offers adult day services.

10 South Dakota also offers nursing services and adult day care services.

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**
Tennessee[11]	✔	✔	✔		✔			✔		✔		✔		✔	✔	✔						
Texas	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	
Utah	✔	✔	✔	✔	✔					✔		✔		✔	✔	✔						
Vermont[12]	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔	✔	✔
Virginia***																						
Washington[13]	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔	✔
West Virginia	✔		✔	✔								✔				✔						
Wisconsin***	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔					✔
Wyoming	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔		✔		✔						

* Personal Emergency Response Systems

** One-time expenses associated with move from an institution to the community, e.g., security deposits, moving expenses.

*** SUA does not operate Medicaid HCBS waivers, but, in some instances, provided information about services offered in the state.

[11] Tennessee also offers pest control and adult day care.

[12] Vermont provides services under its 1115 waivers.

[13] Washington provides case management as an administrative function.

APPENDIX

Table 12: State Funded HCBS Services Administered by SUA

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**	FY2009 Funding
Alabama*																							
Alaska[1]	✔	✔						✔		✔		✔											
Arizona		✔														✔							$17M
Arkansas*																							
California[2]	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			$8M
Colorado	✔	✔	✔	✔	✔	✔				✔				✔		✔							$20M
Connecticut[3]	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔		✔	✔					✔	$2.2M
Delaware	✔	✔	✔	✔				✔		✔		✔		✔		✔						✔	$2.3M
District of Columbia	✔	✔	✔	✔						✔				✔		✔	✔						$15M
Florida	✔	✔		✔	✔					✔		✔		✔		✔							
Georgia	✔	✔	✔		✔	✔		✔						✔									
Hawaii	✔	✔	✔	✔		✔								✔		✔							$4.85M
Idaho																✔							$1.3M
Illinois	✔												✔	✔		✔						✔	$400M
Indiana	✔	✔	✔	✔	✔		✔	✔		✔	✔	✔		✔	✔	✔							$48M
Iowa	✔	✔	✔	✔		✔	✔		✔	✔	✔	✔	✔	✔		✔	✔						$5.6M
Kansas[4]	✔	✔	✔			✔				✔		✔				✔							$3M
Kentucky[5]	✔	✔	✔										✔	✔		✔							$26.9M
Louisiana	✔	✔		✔						✔				✔		✔							$20M
Maine	✔	✔	✔	✔	✔					✔		✔				✔		✔		✔	✔		$11M
Maryland	✔	✔	✔	✔	✔		✔	✔[6]				✔		✔	✔								$12.3M
Massachusetts	✔	✔	✔	✔	✔					✔		✔	✔	✔		✔						✔	

Continues

*SUA does not offer state funded HCBS.

1 Alaska also offers adult day care, ADRD Education and Support for Adults (60) plus.

2 Services eliminated and funding cut October 2009.

3 Connecticut also offers adult day care, skilled nursing, chore, and mental health counseling.

4 Kansas also offers chore services.

5 Kentucky offers adult day care.

6 Maryland also offers a congregate housing services program assisted living subsidies.

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**	FY2009 Funding
Michigan*																							
Minnesota	✔	✔	✔	✔	✔							✔		✔	✔	✔							$45M
Mississippi														✔									$250K
Missouri[7]		✔	✔											✔		✔							$9.4M
Montana*																							
Nebraska	✔																						$1.9M
Nevada	✔	✔	✔		✔											✔							$1.9M
New Hampshire	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	✔	✔	✔	✔	✔					✔	
New Jersey	✔	✔		✔	✔	✔				✔	✔	✔		✔		✔							$21.1M
New Mexico*																							
New York[8]	✔	✔			✔					✔		✔		✔		✔							$77.4M
North Carolina	✔	✔	✔	✔				✔		✔			✔	✔	✔	✔							$102.6M
North Dakota[9]							✔							✔									
Ohio*																							
Oklahoma	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔	$450K
Oregon		✔	✔	✔	✔	✔								✔		✔							$2-12M
Pennsylvania	✔	✔	✔	✔	✔	✔	✔			✔		✔		✔	✔	✔						✔	
Rhode Island	✔	✔		✔	✔			✔		✔		✔		✔	✔	✔	✔	✔	✔	✔	✔	✔	$7.1M
Samoa																							
South Carolina	✔	✔	✔	✔						✔				✔		✔							$4.25M[10]
South Dakota							✔	✔				✔											$1.7M
Tennessee	✔		✔											✔		✔							$9M
Texas	✔	✔			✔	✔	✔	✔		✔	✔	✔	✔			✔	✔	✔		✔	✔		$13.2M
Utah	✔		✔		✔					✔		✔			✔	✔							$2.9M

Continues

*SUA does not offer state funded HCBS.

7 Missouri also offers Alzheimer's Support Services.

8 New York also offers shopping assistance, nutrition counseling and education, social adult day care, housekeeper/chore, and personal care.

9 State funded HCBS services are administered in North Dakota's Medical Services Division under its umbrella agency, the Department of Human Services.

10 $2.9M non-recurring.

State	Case Management	Respite	Personal Assistance	Transportation	PERS*	Day Habilitation	Adult Foster Care	Assisted Living	Behavioral Supports	Environmental Modifications	Residential Habilitation	Equipment & Supplies	Supported Living	Home Delivered Meals	Nutritional Supplements	Homemaker	Supported Employment	Speech Therapy	Recreational Therapy	Occupational Therapy	Physical Therapy	Community Transition**	FY2009 Funding
Vermont[11]		✔	✔	✔							✔												$8.4M
Virginia[12]	✔	✔												✔									$3.3M
Washington	✔	✔[13]	✔	✔		✔	✔	✔			✔			✔			✔					✔	$20M
West Virginia		✔		✔										✔		✔							$28M
Wisconsin*																							
Wyoming	✔	✔	✔		✔	✔		✔		✔		✔				✔							$6.9M

*SUA does not offer state funded HCBS.

11 Vermont also offers home sharing, flexible LTC funding to AAAs, state GF attendant services, home delivered meals to persons under 60 with disabilities, foster grandparents, housing and supportive services.

12 Virginia also offers selected adult day programs.

13 Washington also offers a state funded family caregiver support program, in addition to respite.

APPENDIX

Table 13: Financial Management Services Models Used By SUAs in Self Directed Programs

State	Fiscal conduit (government or vendor)	Government fiscal/employer agent	Vendor fiscal/employer agent	Agency with choice	Other
Alabama			✔		
Alaska					
Arizona					
Arkansas			✔		
California					No OAA self-directed services
Colorado			✔		
Connecticut			✔		
Delaware			✔		
District of Columbia					No self-directed services
Florida			✔		
Georgia	✔				
Hawaii					No self-directed services
Idaho					
Illinois			✔		
Indiana	✔				
Iowa	✔				
Kansas			✔		
Kentucky	✔				
Louisiana					
Maine	✔				
Maryland	✔				
Massachusetts	✔				
Michigan			✔		
Minnesota	✔		✔	✔	
Mississippi	✔				No self-directed services
Missouri	✔				
Montana					No self-directed services

Continues

State	Fiscal conduit (government or vendor)	Government fiscal/employer agent	Vendor fiscal/employer agent	Agency with choice	Other
Nebraska					
Nevada				✔	
New Hampshire			✔		
New Jersey			✔		
New Mexico			✔		
New York					No self-directed services
North Carolina			✔		
North Dakota					No self-directed services
Ohio			✔		
Oklahoma			✔		
Oregon					
Pennsylvania			✔		
Rhode Island	✔		✔		
South Carolina					No self-directed services
South Dakota					No self-directed services
Tennessee			✔		
Texas			✔		
Utah					
Vermont			✔		
Virginia			✔		
Washington		✔	✔		
West Virginia					
Wisconsin					No self-directed services
Wyoming					No self-directed Services

Financial Management Services Models
DEFINITIONS[1]

Fiscal Conduit—A government entity or vendor disburses public funds via cash or vouchers to participants or representatives. If the participant chooses to directly hire workers and serve as their common law employer, the participant is responsible for managing all payroll-related duties, including paying wages, tax withholding, calculating, depositing and filing and for doing so in compliance with Federal, State and Local tax, wage and hour rules and regulations. If the participant uses agency or vendor services, the participant is responsible for making payments to the agency or vendor.

Fiscal/Employer Agent (F/EA)—With an F/EA model, the program participant or representative is the common law employer of workers hired, trained and managed by the participant/representative. The F/EA serves as the participant employer's employer agent. The F/EA pays workers and vendors on the participant's behalf and, using a separate Federal Employer Identification Number (FEIN) for the purpose of serving as an F/EA, the F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both employer and employee Social Security and Medicare Taxes. The F/EA is jointly liable with the participant for any unfulfilled tax obligations for the above mentioned taxes. The Fiscal/Employer Agent model can be separated into two sub-models, each of which is subject to specific IRS Revenue Procedures. The sub-models of the F/EA model are the *Government F/EA* and *Vendor F/EA* models.

Government F/EA—An F/EA operating per the Government F/EA model must be a Federal, state or local government entity. The Government F/EA obtains a separate FEIN to serve as an employer agent of participant employers. The Government F/EA performs the standard F/EA duties, but the Government F/EA can also file and deposit Federal Unemployment Tax Act (FUTA) taxes in aggregate on behalf of all participant employers represented using a separate FEIN for that purpose. Depending on State requirements, employers represented by a Government F/EA may not need to obtain individual FEINs. Per IRS Notice 2003-70, a Government F/EA can designate Fiscal/Employer Agent duties to a sub-agent who represents the Government F/EA as an *employer agent*. The sub-agent can be a contracted vendor. Government F/EAs are subject to IRS Revenue Procedures 80-4 and as modified by IRS Proposed Notice 2003-70.

---

[1] Financial Management Services: Models and Costs, Fact Sheet Fiscal Models, Mollie Grotpeter, National Resource Center for Participant Directed Services (NRCPDS), *http://hcbs.org/files/154/7671/FMS_Models.pdf*

Vendor F/EA—An F/EA operating per the Vendor F/EA model must not be a government entity, but can be a for-profit or non-profit organization. The Vendor F/EA performs the standard F/EA duties, but as of February 2009, the Vendor F/EA can file and deposit FUTA taxes in aggregate on behalf of all participant employers represented using a separate FEIN for that purpose per *verbal* guidance provided by IRS staff at the December 5, 2005 F/EA Conference and Workshop. The IRS is in the process of developing formal guidance that directs Vendor F/EAs to file and deposit FUTA in the aggregate using the Vendor F/EA's separate FEIN. Employers represented by a Vendor F/EA must always obtain an FEIN to be used to designate the Vendor F/EA as the *agent of employer* using IRS Form 2678, *Employer Appointment of Agent,* under Section 3504 of the Internal Revenue Code. A Vendor F/EA can designate certain wage payment and tax withholding, depositing and filing duties to a reporting agent, but the reporting agent will not incur liability for any unfulfilled Federal tax obligations. Vendor F/EAs are subject to IRS Revenue Procedure 70-6.

Agency with Choice—In an Agency with Choice model, an agency is the primary employer of workers who provide service to the participant for human resource, payroll and insurance requirements. The program participant or representative serves as the "managing employer" of workers and in that role refers workers to the Agency with Choice for hire, participates in training and setting terms and conditions of work, supervises worker activities and discharges the worker from the work site, which is usually the participant's home. The agency may provide supportive services to workers or participants.

APPENDIX

Table 14: Total Expenditures*

50 STATES, DC, & TERRITORIES

Year	Total Expenditures All Services	Personal Care	Case Management	Home Delivered Meals	Congregate Meals	Transportation	Information & Assistance
2008	$3,428,178,646	$312,625,658	$257,126,283	$753,326,662	$636,310,615	$201,961,170	$146,814,548
2007	$3,173,438,705	$236,054,216	$223,193,079	$723,114,513	$625,408,698	$202,559,757	$138,611,304
2006	$2,970,337,999	$203,187,181	$137,248,926	$699,350,894	$605,537,993	$186,271,469	$127,082,810
2005	$2,478,878,580	$162,956,790	$116,683,574	$646,481,890	$582,698,389	$176,696,799	$105,899,513
2004	$2,371,468,241	$100,715,842	$113,870,026	$670,205,895	$613,238,651	$186,276,714	$103,586,367
2003	$2,414,531,289	$102,023,088	$114,064,191	$661,458,790	$621,718,380	$186,389,706	$105,407,221
2002	$2,325,015,974	$110,228,344	$96,596,033	$626,312,763	$591,894,748	$195,003,121	$99,333,166
2001	$2,280,860,764	$100,932,296	$85,783,647	$597,710,089	$591,049,195	$185,267,504	$99,272,359
2000	$2,097,177,594	$131,132,733	$80,272,618	$533,948,901	$563,419,943	$162,426,069	$89,642,645

Total Expenditures Per Unit*

50 STATES, DC, & TERRITORIES

Year	Personal Care	Case Management	Home Delivered Meals	Congregate Meals	Transportation	Information & Assistance
2008	$18.10	$57.91	$5.14	$6.75	$7.13	$12.15
2007	$16.73	$57.99	$5.13	$6.59	$6.89	$11.14
2006	$13.94	$35.46	$4.99	$6.18	$6.51	$9.66
2005	$14.03	$30.13	$4.61	$5.80	$5.63	$8.08
2004	$10.94	$29.91	$4.68	$5.81	$5.46	$7.70
2003	$11.25	$30.45	$4.63	$5.87	$5.16	$8.36
2002	$12.23	$24.98	$4.41	$5.46	$5.26	$8.11
2001	$10.30	$22.80	$4.16	$5.27	$4.69	$7.58
2000	$11.61	$24.81	$3.71	$4.86	$4.02	$6.67

*Source: Aging Integrated Database (AGID), State Program Reports 2000-2008, *www.aoa.gov.*

Total Service Units*

50 STATES, DC, & TERRITORIES

Year	Personal Care	Case Management	Home Delivered Meals	Congregate Meals	Transportation	Information & Assistance
2008	17,269,583	4,439,804	146,419,344	94,216,547	28,330,568	12,079,465
2007	14,108,228	3,848,615	140,990,834	94,875,935	29,389,427	12,442,237
2006	14,580,614	3,870,445	140,212,524	98,031,661	28,622,398	13,154,814
2005	11,616,818	3,872,927	140,132,325	100,530,354	31,409,896	13,105,303
2004	9,209,726	3,806,982	143,163,389	105,606,162	34,106,651	13,445,892
2003	9,072,595	3,745,400	142,889,385	105,905,622	36,100,323	12,601,715
2002	9,011,187	3,866,325	141,958,732	108,333,836	37,094,425	12,255,160
2001	9,797,767	3,762,605	143,719,629	112,243,758	39,515,317	13,099,628
2000	11,291,265	3,234,970	143,804,683	116,016,249	40,368,942	13,446,133

Total Unduplicated Clients Served*

50 STATES, DC, & TERRITORIES

Year	Personal Care	Case Management	Home Delivered Meals	Congregate Meals
2008	109,488	502,675	909,913	1,656,634
2007	114,106	494,607	916,708	1,667,218
2006	112,111	446,154	921,475	1,695,740
2005	96,253	426,559	940,767	1,748,994
2004	83,558	404,526	969,010	1,778,516
2003	80,356	414,594	952,672	1,839,064
2002	96,563	412,099	1,000,662	1,905,416
2001	98,645	435,609	929,460	1,747,751
2000	114,339	458,573	954,504	1,744,862

*Source: Aging Integrated Database (AGID), State Program Reports 2000-2008, *www.aoa.gov.*

APPENDIX

State by State Summary Chart: Programs and Services Administered by SUAs

State	Home Delivered Meals	Congregate Meals	Family Caregiver Support	Disease Prevention and Health Promotion	Transportation	Personal Care	Homemaker	Chore	Case Management	Respite	Low Income Home Energy Assistance Program (LIHEAP)	Adult Day Care	Senior Centers	Senior Service Community Service Employment Program
Alabama	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Alaska	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	
Arizona	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Arkansas	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
California	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔
Colorado	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Connecticut	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Delaware	✔	✔	✔	✔	✔	✔	✔		✔	✔		✔		✔
District of Coulmbia	✔	✔	✔		✔		✔	✔	✔	✔		✔	✔	✔
Florida	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Georgia	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Hawaii	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔	
Idaho	✔	✔	✔	✔	✔		✔	✔	✔	✔				✔
Illinois	✔	✔	✔	✔			✔		✔			✔	✔	✔
Indiana	✔	✔		✔	✔	✔	✔	✔	✔	✔		✔		✔
Iowa	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
Kansas	✔	✔	✔	✔		✔	✔	✔	✔	✔		✔		
Kentucky	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔	✔	✔
Lousiana	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Maine	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔
Mariana Islands	✔	✔	✔	✔	✔	✔				✔			✔	✔
Maryland	✔	✔	✔	✔		✔	✔	✔	✔	✔			✔	✔
Massachusetts	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Michigan	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Minnesota	✔	✔	✔	✔	✔		✔	✔		✔				
Mississippi	✔	✔	✔	✔	✔	✔	✔		✔	✔		✔	✔	✔
Missouri	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔	✔	✔
Montana	✔	✔	✔		✔	✔	✔	✔	✔	✔	✔		✔	
Nebraska	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Nevada	✔	✔	✔	✔		✔	✔	✔	✔	✔		✔	✔	✔
New Hampshire	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	
New Jersey	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	

Long-Term Care Ombudsman (LTC facility)	Long-Term Care Ombudsman (in home services)	Legal Assistance Development	Elder Abuse Prevention	Adult Protective Services	State Pharmaceutical Assistance	Senior Medicare Patrol	State Health Insurance Assistance Program (SHIP)	Information and Referral	State Adult Guardianship Program	Medicaid Institutional Care (nursing facility)	Preadmission Screening and Resident Review (PASRR)	Supplemental Nutrition Assistance Program (formerly Food Stamps)	Child and Adult Care Food Program (CACFP)	Emergency Food Assistance Program (TEFAP)	Commodity Supplemental Food Program (CSFP)	Senior Farmers' Market Nutrition Program (SFMNP)
✔		✔	✔		✔	✔	✔	✔								✔
		✔	✔	✔		✔	✔	✔		✔	✔	✔	✔	✔		✔
✔		✔	✔	✔		✔	✔	✔								
✔		✔	✔	✔		✔		✔								✔
✔		✔	✔				✔	✔								
✔		✔	✔	✔				✔								
✔		✔	✔			✔	✔	✔								
✔		✔	✔	✔		✔		✔			✔				✔	
✔	✔	✔	✔				✔	✔		✔						
✔		✔	✔		✔	✔	✔	✔	✔		✔		✔			✔
✔		✔	✔	✔	✔	✔	✔	✔	✔							✔
✔			✔			✔	✔	✔								
✔		✔	✔	✔		✔		✔								
✔		✔	✔		✔			✔			✔		✔			✔
✔				✔				✔	✔	✔	✔					✔
✔		✔	✔					✔	✔							✔
✔		✔	✔	✔[1]		✔	✔	✔		✔	✔					
✔		✔	✔				✔	✔	✔							
✔		✔	✔	✔	✔											
✔	✔	✔	✔	✔		✔	✔	✔	✔							
		✔	✔				✔	✔				✔				
✔		✔	✔			✔	✔	✔	✔							✔
✔	✔	✔	✔	✔	✔		✔	✔	✔						✔	✔
✔		✔	✔				✔	✔								✔
✔	✔	✔	✔	✔	✔	✔	✔	✔			✔					
✔		✔	✔	✔		✔	✔	✔					✔			✔
✔		✔	✔	✔				✔								
✔		✔													✔	✔
✔		✔	✔			✔		✔								✔
✔		✔	✔	✔	✔		✔	✔								✔
✔	✔		✔	✔		✔	✔	✔	✔	✔						
		✔	✔	✔			✔	✔	✔		✔					

[1] The Kansas SUA prosecutes adult abuse and neglect in elder care homes. The Kansas Department of Social and Rehabilitative Services is responsible for APS in other settings.

Continues

State	Home Delivered Meals	Congregate Meals	Family Caregiver Support	Disease Prevention and Health Promotion	Transportation	Personal Care	Homemaker	Chore	Case Management	Respite	Low Income Home Energy Assistance Program (LIHEAP)	Adult Day Care	Senior Centers	Senior Service Community Service Employment Program
New Mexico	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
New York	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
North Carolina	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
North Dakota	✔	✔	✔	✔						✔			✔	✔
Ohio	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔
Oklahoma	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	
Oregon				✔		✔	✔	✔	✔	✔		✔		✔
Pennsylvania	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	✔
Rhode Island	✔	✔	✔	✔	✔	✔	✔		✔	✔		✔	✔	
South Carolina	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔	✔	✔
South Dakota	✔	✔	✔		✔	✔	✔	✔	✔	✔				
Tennesse	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	
Texas	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	
Utah	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔			✔	✔
Vermont	✔	✔	✔	✔	✔	✔	✔		✔	✔		✔		✔
Virginia	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔		✔
Washington	✔	✔	✔	✔	✔	✔		✔	✔	✔		✔		✔
West Virginia	✔		✔	✔	✔	✔	✔	✔		✔		✔	✔	✔
Wisconsin	✔	✔	✔	✔	✔		✔	✔	✔	✔		✔	✔	✔
Wyoming	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔		✔	✔	

Long-Term Care Ombudsman (LTC facility)	Long-Term Care Ombudsman (in home services)	Legal Assistance Development	Elder Abuse Prevention	Adult Protective Services	State Pharmaceutical Assistance	Senior Medicare Patrol	State Health Insurance Assistance Program (SHIP)	Information and Referral	State Adult Guardianship Program	Medicaid Institutional Care (nursing facility)	Preadmission Screening and Resident Review (PASRR)	Supplemental Nutrition Assistance Program (formerly Food Stamps)	Child and Adult Care Food Program (CACFP)	Emergency Food Assistance Program (TEFAP)	Commodity Supplemental Food Program (CSFP)	Senior Farmers' Market Nutrition Program (SFMNP)
✔	✔	✔	✔	✔	✔	✔	✔	✔								
✔		✔	✔			✔	✔	✔								
✔		✔	✔	✔				✔	✔							✔
✔		✔	✔	✔				✔	✔							
✔	✔	✔	✔			✔		✔			✔					✔
✔		✔	✔					✔	✔	✔	✔					✔
		✔	✔	✔		✔		✔	✔	✔	✔	✔				✔
✔		✔	✔	✔	✔		✔	✔	✔	✔	✔					
✔	✔	✔	✔	✔	✔	✔	✔	✔	✔							✔
✔		✔	✔			✔	✔	✔								
✔		✔	✔	✔			✔	✔	✔	✔	✔					
✔		✔	✔			✔	✔	✔	✔							
✔		✔	✔				✔	✔	✔	✔	✔					
✔		✔	✔	✔		✔	✔	✔								
✔	✔		✔	✔	✔		✔	✔	✔	✔	✔				✔	✔
✔		✔	✔				✔	✔	✔							✔
✔		✔	✔	✔	✔			✔		✔	✔	✔		✔	✔	✔
✔		✔	✔				✔	✔								
✔		✔	✔	✔		✔	✔	✔			✔					✔
✔	✔	✔	✔					✔							✔	

APPENDIX

State Aging Councils, Boards or Other Bodies—Authorities[1]

Arizona

Arizona Revised Statutes 46-183
http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/46/00183.htm&Title=46&DocType=ARS

Colorado

Colorado Revised Statutes 2008 26-11-100.1
http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp=

Connecticut

General Statutes of Connecticut Section 17b-420
http://search.cga.state.ct.us/dtsearch_pub_statutes.html

Delaware

Delaware Code Title 29, Chapter 79, Subchapter 1, Section 7915
http://delcode.delaware.gov/title29/c079/sc01/index.shtml

Georgia

Official Code of Georgia, Title 49, Chapter 6

Idaho

Idaho Code 67-5001

Indiana

Indiana Code 12-10-2
http://www.in.gov/legislative/ic/code/title12/ar10/ch2.html

Iowa

Iowa Code Chapter 231.11
http://search.legis.state.ia.us/NXT/gateway.dll/ic/2009code/1/7706/8436/8437/8443?f=templates$fn=document-frameset.htm$q=[field%20folio-destination-name:'sec_231_11']$x=Advanced#0-0-0-38983

---

[1] Only those states that provided information about their state aging councils, boards or other oversight authorities are represented in this list.

Kansas

Kansas Statutes Annotated 75-5914
http://www.kslegislature.org/legsrv-statutes/getStatute.do

Louisiana

Louisiana Code RS 46:933
http://law.justia.com/louisiana/codes/66/101039.html

Maryland

Maryland Code, Human Services, Article 10
http://www.michie.com/maryland/lpext.dll?f=templates&fn=main-h.htm&2.0

Michigan

Older Michiganians Act
http://198.109.173.11/(S(nnishteywwkcme45fnsqnvyc))/documents/mcl/pdf/mcl-Act-180-of-1981.pdf

Minnesota

Minnesota Revised Statutes Chapter 256, Section 975
https://www.revisor.leg.state.mn.us/statutes/?id=256.975

Missouri

Executive Order 01-02
http://sos.mo.gov/library/reference/orders/2001/eo01_002.asp

Nebraska

Nebraska Revised Statutes 68-1104 and 81-2212
http://nebraskalegislature.gov/laws/statutes.php?statute=s6811004000
http://nebraskalegislature.gov/laws/browse-chapters.php?chapter=81&print=true

Nevada

Nevada Revised Statutes 427A.032-427A.038
http://www.leg.state.nv.us/Nrs/NRS-427A.html

New Hampshire

New Hampshire Statutes Chapter 161-F: Elderly and Adult Services
http:www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-x11-161-F.htm

New Jersey

Independence, Dignity and Choice in Long-Term Care Act
http://www.njleg.state.nj.us/2006/Bills/AL06/23_.PDF

New Mexico

New Mexico Statutes Annotated 1978, Article 4, Section 28-4-9
http://conwaygreene.com/nmsu/lpext.dll?f=templates&fn=main-hit-h.htm&2.0

New York

New York State Elder Law, Title 1, Section 210
http://public.leginfo.state.ny.us/menugetf.cgi

North Carolina

North Carolina General Statutes 143B-180
http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_143B/GS_143B-180.html

North Dakota

North Dakota Century Code Chapter 50-06-01.4(3); NDCC 50-06-05.6 and NDCC 54-07-01.2
http://www.legis.nd.gov/cencode/t50.html

Oklahoma

Oklahoma Administrative Code 340:105-10-12
http://www.okdhs.org/library/policy/oac340/105/01/0010000.htm

Oregon

Oregon Revised Statutes (ORS), Chapters 410.320 to 410.340
http://www.leg.state.or.us/ors/

South Carolina

South Carolina Code of Law Section 43-21-10
http://www.scstatehouse.gov/code/t43c021.htm

Tennessee

Rules of Tennessee Commission on Aging
Chapter 0030—3 Commission Organization and Conduct of Business
http://www.tennessee.gov/sos/rules/0030/0030-history.pdf

Texas

Texas Administrative Code, Title 40, Part I, Chapter 1, Subchapter A, Rule 1.4
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=40&pt=1&ch=1&sch=A&rl=Y

Vermont

Vermont Statutes, Title 33: Human Services, Chapter 5: Disabilities, Aging, and Independent Living Program, Section 505 Advisory Board
http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=33&Chapter=005&Section=00505

Virginia

Section 2.2-2626 Code of Virginia
http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-2626

Washington

Revised Code of Washington (RCW) 43.20A.680
http://apps.leg.wa.gov/RCW/default.aspx?cite=43.20A.680

APPENDIX
Evolution of the State Units on Aging

Within the policy context, the origins of state attention to the needs of the aging population predate the adoption of the Social Security Act of 1935 (P.L.74-271). In 1915, Alaska passed the first old age pension act in the nation whose constitutionality went unchallenged. By 1933, at the height of the Great Depression, twenty-five states had passed laws establishing old-age pensions for unemployed older workers. Although these laws faced many constitutional challenges, they clearly laid the foundation for support of the Social Security retirement program. The Social Security Act of 1935 also expanded state government's capacity to finance public assistance programs, and served to firmly establish a federal–state partnership in serving older persons. By 1938, all of the states provided old-age assistance payments under the Social Security Act.

In the area of social services, documentation usually dates to the early 1920s as a period in which efforts were begun at the state and local level to address the needs of the elderly poor, specifically, alms and settlement houses sponsored and subsidized by individual state and county governments and private philanthropy.

The years following the enactment of the Social Security Act in 1935 represent a significant departure in state activity for the elderly. Most observers attribute the increased attention to a new awareness of the growing proportion of older persons in the U.S. population, to the substantial medical advances being made, and to their implications for the society as a whole. Likewise, the early efforts of human service personnel, primarily public assistance caseworkers, to document the widespread social and economic problems of aging were also an impetus. Evidence of the increasing concern can be found in a number of developments that were beginning to emerge at the state level. Some examples include:

- **Maryland** in 1943 established a state foster care program for the aged.
- **Connecticut** in 1945 established a "Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm" which, subsequently, in 1957, was reconstituted as the "Commission on Services for Elderly Persons."
- **Indiana** in 1946 set up a Division of Geriatrics in its State Health Department, followed almost immediately by the convening of one of the first conferences on the relation of community services to the problems of aging.
- In 1947, **New York** and then **Massachusetts** set up Joint Legislative Committees on the Problems of the Aging with the purpose of conducting statewide needs assessments of older persons.

State activity expanded remarkably during the early 1950s. The first national Conference on Aging was convened in August of 1950 by the Federal Security Agency, the predecessor to the U.S. Department of Health, Education and Welfare. In preparation for the conference, study commissions—the forerunners to today's State Units on Aging—were set up in many states to inventory various approaches underway to serve the needs of the elderly. California, Wisconsin, Minnesota and North Carolina led the way in moving their committees to permanent state commissions and establishing state legislative bases for aging programs.

By 1952, fifteen states had designated state agency personnel or whole units of state government to work on aging issues. In September of 1952 and June of 1956, the first and second federal–state convocations on aging were held, titled "A Conference of the State Commissions on Aging and Federal Agencies." By 1955, the number of states with such designated personnel or units had grown to thirty-two. For the most part, state personnel or units were not directly involved in administering programs or providing services. Instead they tended to be advisory bodies charged with responsibility for conducting studies, developing plans and proposed legislation, and statewide coordination.

During this time, the Council of State Governments released two reports documenting activities underway in the states, focusing on the needs of older persons. The reports were titled "The States and Their Older Citizens" (published in 1955) and "State Action in the Field of Aging: 1956-57." Both of these reports documented a veritable multiplication of age-related activities and both included recommendations to governors and state legislatures on aging service needs. Interestingly, a major theme of both reports was the need for enhanced coordination among state level agencies dealing with aging issues. The Council recommended not the establishment of new state executive agencies on aging, but rather the creation of interdepartmental committees focusing on aging; that governors appoint special assistants on aging; and that citizen advisory boards should be created to guide statewide aging efforts.

By 1960, a number of states, including California, New York, Maryland, Louisiana, Minnesota, New Jersey, and Rhode Island, had full time executive officers on aging (the forerunners to today's state aging directors) with staffs and budgets ranging from $10,000 to $100,000 a year. Practically speaking, however, most states had housed their aging activities in at least two governmental agencies, and a number of the states juggled programs in four or more departments. More importantly, by 1961, the year of the first White House Conference on Aging (WHCoA), every state had established a committee or commission on aging, and each was provided with federal resources to help plan and attend the conference.

A number of recommendations in the final report from the 1961 WHCoA (*The Nation and Its Older People*) focused on the need for a state level entity on aging, most notably:

In each State there should be established a permanent unit (office, commission or agency) on aging, to provide statewide leadership in aging.

It was further recommended that such units should be established by legislative action as permanent and official parts of state government. While they should be independent of the existing state agencies, they should include representation from all other related departments. Another series of conference resolutions proposed specific functions for the units and stressed the importance of adequate funding. Finally, there was an expectation of federal support through grant funds and technical assistance.

During the early 1960s, a number of state legislatures began to appropriate targeted funds (albeit relatively small) for aging service demonstration programs. For example, in Pennsylvania, $216,000 was made available to counties in the Commonwealth to provide a range of aging services. In California, a special state appropriation of $150,000 was approved to "help older people remain in the community." And in Wisconsin, the State Commission on Aging was allocated $50,000 initially to address the needs of the aged, with a particular focus on coordination and review activities. These early efforts, as well as those of many other states, played a key role in raising national attention to the needs of the elderly and gaining national acceptance for increasing the allocation of the nation's resources to meet those needs.

After much public and congressional debate, forums, platforms, and dialogues throughout the early 1960s, President Lyndon Johnson, on July 14, 1965, signed into law the Older Americans Act (PL-89-73). Title III of the new law provided for a program of grants to states for developing and establishing social services for the elderly. In order to qualify for those grants states were required to designate a single state agency to put forth a plan for developing and implementing a statewide aging program.

NOTES

NOTES

NOTES