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OLDER AMERICANS ACT: PROTECTING AND SUPPORTING SENIORS AS THEY AGE

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Chairman Collins, Senator Casey, and Members of the Committee, thank you for the opportunity to discuss the important and successful programs made available by Older Americans Act (OAA).

For more than 50 years, the OAA has provided critical services that have enabled millions of older Americans to live independently, with dignity, and in their homes and communities. OAA's programs are highly successful because they are flexible, meet the unique needs of each state and community, and because they require the input and participation of each individual served.

Every seven seconds, one of America's 78 million Baby Boomers will celebrate their 60th birthday. That's a rate of 10,000 people – the equivalent of the population of a small town in America – joining the "senior" ranks every day. Put another way, the census estimates that the number of Americans age 60 and older will increase by over 8.9 million older adults between 2016 and 2020, to reach a total of 77.6 million.[1] During this period, the number of Americans age 65 and over with severe disabilities (defined as three or more limitations in activities of daily living), who are most likely to receive nursing home admission and qualify for Medicaid, will increase by 15 percent.[2]

The OAA has been at the foundation of my entire career. Before I was appointed to serve as the Assistant Secretary for Aging within the Department of Health and Human Services (HHS), I had the privilege of administering OAA programs at the state level for a decade (serving two very different governors) in Oklahoma. During my 12 years as an administrator at Oklahoma

[1] U.S. Census Bureau. Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2016. Release Date: June 2017. Accessed January 2018. U.S. Census Bureau. Population Division. Table 9. Projections of the Population by Sex and Age for the United States: 2015 to 2060 (NP2014-T9). Release Date: December 2014. Accessed January 2018.

[2] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html Accessed January, 2018.

State University, which included co-founding the University's Gerontology Institute, I was very involved in OAA work. In addition, we were the Area Agency on Aging (AAA) subgrantee for the Title III-E Caregiver program. Based on my experience, I believe the OAA is one of our nation's great success stories.

For these reasons, I am honored to have this opportunity to present information and answer questions about this visionary and successful piece of legislation, which created our country's infrastructure for home and community-based care. In addition, I am honored to represent the federal agency that leads the national aging services network of states, tribes, area agencies on aging, local service providers and thousands of dedicated volunteers who work tirelessly to enhance the health, independence and dignity of our country's senior citizens.

The Administration for Community Living (ACL) was created in 2012 around the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and with the ability to fully participate in their communities. ACL currently funds services and supports provided by networks of community-based organizations, and through our work to advance research, education, and innovation, helps make this principle a reality for millions of Americans.

As part of this important mission, ACL's Administration on Aging (AoA) advocates for the interests of older people and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers. Authorized under OAA, AoA's core programs help older adults remain at home for as long as possible and advocate for individuals who live in long-term care facilities (nursing homes, board and care, assisted living, and similar settings).

OAA Vision

Over five decades ago, the OAA charted a bold vision for building a nationwide network of

public and private agencies and organizations focused on one common mission -- to ensure the dignity and independence of older people. The OAA has a limited federal presence that establishes broad policy and guidance. It works in partnership with states, tribes, area agencies, volunteers, and service providers at the community level with appropriate flexibility to assess and respond to local needs based on the input of consumers. It is a model based not on federal prescriptiveness, but instead on "bottom-up planning." This approach is recommended by global leaders[3] as the most effective model for aging policy planning.

The OAA created the national aging services network, which today includes 56 state and territorial units on aging (SUAs), 618 AAAs, 274 Tribal and Native Hawaiian organizations, more than 20,000 direct-service providers, and hundreds of thousands of volunteers. The OAA then charged this network with responsibility to promote the development of a comprehensive and coordinated system of home and community-based services that would enable our seniors to remain independent in their own homes and communities for as long as possible.

In passing the OAA, Congress intentionally did not create a stand-alone system; nor did it intend to cover all costs associated with serving every older American. Rather, OAA funds are to be used strategically to advance changes in our overall system of care and to fill gaps in services. The aging services network has done an outstanding job in meeting this intent. These programs have strong partnerships with state and local governments, philanthropic organizations, and private donors that also contribute funding. Many program participants also contribute. For every federal OAA dollar, the programs typically secure about three dollars from other sources, significantly exceeding the programs' match requirements.[4]

As a result of our investments in the OAA, we now have a nationwide infrastructure that reaches every community in this country. OAA-funded programs complement efforts of the nation's public health networks, as well as existing medical and health care systems. While each

[3] United Nations "Guidelines for review and appraisal of the Madrid International Plan of Action on Ageing; Bottom-up participatory approach," 2006
[4] AoA's FY 2017 State Program Report.

program or service is valuable, the goal of helping older people remain in their own homes and communities instead of entering nursing homes or other types of institutional care often requires a combination of supports tailored to the needs of the individual.[5]

OAA programs include information and personalized assistance, as well as access to a broad array of benefits and services. Those services support some of life's most basic functions, such as bathing and preparing meals. They also include case management, specialized transportation services, congregate and home-delivered meals, adult day care, senior centers and activities, personal care, homemaker and chore services, health promotion, and disease prevention. The programs assist with practical considerations such as home modifications; issues of exploitation, neglect, and abuse of older adults; and services adapted to the unique needs of Native Americans. They also support family caregivers, who provide the majority of long-term support to older family members and without whom far more people would need care in institutional settings – generally at much higher costs.

In fiscal year (FY) 2017, AoA and the national aging services network provided services to over 11 million individuals age 60 and over (one out of every six older adults), including nearly three million clients who received intensive in-home services. In addition, it provided critical support, such as respite care, to over 716,000 caregivers.

In more than half of the states, the SUA has responsibility for managing one or more of their Medicaid waivers, and the aging network has been charged with serving other populations, including people of all ages with all types of disabilities.

OAA programs are especially critical for the nearly three million older adults who receive intensive in-home services, more than 485,000 of whom meet the disability criteria for nursing

[5] Brock, D et al. "Risk Factors for Nursing Home Placement among OAA Service Recipients: Summary Analysis from Five Data Sources" Westat; U.S. Administration on Aging Contract No. 233-02-0087. http://www.aoa.gov/AoARoot/Program_Results/POMP/docs/Risk_Factors.pdf

home admission.[6] These services help to keep these individuals from joining the 1.9 million older adult residents who live for extended periods of time in nursing homes.[7] This is particularly important given the limited long-term coverage under Medicare and constrictions in the long-term care insurance market, many Americans with few resources will continue to rely on Medicaid to furnish their long-term care. Supporting less costly community-based options will continue to be an important tool in managing federal expenditures.

Our OAA network is making a real difference in the lives of people every day all across this nation. However, if we are to continue to be successful, we must evolve to meet the growth in demand and the increasingly complex combinations of needs of the people we serve. We also must keep pace with the changes occurring in the larger policy environment.

Transformation of Health Care

The effective prevention role that our programs play through the provision of critical services and supports to often vulnerable individuals is pivotal to one of Secretary Azar's top priorities: transforming health care to a value-based healthcare system – one which focuses on sustaining health to avoid the need to treat disease. Such a system will pay providers based on outcomes, rather than on procedures performed. The goal is to lower costs, while also improving outcomes for Americans.

The value-based transformation has multiple components, and one of them is providing care in the lowest-cost appropriate setting. That means avoiding hospitalization and nursing home admissions, shortening duration of stays when they happen, and preventing readmissions after discharge, whenever possible.

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[6] Ibid.

[7] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2013]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed January 2, 2018.

Addressing the social determinants of health – factors that are not specifically "about" health, but which have a direct impact on health and well-being – is critical to that goal. The social determinants include things like having enough nutritious food options, having a safe place to live, and having access to education, medical care, social support, and employment. As the Secretary recently remarked, "Social determinants of health is an abstract term, but for millions of Americans, it is a very tangible, frightening challenge: How can someone manage diabetes if they are constantly worrying about how they're going to afford their meals each week?"[8]

Considering the depth and breadth of services and supports ACL provides to millions of Americans through programs that target the social determinants of health, Secretary Azar has pointed out that we need to better incorporate the aging and disability networks into the overall health care system if we are going to achieve the goal of a value-based system.

I am pleased to be working closely with the Secretary and his team to realize that goal. We are putting significant effort into building our relationships across HHS – and in particular, with the Centers for Medicare & Medicaid Services (CMS) – to enhance systems to better address the issues of Medicare and Medicaid beneficiaries. Together, Medicare, Medicaid, and programs under the OAA, all of which were signed into law in 1965, form one of the cornerstones of a national effort to support the health and well-being of our older citizens and people of all ages with disabilities. These programs are designed to complement one another, so it is critical that ACL and CMS coordinate our efforts.

Key provisions of the OAA

The OAA authorizes a wide array of service programs, including:

Home and Community-Based Supportive Services (HCBSS)

The services provided through the HCBSS program include access services such as

[8] https://www.hhs.gov/about/leadership/secretary/speeches/2018-speeches/the-root-of-the-problem-americas-social-determinants-of-health.html

transportation; case management and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care and physical fitness programs. In addition, HCBSS also funds multi-purpose senior centers, which coordinate and integrate services for the elderly.

Data from AoA's national surveys of elderly clients show that HCBSS are helping older adults remain in their own homes. For example, over 82 percent of clients receiving case management reported that as a result of the services arranged by a case manager they were better able to care for themselves.[9] In addition, a study published in the *Journal of Aging and Health*[10]shows that assistance provided through the "personal care services" component of HCBSS are the critical services that enable frail seniors to remain in their homes and out of nursing home care.

These programs are particularly important to people who live alone (a key predictor of nursing home admission), especially for those who do not have an informal caregiver to assist with their care. Research has shown that childless older adults who live in a state with higher home and community-based services expenditures had significantly lower risk of nursing home admissions.[11] HCBSS programs serve a disproportionate number of people who live alone. For example, 67 percent of transportation clients live alone.[12] In contrast, nationally, 24 percent of individuals 60 and older live alone.[13]

Nutrition Programs

[9] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov
[10] Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors that Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. v22:267. Accessed March 23, 2018 at http://jah.sagepub.com/cgi/content/abstract/22/3/267.
[11] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.
[12] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov
[13] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2015), accessed January 2018.

Half of older Americans are malnourished or at risk of being malnourished[14], and nearly 5 million Americans lack consistent access to enough food for a healthy life. With food insecurity and malnutrition associated with a variety of negative health outcomes, including more frequent and longer hospitalizations, the nutrition programs play an important role in helping older adults remain healthy and independent.

Nutrition programs under OAA help approximately 2.4 million older adults receive meals in order to stay healthy and decrease their risk of disability.[15] The federal funding provided through the OAA is combined with state and local funding, as well as private donations, to assist 5,000 community-based providers in serving nearly 1.5 million meals a day to older adults across the country in both group (congregate) meal settings and through home-delivered meals.[16]

All local service providers serve a meal at the lunch hour, but more than one in ten also serve breakfast or dinner as well. Fifteen percent are open on the weekend.[17]

OAA nutrition programs provide more than just food – they also address other health-related issues. The program's goal is to decrease hunger and food insecurity, decrease isolation, and offer health promotion activities, such as lifestyle modification programs and evidence-based nutrition education and counseling.

This combined approach is particularly important given that older adults who participate in these programs are more likely than the general Medicare population to have chronic health conditions. Overall, 76 percent of community-living Medicare beneficiaries age 65 or older

[14] Hamirudin AH, et al Outcomes related to nutrition screening in community living older adults: a systematic literature review Arch Gerontol Geriatr 2016 62 9-25
[15] AoA's FY 2017 State Program Report.
[16] Ibid.
[17] Mabli et al. Final Report: Process Evaluation of Older Americans Act Title III-C Nutrition Services Program. Report prepared for Administration for Community Living. September 30, 2015.

have multiple chronic conditions.[18] AoA's FY 2017 National Survey of OAA Participants found that 95 percent of participants in the meals programs have multiple chronic conditions; 47 percent of congregate and 64 percent of home-delivered participants have six or more. Over 21 percent of congregate and 40 percent of home-delivered participants take more than six medications per day and some take more than 20. They also are older – the average age is 77 – and more frail than the general Medicare population.

Increasingly, the issue of social isolation – among older adults and the population in general – has been gaining more traction in the field of public health. As one of the earliest programs authorized by Congress under the OAA, the nutrition programs have been at the forefront of tackling social isolation, and participants in both the congregate and home-delivered meals programs report increases in social interaction as a result of the programs. In fact, sometimes the person delivering the meal is the only person the older adult sees regularly; without the meal delivery, the older adult could be completely isolated.

These programs are making a critical difference. In the recent program evaluation[19], 63 percent of congregate meal recipients and 93 percent of home-delivered meal recipients have reported that the meals allowed them to continue living in their own homes. Participants in the congregate meals program also had fewer emergency room visits and fewer hospital admissions than their non-participant peers.

Preventive Health Services

These programs provide states and territories with the flexibility to allocate resources among the preventive health programs of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have

[18] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [data tables 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 02 January 2018.
[19] Mabli et al. Final Report: Process Evaluation of Older Americans Act Title III-C Nutrition Services Program. Report prepared for Administration for Community Living. September 30, 2015.

the greatest economic need.

Evidence-based programs empower older adults to take control of their health by increasing knowledge, changing behavior, and improving self-efficacy and self-management techniques. They are established activities, inputs, and resources for implementing health interventions that have been tested in a controlled trial setting and have been shown to be effective at improving health and/or reducing disease, illness, or injury. The more common programs include Chronic Disease and Diabetes Self-Management Education, behavioral health, and falls prevention programs.

Caregiver Services

Family and other informal caregivers are the backbone of America's long-term care system, and their numbers are growing. Like many of you, I have personally been a caregiver and I appreciate the enormity of what they do and the critical role they play.

A recent National Alliance for Caregiving and AARP research report indicated that approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[20] In other words, approximately 14.3 percent of all adults provided care to someone age 50 years and older.[21] AARP estimated the economic cost of replacing unpaid caregiving in 2013 to be about $470 billion, an increase from $450 billion in 2009 (cost if that care had to be replaced with paid services).[22] Another recent study by the Rand Corporation[23] estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually.

[20] Research Report: Caregiving in the U.S. 2015: A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf. Accessed February 15, 2018.
[21] Ibid.
[22] Valuing the Invaluable: 2015 Update, The Growing Contributions and Costs of Family Caregiving. AARP Public Policy Institute. July 2015. http://www.aarp.org/ppi/info-2015/valuing-the-invaluable-2015-update.html. Accessed February 15, 2018.
[23] The Opportunity Costs of Informal Elder-Care in the United States. Rand Corporation. http://www.rand.org/pubs/external_publications/EP66196.html.

On a daily basis, these individuals, the majority of whom are women, assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. Data from the 2017 National Survey of OAA Participants show that over 20 percent of caregivers are assisting two or more individuals.[24]

Support for caregivers is critical because often it is their availability that determines whether an older person can remain in his or her home. Caregiving is a labor of love, and most report finding it incredibly rewarding. However, it also can create challenges. Many caregivers report difficulty managing physical and emotional stress and balancing work and family responsibilities.

For example, caregivers often experience conflicts between work and caregiving. Among working caregivers caring for a family member or friend, 60 percent report work impacts due to caregiving such as having to rearrange their work schedule, decrease their hours, or take unpaid leave in order to meet their caregiving responsibilities.[25] In addition, over 70 percent of caregivers are themselves 60 or older, making them more vulnerable to a decline in their own health, and over 30 percent describe their own health as fair to poor.[26] Approximately 11 percent of caregivers report that caregiving has caused their physical health to decline.[27]

In the recent survey of participants in the OAA National Family Caregiver Support Program (NFCSP), caregivers reported that the types of support provided through the NFCSP can enable

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[24] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov

[25] Research Report: Caregiving in the U.S. 2015- A Focused Look at Caregivers of Adults Age 50+. National Alliance for Caregiving and AARP Public Policy Institute. June 2015. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf.

[26] 2017 National Survey of Older Americans Act Participants. http://www.agid.acl.gov.

[27] Center on Aging Society. (2005) How Do Family Caregivers Fare? A Closer Look at Their Experiences. (Data Profile, Number 3). Washington, DC: Georgetown University.

them to provide care longer (77 percent) while often continuing to work,[28] thereby avoiding or delaying the need for their loved ones to move to more costly institutional care. Another study indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home at significantly less cost for an average of an additional year before being admitted to a nursing home.[29]

Tribal Programs

Between 2000 and 2010, the number of older American Indian and Alaska Native (AI/AN) adults increased by 40.5 percent, a growth that is 2.7 times greater than that of the overall population of older adults over the same 10-year period.[30] In addition, this rapidly growing population is also experiencing some of the highest rates of disability,[31] chronic disease, and poverty[32] in the United States. Because of the combined factors of an aging population and high disability rates, AI/ANs have a great need for access to home and community-based services in their communities.

Grants from the Native American Nutrition and Supportive Services program support a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, personal care, help with chores, and other services. Currently, the OAA's congregate meals program reaches 42 percent of eligible Native American seniors in participating tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 30 percent of such persons.[33] These programs,

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[28] 2017 National Survey of Older Americans Act participants. http://www.agid.acl.gov.

[29] Mittelman, M., Ferris, S., Shulman, E., Steinberg, G., Levin, B. (1996). A family intervention to delay nursing home placement of patients with Alzheimer's disease - A randomized controlled trial. *The Journal of the American Association*, 276(21), 1725-1731.

[30] Administration on Aging, U.S. Population by Age: 65+ Minority Population Comparison using Census 2000 and Census 2010 (July 1, 2011).

[31] National Council on Disability, "Understanding Disabilities in American Indian and Alaska Native Communities: Toolkit Guide" (2003).

[32] Centers for Disease Control and Prevention, "CDC Health Disparities and Inequalities Report – United States" (2013).

[33] ACL's OAA Title VI Program Performance Report, PY 2017. Title VI of the Older Americans Act permits tribes to establish age of eligibility for services below age 60. Calculation based on eligible population as reported in grantee applications

which can help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and are an important part of each community's comprehensive services.

Grants assist American Indian, Alaska Native, and Native Hawaiian families who are caring for older relatives with chronic illness or disability and help grandparents care for their grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Annually, tribal grantees provided over 100,000 hours of respite care, delivered just over 23,000 hours of caregiver training, and assisted 16,000 caregivers to access needed services.[34]

Reports from the people we serve through these programs have been very positive. I have been very involved in the HHS Secretary's Tribal Advisory Council and those national leaders are very pleased with the services we provide through OAA Title VI as well as other ACL tribally-directed programming.

Elder Rights Protections

The most reliable data on the prevalence of elder abuse tells us that 1 in 10 older people are abused, neglected, or exploited each year, and as many as 4 in 10 are the victims of financial exploitation[35]. Two studies show that about half of people with dementia will be abused or neglected by their family caregivers[36].

[34] Ibid.

35 Lachs, M., & Pillemer, K. (2015). Elder abuse. *New England Journal of Medicine, 373*, 1947–56. doi: 10.1056/NEJMra1404688

[36] Quinn, K., & Benson, W. (2012). The states' elder abuse victim services: a system in search of support. Generations 36(3), 66–71 and Cooper, C., Selwood, A., Blanchard, M., Walker, Z., Blizard, R., & Livingston, G. (2009). Abuse of people with dementia by family carers: representative cross sectional survey. British Medical Journal, 338, b155.

To combat elder abuse, neglect, and exploitation in America, ACL's goal is to establish a comprehensive system to provide a coordinated and seamless response for helping adult victims of abuse, to prevent abuse before it happens, and to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. ACL, along with the National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, and legal systems development and assistance programs, create an interconnected framework for carrying out the OAA's Vulnerable Elder Rights Protection activities under Title VII. Among other things, these programs provide a full array of services that effectively address complaints of abuse, neglect, or violation of rights; advocate for system improvements; and support innovation. The Elder Justice Coordinating Council, which ACL leads on behalf of Secretary Azar, helps ensure that this work spans the whole of government.

The aging services network plays a critical role in this work. For example, the AAA network in Massachusetts builds and promotes partnerships with community colleges, long-term care facilities, adult protective services agencies, law enforcement organizations, area community centers, Long-Term Care Ombudsman programs, financial institutions, housing advocacy groups, and many others to ensure that elder rights are prioritized across the state. In building strong partnerships, the AAAs and community organizations join forces to advocate for and ensure that elders have necessary information available to access community resources for services and care decisions.

Through educational efforts, exposing problems that would otherwise be hidden from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

Long-Term Care Ombudsman Program

State Long-Term Care Ombudsman programs work to resolve problems related to the health, safety, welfare, and rights of individuals who live in long-term care facilities (i.e., nursing homes, board and care, assisted living, and other residential care communities). Ombudsman

programs promote policies and consumer protections to improve long-term services and supports at facility, local, state, and national levels and play an important role in elder justice networks.

Ombudsman programs respond to a wide variety of problems faced by residents of long-term care facilities, including discharge and eviction, inadequate care, rights violations, and quality of life concerns. In FY 2017, they addressed over 200,000 complaints and resolved 73 percent of these complaints to the full or partial satisfaction of the resident or complainant.

Inappropriate discharge or eviction from a nursing home or assisted living continues to be the most common complaint (over 14,000 in FY 2017) and Ombudsman programs employ a number of strategies to support residents to remain in their facility, which is their home. Strategies include informal complaint resolution to address the causes and to find solutions to rescind the discharge, collaboration with legal services to support residents to request an administrative hearing, and calling upon the state survey agency to conduct a regulatory compliance investigation. Ombudsman programs also use systemic approaches such as developing task forces, training both hospital social workers and long-term care facility staff on relevant requirements, and educating residents and their families about their rights.

Reauthorization –

As you know, the current authorization of the OAA expires at the end of September 2019. ACL has been engaged, along with many national organizations, in providing to members of Congress and their staff information about how the OAA programs work and their effectiveness, as well as providing technical assistance related to specific policy proposals being considered.

HHS has developed three proposals for your consideration. For the development of our proposals, we looked at hundreds of comments and the information we received over the past three reauthorizations through formal listening sessions, online submissions, and from engagements at conferences and meetings where we listened intently to the issues raised. When reviewing all of this information, we discovered that about 90 percent of the comments were

related to appropriations, not authorizations. The balance of the items mentioned related to issues that confirmed what we have heard previously:

- That the Act is not "broken" and doesn't need major restructuring – instead, it can use some tinkering to make it consistent with current needs and changing environments;
- It has been effective in achieving the goals established by Congress; and
- It has been the glue in the community that knits together the components that comprise a comprehensive system of supports and services – regardless of funding source.

As a result, it was not necessary to conduct a series of formal listening sessions around the country and we instead used a variety of opportunities to hear stakeholders about their needs and what they believe should be considered as we address reauthorization.

The Administration is advancing the following proposals:

1) Eliminate the Right of First Refusal;
2) Eliminate Older Relative Caregivers Support Services Limit; and
3) Increase Limit on Use of Allocated Funds for State Administrative Costs.

<u>Eliminate the Right of First Refusal</u>

We have heard from states – and I can attest from my time as the administrator of these programs in Oklahoma – that this is needed to enhance their flexibility and to promote greater degrees of federalism.

Currently, the statute prescribes that whenever a state is designating a new AAA that a preference be given to units of local government over other agencies, including established offices of aging. This provision was first added to the Act in 1984 as a means of enhancing the involvement of local government in aging programs. Today, the need to attract the interests of local government in aging programs does not appear to exist to the same degree. As a result, states looking to consolidate AAAs and create efficiencies may wish to offer the role to units of local government, but do not see the need for a mandatory preference.

Eliminate Older Relative Caregivers Support Services Limit

This proposes to remove the 10 percent limit that states can spend out of funding appropriated to the National Family Caregiver Support Program in support of grandparents raising grandchildren. The cap was added in 2000 when the NFCSP was first established. At the time, needs were not known and considering that the initial intent of the program was to serve caregivers supporting older individuals, a cap was placed on the amount that could be used to support care for younger individuals. Since that time, there has been growing awareness of grandparents raising grandchildren, as well as a growing recognition of the need to support them. Unfortunately, this population also is growing, due in part to the opioid crisis. This proposal is consistent with the Administration's budget proposal to afford states maximum flexibility in administering their programs.

Increase Limit on Use of Allocated Funds for State Administrative Costs

Our third proposal is to update and increase the amount that states can use to administer OAA programs. The administration allowance in the statute was last increased from $300,000 to $500,000 in 1992. Over the 27 years since that reauthorization, the older adult population and inflation have risen as well as the costs of administering the State Plan on Aging. Currently, 16 states and DC are limited to $500,000: AK, DE, HI, ID, ME, MT, NE, NH, NM, ND, RI, SD, UT, VT, WV, and WY. The proposal would also impact states that are currently above the limit of $500,000, but below the proposed $750,000: AR, CT, IA, KS, MS, NV, and OK.

Conclusion

Our strategy focuses on empowering our consumers by giving them more choices and greater control over their own health and long-term care, including more control over the types of benefits and services they receive, and the manner in which those benefits and services are delivered. We also are empowering seniors to make evidence-based behavioral changes that will improve their health and well-being and avoid the risk of chronic disease and injury.

Additionally, we are looking at new ways of targeting our limited resources at seniors most in need.

We have made tremendous progress in advancing the goals and objectives of the OAA through the combined efforts of the aging services network. This network literally has built the foundation of this nation's formal system of home and community-based care, and we have done it in partnership with older Americans and their families. I believe keeping consumers front and center is the best way to ensure our success in our OAA programs and the aging services network for the balance of the 21st century.

Thank you for the opportunity to participate in today's hearing. I have appreciated the Committee's support of the OAA and the national aging services network and I look forward to our continued work together. I am happy to answer any questions that you may have.