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Report to Congressional Requesters

June 1992

ADMINISTRATION ON AGING

Operations Have Been Strengthened but Weaknesses Remain

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Program Evaluation and
Methodology Division

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The Honorable Thad Cochran, Ranking Minority Member
Subcommittee on Aging
Committee on Labor and Human Resources
United States Senate

The Honorable Edward M. Kennedy, Chairman
Committee on Labor and Human Resources
United States Senate

The Honorable David Pryor, Chairman
The Honorable William S. Cohen, Ranking Minority Member
Special Committee on Aging
United States Senate

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The Honorable Olympia J. Snowe, Ranking Minority Member
Subcommittee on Human Services
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The Honorable Edward R. Roybal, Chairman
The Honorable Matthew J. Rinaldo, Ranking Minority Member
Select Committee on Aging
House of Representatives

In your letter of June 28, 1991, you requested that we determine how the organizational changes that have taken place in the Department of Health and Human Services (HHS) in the past year have affected the operations of the Administration on Aging (AOA) within the Department.

This report is a continuation of our work on the role of AOA, as set out under the Older Americans Act, in helping to meet the special needs of the elderly by providing them with a wide array of social and nutritional services. Over the past year, we have testified at several congressional hearings on the issue of AOA's ability to carry out its numerous and diverse functions under the act. During this time, HHS made certain internal changes aimed at improving the operations of AOA, as well as enhancing its status within the Department. It was with these changes in mind that you asked us to examine AOA's present ability to fulfill its responsibilities.

Objectives, Scope, and Methodology

The purpose of this report is to provide the Congress with information on (1) how HHS has reallocated staff and funds to allow AOA to perform newly assigned administrative functions, (2) the implications of the reorganization of HHS both for the authority of the Commissioner on Aging and for the congressionally mandated direct reporting relationship between the Commissioner and the Secretary of HHS, and (3) the degree to which our previous findings were taken into account during this reorganization. To address these issues, we interviewed officials from HHS, including the Secretary's chief of staff, the Assistant Secretary for Personnel Administration, representatives of the Assistant Secretary for Management and Budget, the Commissioner on Aging, and other AOA officials. In addition, we reviewed documentation from HHS and AOA.

Our work was performed between October 1991 and April 1992 in accordance with generally accepted government auditing standards.

Results in Brief

In April 1991, HHS officials announced an organizational change that elevated the status of AOA within the Department's organizational structure. As a result, AOA is now responsible for performing numerous administrative functions in addition to its existing programmatic functions. To facilitate the performance of these new functions, AOA received an infusion of full-time-equivalent (FTE) staff for fiscal year 1992.

The enhanced status of AOA means that the Commissioner on Aging is theoretically on an equal footing with other HHS division heads. The Commissioner now has authority over AOA's resources and greater access to the Secretary of HHS, as well as greater leverage to deal with the heads of other divisions. This increased access and strength should reinforce AOA's role as an effective and visible advocate for the elderly.

In addition to its elevation in status, AOA has received a substantial infusion of travel funds, has filled many key leadership positions that had long been vacant, and plans to enhance its program expertise. At the same time, however, AOA's oversight capabilities remain in question, its expertise in the regions has not been enhanced, and its plans to address certain program responsibilities may be inadequate. In addition, the need to harmonize AOA's responsibilities, its program funds, and the demands of the elderly population continues to exist.

Background

Organizational Placement of the Administration on Aging

Since its inception in 1965, AOA has been located within HHS, formerly the Department of Health, Education, and Welfare. Though AOA was placed at a relatively high level within the Department, changes in the Department's structure diminished the visibility and autonomy of AOA. For instance, in the mid 1970's, AOA was placed in the Office of Human Development Services (HDS) along with other social service programs.

While AOA was housed in HDS, HDS performed various administrative functions for AOA (for example, grants management, fiscal management, legislative and public affairs, and so on). Additionally, AOA's administrative budget was under the authority of the Assistant Secretary for HDS. Though the Commissioner on Aging requested salaries and expenses from the Assistant Secretary, it was the latter official who presented the final HDS budget request to the Secretary of HHS. By necessity, the Assistant Secretary for HDS considered the needs of the other agencies within HDS (that is, the Administration for Children, Youth, and Families; the Administration on Developmental Disabilities; and the Administration for Native Americans) when making the request. In effect, AOA competed with the other three agencies within HDS for administrative resources. Moreover, since AOA's salaries and expenses were not separately allocated, HDS had the authority to shift administrative resources from AOA to another agency within the division if necessary.

Although the Congress made various attempts to increase AOA's visibility and autonomy throughout the 1980's (for instance, by strengthening the direct reporting relationship between the Commissioner and the Secretary of HHS), AOA remained within HDS until April 1991. At that time, HDS was disbanded and most of its programs were merged into a new division, the Administration for Children and Families. AOA was the only agency within

HDS to be exempted from the merger. A statement of organization issued by HHS at that time indicated that the Commissioner on Aging would report directly to the Secretary on policy matters and would receive administrative and logistics services from the Office of the Secretary. HHS provided further clarification on the status of AOA in a statement of organization, functions, and delegations of authority in September 1991. This statement formally established AOA as an independent entity within HHS.

Previous Findings

Around the time that HHS announced its reorganization plans, we testified at several congressional hearings about AOA's ability to carry out its numerous functions.[1] During these hearings, we identified the following areas of concern in AOA: (1) the discrepancy between AOA's mission and its level of program funding, (2) the level of administrative resources, and (3) difficulties with the performance of program functions.

AOA's Mission and Program Funding

We previously reported that the mission of AOA had expanded substantially since its creation in 1965: Its objectives broadened, its functions increased in number, and its programs and services mushroomed from a small set of demonstration projects to a vast network of social and community services. Some of this expansion occurred during the 1980's, a period when funding for AOA's programs and services decreased substantially in inflation-adjusted dollars from $650 million in 1980 to about $460 million in 1990. We noted that this expansion in AOA's program responsibilities and its decline in funding occurred at a time of growth in the elderly population. We concluded that there would need to be some overall conciliation process that could harmonize AOA's increasing responsibilities, the elderly population's growing demand for services, and shrinking funds.

Administrative Resources

We reported previously that AOA experienced a substantial decline in staff between 1980 and 1990, from nearly 300 to 160 persons. We also found that many of AOA's key leadership positions had been vacant for a number of years and that AOA lacked personnel slots for potentially important positions. We further noted that the paucity of staff at the regional

[1]See "Minority Participation in Administration on Aging Programs" (GAO/T-PEMD-91-1); "Adequacy of the Administration on Aging's Provision of Technical Assistance for Targeting Services Under the Older Americans Act" (GAO/T-PEMD-91-3); The Administration on Aging: Harmonizing Growing Demands and Shrinking Resources (GAO/PEMD-92-7); and The Older Americans Act: Access to and Utilization of the Ombudsman Program (GAO/PEMD-92-21).

offices—and the lack of funds for training these staff—meant that regional office personnel were constrained in their ability to develop the necessary expertise in the provision of technical assistance.

In addition to the decline in staff, AOA experienced a severe decline in travel funds between 1980 and 1990, from nearly $350,000 to $90,000. We noted that this decline was especially important because travel funds affect the ability of the regional offices to provide sufficient technical assistance to, and conduct adequate oversight of, the state agencies on aging.

Program Functions

Finally, we reported our concerns about AOA's ability to perform several critical functions. First, we pointed out that AOA could not accurately measure participation in its programs because of flaws in its data collection instrument and in its methodology for gathering data. Second, we noted that state and area agencies on aging lacked the necessary demographic data to target particular elderly groups for services (as required by the Older Americans Act). Third, we reported that many state agencies on aging had important unmet requirements for technical assistance and that AOA needed to take steps to identify these states and then provide the necessary assistance. Finally, in examining the effectiveness of the ombudsman program, we reported that exactly what constitutes a board-and-care facility needed defining and noted that AOA should modify its data collection instrument to allow measurement of utilization rates for the ombudsman program across states.

Findings

Plans to Provide AOA With Adequate Staffing and Funding

You first asked us to determine how HHS officials plan to allocate staff and funding to AOA to ensure the maintenance of support functions that had previously been provided by HDS. According to HHS officials, AOA is now considered to be an independent operating division. As such, it is responsible for performing all the administrative functions that had previously been performed by HDS (for example, public affairs, budgeting, grants management, regional financial management, and so on).

The Office of Management and Acquisition within the Office of the Assistant Secretary for Management and Budget conducted a resource analysis to determine how many and what types of staff AOA would need to function as an operating division. Based on this study, the Office of

Management and Acquisition recommended that AOA receive 33.5 additional FTEs in administrative areas ranging from public affairs to grants and regional financial management.[2] (See table 1.) Subsequent to this recommendation, 33 new FTEs were assigned to AOA in fiscal year 1992.

Table 1: Office of Management and Acquisition Recommendations for Additional AOA Administrative Staff

Functional area	Recommended FTEs
Public affairs	1.0
Executive secretariat	2.0
Grants and contracts	5.5
Budget	2.5
Regional financial management	10.0
Legislation	3.0
Information resource management	2.0
Administration, management, and personnel	7.5
Total	**33.5**

Source: Office of Management and Acquisition, Assistant Secretary for Management and Budget, HHS, 1991.

Although the 33 new FTEs are intended to allow AOA to operate independently, HHS officials acknowledged that some of AOA's functions will continue to be performed by other offices within the Department. For instance, the Office of the Assistant Secretary for Management and Budget will handle procurement and accounting for AOA. According to officials from the Assistant Secretary's office, it is common for smaller operating divisions, such as AOA, to have some functions performed for them by other offices.

In summary, the reorganization of HHS has made AOA an independent operating division, elevating its status within the Department's organizational structure. As a result, AOA will be responsible for performing administrative functions that had previously been performed by HDS—the operating division in which AOA had been housed. To facilitate the

[2]AOA officials estimated that they would need 49 additional FTEs to perform these new administrative functions, while HDS officials estimated that AOA would need only 14 additional FTEs.

performance of these new functions, HHS has provided AOA with 33 new FTEs for fiscal year 1992.

Implications of the Reorganization for the Authority of the Commissioner on Aging

You also asked us to report on the implications, under the reorganization of HHS, of the new level of authority of the Commissioner on Aging, as well as of the direct reporting relationship between the Commissioner and the Secretary of HHS.

The elevation of AOA to the level of operating division has given the Commissioner authority that is at least nominally equal to that of the heads of other operating divisions (that is, the Assistant Secretary for the Administration for Children and Families, the Assistant Secretary for the Public Health Service, the Commissioner of the Social Security Administration, and the Administrator of the Health Care Financing Administration). There are two important implications of this change: (1) The Commissioner now has authority and control over AOA's administrative budget (that is, salaries and expenses), and (2) the direct reporting relationship between the Commissioner and the Secretary of HHS is stronger.

Under the new organizational structure, the Commissioner will prepare AOA's administrative budget, submit the budget request to the Assistant Secretary for Management and Budget, and then present the request directly to the Secretary. Thus, AOA's administrative needs, as perceived by the Commissioner on Aging, will be conveyed directly to the highest level of management in HHS. In addition, AOA will no longer compete with other subdivisional agencies for administrative resources (though, of course, it will compete with other operating divisions). Finally, AOA will maintain complete control over salaries and expenses once these resources are allocated to the agency.

In addition to establishing the Commissioner's authority over budgetary matters, the elevation of AOA to operating division status solidifies the direct reporting relationship between the Commissioner and the Secretary. The Commissioner attends the Secretary's senior staff meetings with greater independence and has access to the Secretary equal to that of other division heads. In short, the Commissioner now reports directly to the Secretary of HHS in a manner equivalent to that of other operating division heads.

Additionally, as head of an operating division, the Commissioner now has greater power in dealing with other division heads. This may be especially important as a means of achieving greater coordination between AOA and other divisions that are involved in elderly issues, such as the Social Security Administration and the Health Care Financing Administration.

In summary, our interviews with officials from HHS, including the Commissioner on Aging, indicated that the Commissioner now enjoys greater status and authority in relation to other HHS division heads. In addition, the Commissioner now has authority over AOA's budget and greater access to the Secretary of HHS, as well as greater leverage to deal with the heads of other operating divisions. This increased access and strength should reinforce AOA's role as an effective and visible advocate for the elderly.

Degree to Which Our Findings Were Addressed During the Reorganization

The third issue you asked us to examine was the extent to which our previous findings about AOA were addressed by HHS in the reorganization. As noted earlier, we had identified a number of concerns with regard to AOA, including the discrepancy between its program funding and its expanding mission, the decline in administrative resources, and AOA's ability to perform various program functions. For the present study, we asked officials at HHS how they planned to address these concerns. What follows is a brief synopsis of their responses regarding the current status of these issues and the extent to which HHS either has addressed or plans to address them.

AOA's Program Funding and Mission

AOA's program funding has not changed substantially since 1990, with funds for 1992 standing at $476 million (in 1980 dollars), up only slightly from 1990. Further, AOA officials estimate that their program funding for 1993 will decrease to $461 million (in 1980 dollars)—that is, about the same as the 1990 level.

This anticipated decrease in funding occurs at a time of proposed increases in AOA's responsibilities as the result of the impending reauthorization of the Older Americans Act (including an evaluation of the nutrition program, enhanced data collection efforts, and provisions for vulnerable-elder rights protection activities), as well as continued growth in the elderly population. In light of these factors, it is clear that neither the Congress nor HHS has addressed our previous finding and that the need continues to exist for some overall conciliation process capable of harmonizing AOA's

increasing responsibilities, the growing elderly population, and shrinking funds.

Administrative Resources

Since 1990, staffing levels at AOA have fluctuated dramatically. When AOA was removed from HDS in 1991, its staffing level was set at 164 FTEs, up slightly from 1990. AOA then received 15 additional FTEs for fiscal year 1992, on top of the 33 administrative FTEs it received as a direct result of the reorganization of HHS. This gave AOA a total of 212 FTEs for fiscal year 1992. However, before AOA could staff itself up to that level, the Office of Management and Budget approved enough funding for only 185 FTEs in 1993. In other words, AOA has the funding for 212 FTEs in 1992 but will only be able to fund 185 of these positions in 1993. Rather than use the available funding to hire temporary personnel for 1992, AOA officials have chosen to staff only to the level that they will be able to sustain through 1993—that is, 185 FTEs.

The effect of this fluctuation is that AOA officials have received a net increase of 25 FTEs since 1990. It is important to note, however, that this increase is more than offset by the new administrative functions assigned to AOA as a result of the reorganization of HHS.

Despite these constraints on AOA's staffing, AOA officials have made progress in addressing some of our concerns about their administrative resources. For instance, AOA has filled many key leadership positions that had long been vacant and expects to fill others within a few months. Further, AOA currently is enhancing its substantive expertise in the central office. For example, the agency is in the process of hiring a nutritionist and plans to hire additional specialists in the areas of transportation, employment, health, and long-term care. AOA has also filled nearly all the positions for administrative support in the central office. Thus, the agency appears to be in a position to carry out its newly assigned administrative functions.

In contrast to AOA's progress in its central office, the situation in the regions is more uncertain. On the one hand, long-standing vacancies for two regional program directors have been filled. On the other hand, there is no indication that the level of expertise in the regions is being elevated. We believe it is imperative that regional offices acquire strong expertise in program and methodological issues, given that the regional offices are the first line of assistance to state agencies on aging and that both targeting and measurement require significant analytic skills.

With regard to travel funds, AOA has received a substantial increase since 1990. In 1992, AOA had $197,000 in travel funds (an increase of nearly 120 percent since 1990), and AOA officials have estimated that they will receive $349,000 in 1993 (an increase of nearly 300 percent since 1990). Thus, it appears that AOA's ability to conduct site visits for the provision of technical assistance has been greatly enhanced. We must be cautious, however, in our comment because we do not know what proportion of these funds is earmarked for regional staff, who provide much of the technical assistance.

With regard to administrative resources for oversight, AOA officials informed us that five FTEs will be used for regional financial monitoring—one FTE for every two regions. It remains unclear, however, whether one person for every two regions will be sufficient to handle the fiscal oversight duties of AOA. These duties include (1) reviewing and assessing fiscal systems in the state agencies, as well as providing technical assistance when necessary and appropriate; (2) assisting in audit resolution of state grants; and (3) conducting fiscal monitoring of title IV and title VI grants. Since there are about 6 states in each region, it will be the duty of the fiscal operations staff person to conduct these activities for up to 12 states. Based on the fiscal problems that we cited in our previous report (GAO/PEMD-92-7), we question the extent to which one person can effectively monitor the fiscal operations of 12 state agencies on aging. Additionally, we do not know what proportion of the increased travel funds will be earmarked for regional office staff to help them conduct fiscal oversight.

In sum, although AOA's staffing and travel funds have been increased since 1990, it is not obvious to us that AOA can effectively carry out all its responsibilities. In particular, there is little indication that expertise in the regions is being enhanced or that AOA regional staff will be able to meet the demands of their oversight responsibilities.

Program Functions

Data Collection. Subsequent to our previously cited congressional testimonies, the House and Senate proposed new data collection requirements in their bills to reauthorize the Older Americans Act. These requirements included the design and implementation of standardized data collection procedures, as well as participant identification and description systems. AOA officials informed us that they intend to meet these proposed requirements if they are enacted, though they did not specify how they intend to do so. This means we cannot attest to the adequacy of AOA's plans to ensure the collection of accurate program data, and thus we reiterate

our earlier recommendation of a data collection instrument and methodology devised specifically to gather unduplicated counts of program participants. Without a sound data collection instrument and methodology, AOA will continue to be unable to generate accurate and meaningful data regarding its provision of services to program participants.

Acquisition of Demographic Data. With regard to acquiring demographic data to target particular elderly groups for services, AOA officials are planning to provide state and area agencies on aging with a tabulation of the 1990 census that will allow them to identify and target low-income and minority elderly populations. We believe this will enhance the ability of state and area agencies on aging to target special populations. However, we also continue to believe it is imperative that AOA provide up-to-date demographic data to state and area agencies on aging at periodic intervals between each decennial census. Without the infusion of continually updated information, the targeting strategies of state and area agencies on aging may quickly become obsolete.

Identification of State Agencies With Serious Unmet Needs for Technical Assistance. Regarding the identification of states that have important unmet needs for technical assistance, AOA officials noted that regional offices are carrying out assessments in a sample of states in the following areas: financial management, monitoring, ombudsman activities, nutrition, and targeting. They noted that states that require technical assistance will be identified and provided such assistance. While this approach will allow AOA to identify technical assistance problems in those states that are included in the sample, it will not allow them to identify problems in states outside the sample. We continue to believe it is important that AOA identify all states with real unmet needs for technical assistance and then take the appropriate steps to provide that assistance.

Ombudsman Issues. Finally, AOA officials concurred that there is a need for standard definitions of board-and-care facilities, and they noted that HHS is working towards the development of such standards. Additionally, AOA officials informed us that they intend to meet the proposed requirements in the Senate and House bills to reauthorize the Older Americans Act regarding the collection of data on utilization rates and the impact of the ombudsman program. However, evaluation of how these intentions are translated into reality must await AOA's implementation.

In summary, AOA officials are in the planning stage with regard to most of our programmatic concerns. That is, they plan to amend AOA's data collection procedures, plan to provide needed demographic data to state and area agencies on aging, plan to identify the states with serious unmet needs for technical assistance, and plan to develop standard definitions of board-and-care facilities. However, in our view, AOA's plans for providing demographic information to the state and area agencies on aging, as well as its methods for identifying the unmet needs of the states, appear to be inadequate.

Conclusions

Since we reported our findings about AOA one year ago, changes have taken place in HHS that have dramatically affected the operations of AOA. AOA has been elevated to the level of an operating division within the HHS hierarchy and has received an increase in the number of its FTEs in order to perform the functions of an operating division. This elevation has provided the Commissioner on Aging with authority over AOA's budget, solidified the direct reporting relationship between the Commissioner and the Secretary of HHS, and put the Commissioner on a footing of equal status and authority with other division heads in HHS. It thus appears that progress has been made toward establishing AOA as an effective and visible advocate for the elderly.

During the past year, AOA officials addressed some of the concerns that we previously raised. They filled key leadership positions that had long been vacant, secured more travel funds, and formulated plans to enhance AOA's program expertise. However, we still have concerns about AOA's regional expertise, oversight capabilities, and strategies for meeting the data and technical assistance needs of the state and area agencies on aging. Additionally, we continue to believe that AOA's responsibilities must be better harmonized with its program funding and the increased demand for services by the growing population of elderly. We believe all these concerns must be addressed if AOA is to be effective in performing its mission, in serving its beneficiaries, and in targeting its services to those elderly Americans who are most in need.

We discussed the results of our work with responsible agency officials, who declined to offer an overall assessment of our report. However, since they raised no major objections to our findings, we believe that written agency comments were not necessary in this instance. We will make copies of this report available to interested organizations, as appropriate, and to others upon request.

If you have any questions or would like additional information, please call me at (202) 275-1854 or Robert L. York, Director of Program Evaluation in Human Services Areas, at (202) 275-5885. Other major contributors to this report are listed in appendix I.

Eleanor Chelimsky
Assistant Comptroller General

Major Contributors to This Report

Program Evaluation and Methodology Division

Sushil K. Sharma, Assistant Director
Alan D. Stein-Seroussi, Project Manager
Patrick C. Seeley, Reports Analyst

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