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ADMINISTRATION ON AGING

Autonomy Has Increased but Harmonization of Mission and Resources Is Still Needed

Statement of
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Mr. Chairman and Members of the Subcommittee:

It is my pleasure to be here today to discuss our continuing work on the Administration on Aging (AOA). Over the past year, we testified at several congressional hearings about AOA's ability to carry out its numerous and diverse functions. During this time, major organizational changes took place within the Department of Health and Human Services (HHS) that affected AOA operations. In light of these changes, you requested that we examine the reorganization of HHS as it relates to AOA. Specifically, you asked (1) how HHS plans to reallocate staff and funds to allow AOA to perform administrative functions that were previously performed by the Office of Human Development Services, (2) the implications of this reorganization 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 the reorganization.

To address these issues, we interviewed officials at HHS, including the Secretary's chief of staff, the Assistant Secretary for Personnel Administration, representatives of the Assistant Secretary for Management and Budget, and the Commissioner on Aging. In addition, we reviewed the Department's documentation with regard to the reorganization of HHS. We gathered this information between October 1991 and April 1992.

FINDINGS

Plans to Provide AOA With Adequate Staffing and Funding

Your first question 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 the Office of Human Development Services (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).

As we reported to you earlier, in fiscal year 1990, prior to the reorganization, AOA had 160 full-time-equivalents (FTEs) authorized for their headquarters and regional offices.[1] In addition, HDS performed almost all of the administrative tasks

[1]Administration on Aging: Harmonizing Growing Demands and Shrinking Resources, GAO/PEMD-92-7 (Washington, D.C.: February 1992).

for AOA (for instance, grants management, regional financial management, public affairs, budgeting, and so on), although it was not obvious how many full-time-equivalent staff HDS devoted to such tasks. After the reorganization plans were announced, HHS determined that it would take 33.5 FTEs for AOA to perform the administrative functions that were previously performed by HDS.[2] Subsequently, 33 new FTEs were assigned to AOA. In addition, HHS now performs procurement and accounting functions for AOA.

Since fiscal year 1990, staffing levels authorized for AOA have fluctuated. (See table 1.) When AOA was removed from HDS, its staffing level was set at 164 FTEs, up slightly from fiscal year 1990. AOA was authorized another 15 FTEs for fiscal year 1992, in addition to the 33 administrative FTEs authorized as a direct result of the reorganization of HHS. This gave AOA a total of 212 FTEs for fiscal year 1992. However, the Office of Management and Budget proposed and approved only enough funding for 185 FTEs for fiscal year 1993. In other words, AOA has the funding for 212 FTEs for fiscal year 1992 but will only be able to fund 185 of these positions in fiscal year 1993 under the proposed HHS budget. Rather than use the available funding to hire temporary personnel for fiscal year 1992, AOA officials have chosen to staff only to the level requested for fiscal year 1993--that is, 185 FTEs.

[2]This determination was based on a study conducted in June 1991 by the Office of Management and Acquisition within the Office of the Assistant Secretary for Management and Budget.

Table 1: Positions (Number of Full-Time-Equivalents) Authorized for and in Support of AOA, by Source and Fiscal Year

	Fiscal year			
FTEs	1990	1991	1992	1993
AOA	160	164	212[b]	185
HDS	33[a]	33[a]	--	--
Total	193	197	212[c]	185[c]

[a]These figures represent HHS estimates of the number of FTEs that would be required to perform administrative functions provided by HDS.

[b]AOA has the funding for 212 positions, although it will not staff to this level.

[c]Excludes procurement and accounting.

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).

In summary, the reorganization of HHS has made AOA an independent operating division. As a result of the reorganization, AOA initially received 33 new FTEs to perform administrative functions that were previously performed by HDS; however, anticipated reductions in funding will leave staffing levels at AOA slightly lower than before the reorganization. Finally, AOA has substantially more travel funds than in earlier years.

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 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.

With regard to the Commissioner's new level of authority, one objective of the reorganization was to give the Commissioner control over AOA's administrative budget (that is, salaries and expenses). The Commissioner now prepares AOA's administrative budget and presents the request directly to the Secretary. There have already been a few observable changes as a result. For example, as I will elaborate on later, the Commissioner is making some changes in the types of staff being recruited. Further, the increase in travel funds for AOA is probably an effect of the reorganization. At the same time, the slight decrease in staffing noted previously shows that the reorganization alone cannot solve all of AOA's administrative problems, especially in an era of competition for limited resources.

In addition to establishing the Commissioner's authority over budgetary matters, the reorganization solidifies the congressionally mandated direct reporting relationship between the Commissioner and the Secretary. It appears that the objective has been met and that the Commissioner now has access to the Secretary equal to that of other division heads.

Degree to Which Our Findings Were Addressed During the Reorganization

The third issue we examined is the extent to which our previous findings about AOA were taken into account during the reorganization of HHS. We had previously 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 testimony, we asked officials at HHS how they planned to address these concerns. I will briefly highlight the current status of these issues and the extent to which HHS either has addressed or plans to address them.

AOA's Resources and Mission

As mandated by the Older Americans Act, AOA helps meet the special needs of the elderly by providing them with a wide array of social and nutritional services. The provision of these services has become increasingly important in light of the fact that the U.S. elderly population has increased by nearly 65 percent since the passage of the act in 1965. To meet the challenges of this rapidly growing population, the mission of AOA has been continually expanded to provide more programs and services. Over the last decade, however, the ability of AOA to perform these functions has been hampered by fiscal constraints.

AOA's program funding has not changed much since 1990, with funds for 1992 standing at $476 million (in 1980 dollars), up only slightly from 1990. Further, AOA officials informed us that the Administration's budget request for AOA for fiscal year 1993 is $461 million (in 1980 dollars)--that is, about the same as the 1990 level. In our earlier testimony, we noted that increase in the role and responsibilities of AOA was not accompanied by a commensurate increase in resources. The proposed decrease in funding for fiscal year 1993 occurs at a time of additional increases in AOA's responsibilities as a 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). In light of these factors, it is clear that the mismatch we found may be even slightly greater today, and that the need continues to exist for some overall conciliation process capable of harmonizing AOA's increasing responsibilities, growing elderly population, and shrinking funds.

As we reported earlier, in addition to the decline in real dollars in its program funds, AOA also experienced a significant decline in administrative resources, such as personnel and travel funds, during the 1980s. Many key leadership positions were vacant both at the headquarters and in the regions. In addition, some of the programs under title III were without leadership and expertise at headquarters and regional office levels. After the reorganization, 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 a few others within a few months. Further, AOA currently is planning to enhance its substantive expertise in the central office. For example, the

agency is in the process of hiring a nutritionist and plans to hire other 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. Based on our discussion with AOA officials, there is no indication that the level of expertise in the regions, either programmatic or administrative, is being enhanced. 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.

We noted a significant reduction in AOA travel funds in our earlier report. We found that this decline was particularly significant because the regional offices' ability to provide technical assistance and oversight to the state units on aging, as mandated by the Older Americans Act, depends on the availability of sufficient travel funds. As noted earlier, AOA has received a substantial increase in travel funds since 1990. We do not know, however, what proportion of these funds is earmarked for regions for the specific purpose of on-site technical assistance and oversight.

With regard to administrative resources for oversight, HDS regional office staff provided oversight assistance in each region prior to the reorganization. AOA officials informed us that, under the reorganization, 5 FTEs will be used for regional financial monitoring--1 FTE for every 2 regions. It remains unclear, however, whether 1 person for every 2 regions will be sufficient to handle the fiscal oversight duties of AOA. Regional officials are expected to visit each state within their respective regions at least once in every 2-year period. Since there are about 6 states in each region, it will be the duty of the fiscal operations staff person to conduct oversight activities for up to 12 states. Based on the fiscal problems that we cited in our previous report, we question the extent to which one person can effectively monitor the fiscal operations of 12 state agencies on aging. In addition, 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. As we pointed out in our previous work, AOA could not accurately measure participation in its programs because of flaws in its data collection instrument and in its methodology for gathering data.[3] Subsequent to our previous 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 requirements once they are enacted, although 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. We reported to you that state and area agencies on aging lacked the necessary data to target particular elderly groups for services (as required by the Older Americans Act).[4] 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.

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[3]See "Minority Participation in Administration on Aging Programs," testimony before the Subcommittee on Aging of the Committee on Labor and Human Resources, U.S. Senate (GAO/T-PEMD-91-1), March 15, 1991.

[4]See "Adequacy of the Administration on Aging's Provision of Technical Assistance for Targeting Services under the Older Americans Act," testimony before the Subcommittee on Human Resources, Committee on Education and Labor, and the Select Committee on Aging, House of Representatives (GAO/T-PEMD-91-3), April 25, 1991.

Identification of State Agencies With Serious Unmet Needs for Technical Assistance. We also 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. 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. As we noted in our previous work, different states have different needs for technical assistance. 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, 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.[5]

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

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[5]See "Access to and Utilization of the Ombudsman Program Under the Older Americans Act," testimony before the Subcommittee on Aging of the Committee on Labor and Human Resources, U.S. Senate (GAO/T-PEMD-91-11), June 13, 1991.

on aging, as well as its methods for identifying the unmet needs of the states, appear to be inadequate.

SUMMARY

Since we reported our findings about AOA one year ago, changes have taken place in HHS that have 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 in establishing AOA as an effective and visible advocate for the elderly.

During this past year, AOA officials addressed some of the concerns that we raised in the past. 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.

Mr. Chairman, this concludes my remarks. I would be happy to answer any questions you may have.