Paving the way for a

Longevity Ready Maryland

Maryland's Multisector Plan for Aging: July 2025

Visit **LRM.Maryland.Gov** for more information.

Maryland
DEPARTMENT OF AGING

Verification of Intent

Maryland's four-year State Plan on Aging is incorporated in this ten-year multisector plan for aging and hereby submitted for the State of Maryland for the period of October 1, 2025 – September 30, 2029, by the Maryland Department of Aging, under provisions of the Older Americans Act of 1965, as amended. The Maryland Department of Aging has been given the authority to develop and administer the State Plan on Aging in accordance with the requirements of the Older Americans Act, and is primarily responsible for the coordination of all state activities related to the Act, and serves as the effective and visible advocate for older adults in the State of Maryland.

The plan hereby submitted has been developed in accordance with all state and federal statutory and regulatory requirements and is approved by the Governor and Secretary of the Department of Aging.

Carmel Roques, Secretary
Maryland Department of Aging

June 26, 2025
Date

Wes Moore, Governor
State of Maryland

July 30, 2025
Date

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A Message from the Secretary of the Maryland Department of Aging

On behalf of the Maryland Department of Aging (MDOA), I am pleased to announce the launch of Longevity Ready Maryland (LRM), the state's first multisector plan for aging designed to enhance the wellbeing and quality of life of all Marylanders as we age. Using the framework of longevity creates the opportunity to plan for both the individual and broader societal impact of living longer lives.

Maryland is leading the way by being the first state to integrate its ten-year multisector plan for aging—as directed by the Governor—with its federally-mandated four-year State Plan on Aging under the Older Americans Act. This alignment ensures a cohesive, forward-thinking approach that coordinates immediate state priorities with longer-term strategies to support all Marylanders as we age. It is the product of more than two years of rigorous engagement, research, and development, shaped by the insight and expertise of Marylanders from all walks of life, including local and state governments, advocacy organizations, public and private service providers, caregivers, and older adults.

The public review period provided positive feedback that reaffirmed LRM's priority areas, as well as valuable insight in helping to refine key strategies in improving access to vital services and benefits. The result is a blueprint for the future, offering broad guidance for implementation that will most certainly evolve over time. At the end of the four-year State Plan period in 2029, MDOA will issue the next four-year plan for FY 2030-2033, reporting on progress made and strategies for achieving our remaining objectives within the ten-year multisector plan timeframe.

At its core, LRM is a whole-of-government approach that requires collaboration across all state agencies. While MDOA leads the way through policy development, planning, and strategic coordination, the plan's success depends on collective action. As we move forward, I invite you to join us, lend your expertise, and contribute to the success of Longevity Ready Maryland. Together, we can create a more inclusive, supportive future for Marylanders of all ages.

Thank you for your commitment in paving the way for making Maryland a place where all of us age with dignity and thrive.

Sincerely,

Carmel Roques, Secretary
Maryland Department of Aging

Executive Summary:

Creating Resilient Infrastructure for Longer Lives in Maryland

Maryland is at a demographic crossroads. Longer lives and declining birth rates have introduced a significant shift in how our current systems will need to function as the growing number of older adults continues to expand. With both challenges and opportunities to prepare for, LRM will take Maryland beyond traditional approaches to aging services and better address the multifaceted priorities that 21st-century Maryland communities are facing.

A Call for Multisector Planning

People in Maryland are living, learning, and working longer. As we plan for the emerging needs of Maryland's shifting demographics, we have a real opportunity to holistically address long-standing disparities across the lifespan, and redesign outdated policies, programs, and mindsets that have separated aging from other life experiences in the past.

Many states are adopting a multisector plan for aging approach to prepare for the growing number of older adults in American communities. Like other multisector plans, LRM digs deep into the state's infrastructure to capitalize on the benefits of a rising population of skilled and experienced community members while preparing for those of us who may need help to fully participate in society as we age. It is inclusive of public and private sector participation, requiring all state agencies to work together across the lifespan for better outcomes later in life. By coordinating resources and incorporating a longevity lens in the work we do, we can increase efficiency and reduce redundancy to build a more financially-sustainable model of programs and policies to help us age in place.

Through the multisector planning process, we have gained a better understanding of the practical strategies that can be applied to build relationships and lay a foundation for systematic transformation. Those strategies are reflected across LRM's four Epic Goals and eight defined priority areas. Working together, we can improve the lives of older adults over the next decade while creating a more inclusive, equitable, and sustainable future for Maryland residents to thrive across all stages of life.

Epic Goals:

- **BUILD A LONGEVITY ECOSYSTEM:** Create supportive and inclusive communities for all ages and abilities and build collective capacity at the local level.
- **PROMOTE ECONOMIC OPPORTUNITY:** Support a multigenerational workforce with opportunities for all ages and abilities while advancing Maryland's economic competitiveness.
- **PREPARE MARYLANDERS TO AFFORD LONGEVITY:** Improve economic security for the 100-year lifespan through affordable housing, financial literacy, and access to support services.
- **OPTIMIZE HEALTH, WELLNESS, AND MOBILITY:** Invest in programs that support healthier, more purposeful, and active lifestyles so Marylanders can enjoy longevity and reduce dependency.

Aging in Maryland:
Older Adults and the Aging Services Network

Maryland's public service networks are deeply engaged in leveraging relationships between federal, state, and local partners to make Maryland a place where all residents can age in the community of their choice. Working together, we have defined key priorities to build upon as we move forward to make Maryland a place where no one is left behind.

Where Maryland Stands: Opportunities and Challenges

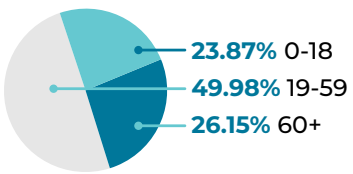
Population Projections for Older Adults

Marylanders are living longer while birth rates are declining in the state. In 2023, there were more than 1.4 million adults over 60 living in Maryland.[1] By 2035, that population is expected to increase by about 6.6%. Maryland's 85 and over population is the fastest growing segment of the older adult population, projected to include more than 315,000 people by 2045 – a 158% increase from 2020.[2] With the older population growing so quickly, there are opportunities to capitalize on and challenges to prepare for as older Marylanders begin to outnumber their younger counterparts.

POPULATION GROWTH PROJECTIONS:[2]

Age 60+ Percent of the Total State Population

Age Group Distribution Projections for 2030



By 2030, one in four Maryland residents will be over 60.

The Positive Impact of Older Adults on Maryland's Economy

Older adults are vital to the Maryland economy. By 2030, Marylanders age 50+ will support 1.7 million jobs and occupy 36% of the workforce. By 2050, the 50+ population will account for 60% of all money spent in Maryland.[3] Their economic contributions across the nation are outpacing all other age categories, yet many older Marylanders are moving out of state to seek more affordable and supportive communities to live in.[4] As we recognize the essential value older adults bring to local economies, we understand why it's in the state's best interest to keep Marylanders in Maryland as we age.

ECONOMIC CONTRIBUTIONS:[3]

Age 50+ Workforce

2030: **36%**

Age 50+ Gross Domestic Product Contributions

2018: **39%** 2050: **43%**

Age 50+ Job Growth Contributions

44% of Maryland's jobs are supported by residents age 50+.

Aging and Independent Living

By 2035, one in three American households will be headed by someone 65 or older.[5] All of us want to remain independent and connected to our communities throughout the lifespan, and we know that the ability to live independently becomes significantly more difficult after the age of 75. Access to care services and housing program assistance can keep more older Marylanders in the homes of our choosing, saving money and improving our ability to safely age in place. But barriers that exist between housing program navigation systems and care workforce supports make it difficult for many to find the services they need to remain in the Maryland communities they've invested in throughout their lives.

AGING IN PLACE:[6]

Median Annual Cost of Care in Maryland (2021)

$146,000 for a Nursing Home

$42,120 for In-Home Care (30 hours per week)

Housing Assistance Enrollment in Maryland

One in five eligible residents with a disability is NOT enrolled.

Financial Security and Older Adults

In 2017, 7.6% of Maryland's 60+ population lived in poverty. Today that amount is at 9.5%. Of the 137,522 Maryland grandparents living in poverty with a grandchild, 17% of them are responsible for that child. Baltimore has the greatest number of the state's low-income older adult residents, with Prince George's County, Baltimore County, and Montgomery County following close behind.[1] However, many rural areas in Maryland have a much higher percentage of lower-income older adults, including Dorchester, Allegany, and Kent Counties. Compounding the needs of these less populated, under-resourced communities are reduced access to affordable housing, community-based services, food security, and caregiving. The cost of living in many Maryland communities creates additional hardships for lower-income adults who are not eligible for income-based programs. Investments in services for older adults and people with disabilities have not kept pace with inflation or demand projections, especially in rural areas.

AGING AND POVERTY:

About 82,000 adults age 65+ are living below poverty level in Maryland.
This represents a 13.63% increase since 2019.[1]

Poverty level income threshold in Maryland

$13,590

$41,508

Average cost of living for a single 65+ adult[7]

Health Trends of Older Marylanders

While Maryland ranks well in overall health of older adults, there are still significant areas of concern. In 2022, Maryland led the nation in drug- and alcohol-related deaths among the 65+ population, with the state's 55+ population eclipsing all other age categories in accidental Fentanyl- cocaine-, and opioid-related deaths.[8] The growing rate of Alzheimer's Disease and related dementias also represents an urgent and costly health crisis in the state. We currently hold the highest rate of Alzheimer's Disease in the country, with Baltimore City and Prince George's County consistently ranking among the top five counties nationwide.[9] An estimated 110,000 Marylanders 65 and over were living with Alzheimer's Disease in 2020, a number that is projected to increase by 18% in 2025.[10] Dementia is the most expensive chronic condition in the nation, with direct and indirect costs of care for Marylanders extremely high compared to other states.

DRUG-RELATED DEATHS:

Marylanders age 65+ who died from drug-related injuries **increased 77%** between 2016-2018 and 2020-2022.[11]

DEMENTIA CARE:

Medicaid Costs for Marylanders Age 65+ with Dementia[12]

2020 **$1.23 Billion**

2025 **$1.54 Billion***

*Cost projections are expected to **increase 25%** in 2025.

The Value of Maryland's Family Caregivers in Dementia Care (2020)[10]

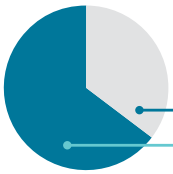
364 million hours of unpaid care

$6.5 billion estimated economic value

Disparities in Aging Across Diverse Communities

The life expectancy of a typical Maryland resident depends heavily on their income, race, and zip code. On average, a white man will live about four years longer than a Black man in Maryland, with Montgomery County residents living about nine years longer than Cecil County residents.[13] Gender also influences the ability to earn and save money, with women earning 14% less than men in the state—a pay disparity that is even more pronounced for Black and Hispanic women.[14] Because women are also much more likely to be caregivers to children and older adults, it impacts their ability to save for the future, care for themselves, and invest in Social Security. While significant racial, gender, and geographic inequities exist across the state, at no stage of life are these disparities more acute than with the older adult population. A lack of access to health care, nutrition, and financial security throughout the lifespan inevitably leads to a lower quality of life for many Marylanders as they age, requiring significant financial resources to address needs that only increase with each decade of life.

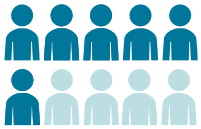
GENDER INEQUALITY:



Marylanders 65+ Below Poverty Level[1]

Men: 28,728

Women: 52,630



6 in 10 caregivers in Maryland are women.[15]

RACIAL INEQUALITY:

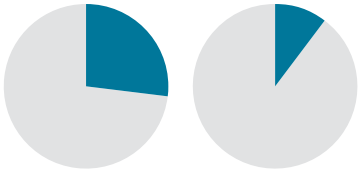
Marylanders 65+ Below Poverty Level[1]

Social Isolation in Maryland

Prioritizing social connection is not only beneficial for older adults. It creates stronger communities by elevating public health standards, expanding economic stability, and lowering costs related to undue burdens on social services and health care systems. We know that social isolation contributes significantly to negative health outcomes for older adults, increasing the risk of heart disease, dementia, mental health challenges, and stroke. It can also increase financial insecurity, homelessness, and the potential for older adults to be victimized by scammers and fraud. The loss of a partner, increasing health and mobility issues, and lack of community resources can make it difficult to remain connected to family, community, and care providers as we age—especially in rural communities where fewer support services and transportation options are available. Targeted expansions of digital literacy programs, age-friendly community planning, and Village model and other civic engagement programming are essential in reducing social isolation where it is most at risk.

LIVING ARRANGEMENTS:[1]

Marylanders who Live Alone



Age 65+: **27.1%**

Under 65: **10.4%**

Homelessness and Older Marylanders

From 2018 to 2024 homelessness for residents age 65+ **increased 77%,** more than other age groups.

DIGITAL CONNECTIVITY:[1]

Among Marylanders age 65+ **92% have internet access.**

> **"The challenges ahead demand that all of us do our part to move Maryland forward – front-line state employees, companies, philanthropies, educational institutions, partners, and Marylanders finding their own way to serve each other."**
>
> ***Wes Moore**, Governor of Maryland*

The Role of the Maryland Department of Aging (MDOA)

MDOA's vision is to transform institutions, systems, and norms so that all Marylanders lead lives that are healthy, financially secure, socially connected, and purposeful. As the designated State Unit on Aging, MDOA's role is to advocate for the equitable inclusion of older adults in planning, policy, resource allocation, and service delivery. Collaborating closely with the departments of human services, health, disabilities, housing, planning, insurance, and other providers, MDOA coordinates supports and services to improve the wellbeing of older adults in Maryland through program development, training, technical assistance, and legislation. Participating in dozens of state councils, committees, and task forces (including the No Wrong Door governance group, the Technology First Advisory Group, the Maryland Advisory Council on Health and Wellness, the Maryland State Coordinating Committee for Human Services Transportation, and others), MDOA addresses opportunities and streamlines access to community-based services and supports for older adults.

MDOA's Relationship with Area Agencies on Aging (AAAs)

MDOA allocates state and federal funding to Maryland's 19 AAAs for local service delivery. Integral to the successful planning, advocacy, and service delivery for older adults at the local level, AAAs are independent local government or nonprofit organizations that partner with local agencies, organizations, and businesses through interagency councils. Each AAA serves as a Maryland Access Point Aging and Disability Resource Center, providing information, assistance, referrals, and counseling for adults and caregivers in need of long-term services and supports.

AAAs use a variety of funding sources that build on community assets to provide innovative programming to support residents as they age. Several AAAs lead multisector planning efforts at the local level through the age-friendly communities model.

Details on the services provided by MDOA and AAAs can be found in Attachment F.

Evidence-Based Programs: **44**

Meals Provided: **3 Million+**

Transportation Trips Provided: **127,206**

Older Americans Act (OAA) Program Management and Oversight

OAA programming is the foundation on which a comprehensive system of services are built to meet the needs of older Marylanders and their caregivers. Core programs are integrated with non-formula-based grant programs to expand reach and increase access to supports and services.

MDOA monitors the quality, reach, and effectiveness of AAA-administered programs to ensure they comply with OAA financial management and policy requirements. Regular meetings with AAAs provide training, technical assistance, and opportunities for collaboration. Mid-year reviews identify challenges, with corrective action plans issued as needed. Quarterly reports and annual reviews ensure quality and compliance with OAA regulations.

During the FY26-FY30 State Plan period, MDOA will develop a statewide data and financial management system to enhance efficiency, transparency, and oversight, and better document technical assistance and corrective actions.

As the state comes into compliance with the OAA Final Rule, monitoring will focus on compliance with state policy updates. A new work group is developing policies that align with new federal requirements and local goals. Policies and procedures for OAA programs are documented in a comprehensive manual and further developed through Aging Program Directives that issue updates and changes to AAAs as needed.

Details on how MDOA meets OAA requirements can be found in Appendix A.

Marylanders Served through OAA (FY24): 292,062

People of Color:	Below Poverty Level:	High Nutrition Risk:	Rural Communities:	Paid and Unpaid Caregivers:	3 or More Activities of Daily Living Needs:
46.1%	**32.64%**	**12,562**	**7.45%**	**110,492**	**6,584**

Sectors that Support Aging

The Collective Roles of State Agencies

While MDOA and the AAAs are the designated aging services network providers in Maryland, programs and services that enable residents to thrive are embedded across all state agencies – this includes programs and services for Marylanders over 60. LRM is built upon the extensive programs, initiatives, and strategic plans of our sister agencies and work to streamline efficiency and coordination across all state and local service providers. The following is a summary of some of the state agencies and their roles in serving Marylanders. A more extensive summary of these efforts can be found in Appendix B.

- **COMPTROLLER OF MARYLAND:** Determining appropriate tax dollar allocations and providing resources to protect Maryland residents.
- **MARYLAND DEPARTMENT OF AGING:** Advocating for the equitable inclusion of older adults in planning, policy, resource allocation, and service delivery.
- **MARYLAND DEPARTMENT OF BUDGET AND MANAGEMENT:** Determining fiscally sound services that advance the interests of all Marylanders.
- **MARYLAND DEPARTMENT OF DISABILITIES:** Providing opportunities, access, and choice for Maryland residents with disabilities.
- **MARYLAND DEPARTMENT OF EDUCATION:** Creating pathways to achievement through general education, planning, and lifelong learning, and promoting career development opportunities across the lifespan.
- **MARYLAND DEPARTMENT OF HEALTH:** Improving the health and safety of Maryland residents through health promotion, access to health insurance and health care, and oversight of health care providers
- **MARYLAND DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT:** Implementing housing policy that promotes home ownership for Maryland residents and creating community development initiatives to meet the needs of all Marylanders.
- **MARYLAND DEPARTMENT OF HUMAN SERVICES:** Assisting Maryland residents in economic need and providing preventive services and protections across the lifespan.
- **MARYLAND DEPARTMENT OF INFORMATION TECHNOLOGY:** Providing vital technology solutions that enable Maryland residents to access information and live and work safely, efficiently, and productively.
- **MARYLAND DEPARTMENT OF LABOR:** Connecting Maryland residents with career development and employment opportunities, and providing protections that foster economic growth for workers of all ages and their employers.
- **MARYLAND OFFICE OF ATTORNEY GENERAL:** Providing consumer protection and fraud prevention services across the lifespan and for older adults.
- **MARYLAND DEPARTMENT OF PLANNING:** Providing guidance, analysis, outreach, and support to enable sustainable community development and growth that is inclusive of all ages and abilities.
- **MARYLAND DEPARTMENT OF SERVICE AND CIVIC INNOVATION:** Providing employment and volunteer opportunities to make Maryland a state that serves, and feeding the talent pipeline across sectors.
- **MARYLAND DEPARTMENT OF TRANSPORTATION:** Providing safe, reliable, accessible, and sustainable transportation and mobility options for adults of all ages and abilities.

The Value of Cross-Sector Collaboration

Strengthening the positive contributors of health across the lifespan for improved outcomes later in life.

Improving the coordination of service delivery systems across sectors, organizations, and communities.

Incorporating longevity readiness across state agencies through a whole-of-government approach.

Improving data-sharing methods to better identify resources for addressing opportunities and needs.

Local Governments, Organizations, Businesses, and Philanthropy

A large network of organizations is hard at work at the local level providing care, services, and employment for older adults, and keeping us connected to our communities as we age. As trusted boots-on-the-ground service providers, they offer perspective to identify needs that determine funding and shape programming. Successful implementation of this plan requires a close working relationship with and among local partners to fulfill identified strategies and measure impact.

- **AREA AGENCIES ON AGING:** Community-led agencies responsible for connecting older adults within each jurisdiction to programs and services in community-based settings, including educational, personal enrichment, and social programming, as well in-home supports, protective services, and temporary disability supports.
- **CAREGIVERS (PAID AND UNPAID):** Providing essential medical, health, and personal care for older adults in their homes.
- **HEALTH CARE PROVIDERS:** Providing medical care across the lifespan to support healthier outcomes as we age, and advocating for patient care with insurance providers.
- **ADVOCACY GROUPS:** Promoting the rights of older adults, and creating policy to protect older adults from scams, fraud, and other forms of victimization.
- **PHILANTHROPIES:** Supporting models, services, and programs that impact older adults, and convening multisector stakeholders in developing researched-based solutions that build capacity.
- **LOCAL GOVERNMENT AGENCIES:** Planning and implementing services that impact the health, security, and wellbeing of residents, including through cross-sector interagency coalition and board participation.
- **COMMUNITY-BASED ORGANIZATIONS:** Providing programs and supports that promote the health and wellbeing of older adults, keeping older adults connected to their communities, and serving as a gateway for other service referrals.
- **BUSINESS AND EMPLOYERS:** Supporting a multigenerational workforce, providing older adults with opportunities to work, and creating products and services for older adults in the community.

Distribution of Resources

Maryland Department Budget Allocations

Just as supportive services that impact older adults are distributed across state agencies, so too are funding resources. In an initial assessment of the budget landscape of Maryland's key agencies serving older adults, the distribution of funds that supported healthy aging in 2019-2025 primarily came from the Department of Health, with programs specifically targeting older adults spanning eight different departments. This whole-of-government approach to the distribution of aging services promotes sustainable governance and aligns with existing state funding flows. To proactively prepare for the significant changes that lie ahead, we must forge new pathways to increase collaboration across agencies and expand service delivery models to align with longevity-based goals.

FY25 APPROPRIATIONS

MDOA worked with the Department of Budget Management to collect and analyze FY2025 state agency funding appropriated to serve older adults.

Programs Targeting Older Adults and People with Disabilities

Programs Targeting Older Adults Only

The Longevity Approach

Aging has evolved considerably in recent years. Longer lives, coupled with advances in community design, transportation, health services, retirement planning, employment, and technology are changing how we age with each new generation. As society changes, how we plan for the future of aging must also evolve. Initiatives that exist within silos or focus solely on a specific age group or issue will not adequately address the social determinants of healthy aging, or factor in the simple fact that *all of us are aging*. Engagement across the lifespan and greater cooperation between government agencies, community organizations, and service providers are essential in creating systemic transformations to ensure Maryland is longevity ready.

The most important thing we can do to prepare for the future is to make sure Marylanders get a healthy start to their life journey. The Moore-Miller administration has laid the groundwork for leaving no one behind by creating programs to reduce childhood poverty, grow the economy, and improve equitable access to health care – all of which are proven to lead to better outcomes as we age.

As the state prepares for longer lives and a growing number of people over 60, we have the opportunity to fundamentally transform how we approach aging in Maryland. This significant demographic shift will be a defining influence in the years to come, impacting the way families, communities, and economies function. By taking a longevity approach in governmental policy, we can develop community-wide systems of care that promote healthy aging, strengthen local economies, and improve the quality of life of all Maryland residents.

On January 3, 2024, Governor Moore solidified his commitment to healthy longevity by establishing the LRM initiative. His executive order mandated cooperation among state agencies to address inequities across the lifespan that impact how well we age. LRM is not intended to simply meet the needs of today's older adult community. It is a research-based blueprint that incorporates a whole-of-government approach to transform the future of aging for the benefit of all Maryland residents. By incorporating a longevity lens in the work we do, we can build upon existing state plans and strategies to collectively prepare for longer lives – improving quality of life as we age in ways we can't if we don't work together.

> **"Maryland must act with urgency and seize the opportunity to build a longevity-ready and aging-friendly state."**
>
> ***Executive Order:*** *Longevity Ready Maryland Initiative*

Guided by the Stanford Center for Longevity's New Map of Life, LRM maximizes the benefits of longer life and addresses the interconnectedness among sectors that influence how well we age. At its core, it promotes the advantages of intergenerational connections – once a fundamental core of our society – and builds stronger communities through the inherent value of diverse perspectives and experiences.

This whole-of-life approach to longevity supports many pathways to achievement, health, and independent living, accessible from different backgrounds and communities. Incorporating a longevity perspective into the policies, programs, and services we develop will foster inclusivity, independence, and quality of life for all Maryland residents – regardless of age, income, or ability. By aligning health spans to lifespans, building financial security, and supporting life transitions across employment, care, community planning, and educational sectors, we can create stronger communities to thrive in as we age.

Community Benefits of Longer Lives

- More adults remaining healthy and independent later in life.
- More time for learning, pursuing an education, and job training.
- More multigenerational households sharing resources.
- More adults contributing to local workforces and economies.
- More caregivers contributing to the wellbeing of family and community.

Plan Development:
Research and Needs Assessment

To effectively address the opportunities and challenges that lie ahead for Maryland communities, MDOA invested a considerable amount of effort in engaging key stakeholders—community members of diverse lived experiences, experts in health and aging, state agencies and local governments, and community-based organizations—to identify a series of well-informed goals, objectives, and strategies that are researched-based, actionable, and community-driven.

Epic Goals: The Executive Order and Longevity Model

LRM is guided by the Executive Order signed by Governor Wes Moore on January 3, 2024, which directed MDOA to evaluate existing services, support and care options for older adults, and recommend a collaborative, multisector plan of action across all sectors to transform Maryland's approach to aging.

Among other mandates, the Executive Order required recommendations on:

- Enhancing coordination among public and private partners on aging-related programs and policies;
- Increasing coordination between federal, state, and local government programs and services to serve the needs of older adults, their families, and caregivers;
- Changes to laws, regulations, and policies that will promote capacity building in housing, transportation, long-term care, and caregiver support;
- Mechanisms to strengthen the direct care workforce and support family caregivers;
- Long-term care and insurance models for older adults and the feasibility of implementing each;
- Opportunities to better support cognitive and behavioral health for older adults;
- Opportunities to improve the economic wellbeing of older adults;
- Increasing access to justice for older adults, including combating abuse, neglect, fraud, and exploitation;
- Creating a more age-integrated state that promotes intergenerational relationships and decreases loneliness across generations;
- Expanding Maryland's workforce to include older adults;
- Funding sources to support any recommended programs or policy changes developed; and
- Any other aging-related matters identified by the MDOA.

"Our four Epic Goals are ambitious, visionary principles that inspire action and drive transformative change. Aiming high is crucial in creating a Longevity Ready Maryland because it pushes boundaries, fosters innovation, and unlocks greater potential."

***Carmel Roques**, Secretary of the Maryland Department of Aging*

Six months prior to the signing of the Executive Order, MDOA joined the Center for Health Care Strategies Learning Collaborative. This multi-state technical assistance workshop, which ran through May 2024, informed the development of LRM's four Epic Goals in alignment with MDOA's vision statement. Each Epic Goal provides a transformational approach in addressing the known social and environmental influences on health that lead to better outcomes as we age.

Acknowledging the OAA as the primary source of community-based support for Marylanders over the age of 60, MDOA has incorporated Maryland's required four-year State Plan on Aging related to OAA programming into this ten-year outlook.

Paving the way for a
Longevity Ready Maryland

LRM is not limited to the work of MDOA. It's a collaborative initiative that needs participation across governments and sectors to succeed. All participating stakeholders are encouraged to engage with the LRM brand as they incorporate longevity-readiness in their work.

Priority Areas: Outreach, Research, and Analysis

Area Agencies on Aging (AAAs)

MDOA distributes federal and state funding to Maryland's 19 AAAs, which are operated primarily by local governments. AAAs provide community-based services and supports across Maryland's 23 counties and Baltimore City to help older adults lead independent, meaningful, healthy, and dignified lives in their homes and communities. Along with personal care, disability support, protective services, nutrition services, emergency preparedness, and other essential community-based supports, they also advocate on behalf of older adults, collaborate with other agencies, and share information that is critical to program planning and resource allocation.

AAA FOUR-YEAR AREA PLAN ANALYSIS

MDOA conducted a systematic analysis of the state's 19 AAA four-year plans to identify region-specific needs and inform potential priorities for LRM. As the challenges facing older adults across diverse Maryland communities can vary significantly, AAA reporting is essential in determining what programs are needed where. For instance, in heavier populated areas, AAA analysis indicates rising behavioral health needs with capacity building challenges that make it difficult to effectively serve the growing need. Among Maryland's rural populations, older adults experience negative health outcomes resulting from social isolation and lack of access to services and support. Priority areas that were most common among AAA reporting and analysis include:

- Enhanced service delivery and accessibility
- Community-based care and independence
- Equity and inclusive aging
- Caregiver support and wellbeing
- Strategic partnerships and collaborations

Priority Populations

For Maryland to be prepared to meet the needs of today's older population and build for a future of healthy longevity across all communities, we must address the long-standing, systemic disparities that impact how well we age. As indicated in Where Maryland Stands: Opportunities and Challenges, disparities across the lifespan lead to significantly lower health and quality of life outcomes as we age. Priority populations (defined by the OAA as those in the greatest social and economic need) that lack adequate access to essential resources and supports include:

- Low-income Marylanders, including those experiencing poverty
- Historically underserved ethnic and racial minorities
- Marylanders living in rural areas
- The LGBTQIA+ community
- Marylanders with disabilities
- Marylanders with limited English proficiency

PRIORITY POPULATION ANALYSIS

Focus group sessions and interviews with populations representing the greatest social and economic need in our state were conducted between August and November of 2024. The six groups identified for engagement provided valuable insight into the diverse experiences of at-risk communities, helping to identify barriers that have the greatest impact on health, wellness, and inclusion among diverse Maryland communities. Priority areas that were most common among the targeted population focus group analysis included:

- Financial security
- Lack of transportation
- Social isolation and limited community engagement
- Digital access and technology proficiency
- Navigating complex systems and accessing information
- Age-related bias and lack of respect
- Health concerns and access to care
- Housing affordability and suitability
- Lack of support for caregivers

Objectives and Strategies: Defining the Path Forward

Stakeholder Work Groups

As indicated in Sectors that Support Aging in Maryland, it takes coordination across a range of subject matter experts to improve the quality of life for Marylanders as we age. To ensure LRM is based on the experience of groups who are impacted the most by planning and implementation decisions, partners invited to participate in LRM Work Groups included:

- Older adults
- AAAs
- Caregivers (paid and unpaid)
- Health care providers
- Social service agencies
- Advocacy groups
- Philanthropies
- Government agencies
- Community-based organizations
- Educators
- Research and academia
- Elected officials
- Businesses and employers

STAKEHOLDER WORK GROUP ANALYSIS

Work Group applicants were invited to participate based on their background and assigned to an Epic Goal that aligned with their skill set. Furnished with a library of resources, data, and analysis from prior planning activities, they were tasked with applying a longevity lens across existing plans and service delivery systems to identify opportunities to promote equity, ensure person-centered care, improve efficiency and collaboration, enhance access to technology-based solutions, and promote community-led solutions. At the conclusion of the two-month work sessions, a series of evidence-based and actionable objectives and strategies were developed within the following priority areas:

- Cross-sector coordination
- Justice, equity, and inclusion
- Caregiving supports
- Employment for all
- Affordable housing
- Financial stability
- Services and benefits
- Access to equitable systems of care

“The extensive research that went into defining LRM’s priority areas revealed some very real opportunities for working together in ways we hadn’t before shifting to a longevity approach. Smarter-not-harder systems of coordinated care are not only essential in reducing costs and improving the lives of all Maryland communities, they are achievable within our ten-year time frame.”

***Liz Woodward**, Assistant Secretary of Planning of the Maryland Department of Aging*

Development Timeline

JANUARY 2023:
Carmel Roques is appointed Secretary of MDOA

JUNE 2023 – MAY 2024:
MDOA participates in the Center for Health Care Strategies Learning Collaborative

MAY – DECEMBER 2023:
MDOA implements outreach and engagement with diverse stakeholders across the state to help define priorities

JANUARY 2024:
Governor Wes Moore Signs Executive Order 01.01.2024.01 The Longevity-Ready Maryland Initiative: A Multisector Plan for Longevity

JANUARY – NOVEMBER 2024:
MDOA continues outreach and engagement through local town halls, committee and task force meetings, and other community events, reaching every jurisdiction in Maryland

SPRING 2024:
MDOA partners with the National Center to Reframe Aging to lead awareness and communication training on strategies foundational to reframe aging

SUMMER 2024:
Key stakeholders are invited to participate in LRM Work Groups

SEPTEMBER – NOVEMBER 2024:
Work Groups convene to develop recommended objectives and strategies

MARCH – APRIL 2025:
LRM undergoes a public review and comment period

JUNE 2025:
LRM is submitted to Gov. Moore and Administration for Community Living for final approval

JULY 2025 – JUNE 2035:
LRM implementation

2025 – 2028:
Short-term outcomes achieved

2029 – 2031:
Mid-term outcomes achieved

2032 – 2035:
Long-term outcomes achieved

FY26 – FY29
Four-Year OAA Plan

FY30 – FY33
Four-Year OAA Plan

FY34 – FY37
Four-Year OAA Plan

Epic Goals:

Priorities, Objectives, Strategies, and Measures of Success

The following plan builds upon existing plans and resources to improve efficiency and collaboration across sectors, promote equity and inclusion, and protect person-centeredness for all Marylanders as we age. Whenever possible, the plan promotes community-led implementation and incorporates access to technology-based solutions.

Build a Longevity Ecosystem

Create supportive and inclusive communities for all ages and abilities and build collective capacity at the local level.

Key Sectors:
Aging, Health, Human Services, Information Technology, Legal, Planning, Service and Civic Innovation

Promote Economic Opportunity

Support a multigenerational workforce with opportunities for all ages and abilities while advancing Maryland's economic competitiveness.

Key Sectors:
Aging, Budget and Management, Health, Human Services, Labor

Prepare Marylanders to Afford Longevity

Improve economic security for the 100-year lifespan through affordable housing, financial literacy, and access to support services.

Key Sectors:
Aging, Comptroller, Disabilities, Education, Health, Housing and Community Development, Human Services

Optimize Health, Wellness, and Mobility

Invest in programs that support healthier, more purposeful, and active lifestyles so Marylanders can enjoy longevity and reduce dependency.

Key Sectors:
Aging, Health, Human Services, Planning, Transportation

> **"Integrating a longevity lens into every government department and agency, promoting coordinated responses, and helping the state shape how public services are planned and delivered will ensure that we maximize the benefits of longer lives in Maryland."**
>
> ***Jennifer Crawley**, Deputy Secretary of the Maryland Department of Aging*

EPIC GOAL 1:
Build a Longevity Ecosystem

Create supportive and inclusive communities for all ages and abilities and build collective capacity at the local level.

Community planning that incorporates a longevity lens across sectors creates stronger, safer, and more inclusive places to live and work in Maryland. Coordinated support among state and local leadership will create more efficient pathways for all Marylanders to age in place.

Local Organizations

Maryland has over 31,000 nonprofit organizations across 24 jurisdictions.[16]

Age-Related Bias

People with negative views of aging have shorter lifespans by about seven years than those with positive views.[17]

State Government

Maryland has 22 principal departments with important roles in longevity readiness.

CROSS-SECTOR COORDINATION: Breaking down silos between government agencies, strengthening local leadership, and improving community cohesion across home- and community-based services can improve equity, safety, and access to resources that impact our ability to age in place. That is why building effective partnerships between Maryland residents and service providers is essential in ensuring equal access to supports across Maryland's diverse communities. Longevity infrastructure that meets the needs of all residents must include methods for improving coordination between transportation, housing, health, workforce development, caregiving, and other important sectors.

JUSTICE, EQUITY, AND INCLUSION: Every Marylander deserves equal access to safeguards and services to stay connected and safe in the community—regardless of age, background, or ability. The impacts of experiencing social, health, and financial harm can be devastating to the individual, but have serious consequences for communities as well. Prioritizing inclusion of all residents will create a stronger and healthier Maryland by elevating public health, expanding economic stability, and lowering costs related to undue burdens on social services, health care, and criminal justice systems.

GOVERNOR'S MANDATE:

Recommend changes to enhance coordination among public and private partners on aging-related programs and policies.

LRM IN ACTION:

- MDOA Supportive Communities Initiative
- MDOA Partnership with the National Center to Reframe Aging
- Task Force on Preventing and Countering Elder Abuse

Build a Longevity Ecosystem:
Objectives, Strategies, and Outcomes

Objective 1: Strengthen partnerships with service providers, community organizations, nonprofits, academia, and the private sector to leverage public-private partnerships and support community-driven action.

STRATEGIES:

- Continually assess longevity readiness across state agencies and increase cross-sector collaboration that embraces a lifespan approach to policy and service delivery.
- Improve data capture and dissemination through coordinated data systems and capacity building at the state and local levels.
- Engage local communities in asset mapping, identifying opportunities to promote healthy longevity.
- Promote the adoption of the age-friendly communities model as an effective means for local governments, organizations, and community members to advance collaboration that supports healthy longevity.
- Enhance innovation and partnerships between government and community-based nonprofit organizations.
- Increase private investment that supports local age-friendly programs and infrastructure.

Outcomes

SHORT TERM (1-3 YEARS)

- Increase awareness of the impact of age-friendly communities model
- Community assets mapped by local action teams
- Expand participation in interagency coalitions

MID TERM (4-6 YEARS)

- Integrate data systems for coordinated service referrals

LONG TERM (7-10 YEARS)

- Increase investment and reach of services for older adults

Objective 2: Enhance multi-disciplinary prevention and response policies for elder abuse, neglect, and exploitation across state agencies.

STRATEGIES:

Review and adopt recommendations of the Task Force on Preventing and Countering Elder Abuse, including:

- Implement policies that promote justice and safeguard older adults across state- and federally-funded programs.
- Enhance accountability and oversight for people moving between levels of care or settings within the health care system.
- Improve systems for monitoring private and public guardianship to preserve the rights of older adults.
- Prevent fraud, cybercrime, and financial exploitation through increased oversight of powers of attorney and representative payees, and implementing collaborative systems of action on bank fraud and exploitation.

Outcomes

SHORT TERM (1-3 YEARS)

- Develop partnerships and implementation plan for enhanced response to elder abuse, neglect, and exploitation

MID TERM (4-6 YEARS)

- Implement the action plan through legislative and programmatic policy development

LONG TERM (7-10 YEARS)

- Improve prevention, detection, assessment, intervention, and investigation policies and programs

Build a Longevity Ecosystem:
Objectives, Strategies, and Outcomes

Objective 3: Increase the distribution of resources across state programs to historically underserved and under-resourced communities.

STRATEGIES:

- Engage under-resourced communities to plan and implement programs and policies that address community needs.
- Establish criteria across agencies for state-funded grants to ensure resources are targeted to communities in need.
- Integrate a longevity lens across state equity planning and implementation to improve reach and access of services among underserved populations, including people living in or near poverty, rural communities, people living with HIV, people of color, LGBTQIA+ community, people with disabilities, people with sight or hearing accessibility challenges, Native Americans, and those at risk of nursing home placement.
- Provide training that supports the adoption of bias-free language principles that promote the benefits and contributions of older Marylanders in all state- and federally-funded communications.
- Continue investment in sustainable growth to build community resiliency, connectivity, affordability, and vitality.

Outcomes

SHORT TERM (1-3 YEARS)

- Develop resources to improve equitable public program delivery
- Map eligibility criteria for programs targeting older adults
- Increase representation of under-resourced communities in collaborative planning

MID TERM (4-6 YEARS)

- Enhance service policy collaborations with local organizations

LONG TERM (7-10 YEARS)

- Increase services to those in greatest social and economic need

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Objective 4: Maximize the benefits of older volunteers across sectors.

STRATEGIES:

- Evaluate the landscape of volunteerism in Maryland and develop an action plan that leverages the growing population of skilled older volunteers.
- Increase awareness and adoption of the neighbor-helping-neighbor Village model.
- Recruit older volunteers and multigenerational volunteer teams into coordinated service opportunities.
- Increase the number of volunteers of all ages providing support to older Marylanders through Maryland Corps, AmeriCorps Seniors, Long-Term Care Ombudsman, Maryland Access Point, SHIP, and other programs through cross-promotion of volunteerism opportunities across state agencies.

Outcomes

SHORT TERM (1-3 YEARS)

- Establish actionable methods to encourage volunteer support for older Marylanders
- Increase awareness of volunteer opportunities

MID TERM (4-6 YEARS)

- Increase volunteers of all ages

LONG TERM (7-10 YEARS)

- Improve and expand services through a multigenerational volunteer workforce

POTENTIAL MEASURES OF IMPACT:

- Increase the number of and diversity of local organizations participating in LRM activities
- Increase participation in volunteer programs available to and for older adults
- Increase people trained in reducing age-related bias in state-developed communications

EPIC GOAL 2:

Promote Economic Opportunity

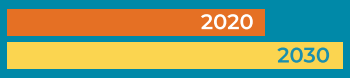
Support a multigenerational workforce with opportunities for all ages and abilities while advancing Maryland's economic competitiveness.

Longer lifespans and the growing population of older adults present both opportunities and challenges for the Maryland economy. Planning ahead to secure the roles of caregivers and older workers will lead to a stronger workforce and better quality of life for all Marylanders as we age.

Family Caregivers

Nearly half of all unpaid caregivers experience financial strain due to related costs and income loss.[18]

Direct Care Workforce



The demand for full-time direct care service providers will increase more than 30% between 2020 and 2030.[19]

Employment 50+

Workers age 50+ will represent more than one third of the Maryland workforce by 2030.[3]

CAREGIVING SUPPORTS: Family caregivers—spouses, partners, siblings, friends, neighbors, kin, cousins, nieces and nephews, grandparents, parents, godparents, and others—are the backbone of Maryland's care system, providing more than 710 million hours of support to loved ones of all ages.[15] The economic contributions of caregivers are significant, yet they often experience emotional, physical, and financial hardship as a result of the important work they do. The direct care workforce is an essential resource for many Marylanders who need help, but low wages and limited career opportunities result in high turnover rates and gaps in training. As we invest in resources and policies that support caregivers of all kinds, we create opportunities for older Marylanders to age in place, avoiding the higher cost of nursing homes or institutional care, and improving the health of Marylanders across the lifespan.

EMPLOYMENT FOR ALL: Perhaps the greatest opportunity longevity brings to Maryland is a multigenerational workforce. Older workers offer great value to employers, providing increased productivity and a greater diversity of skills. Working adults save more as they age and contribute significantly to local economies. Yet older workers have difficulty finding livable employment and earn 18% less than their younger counterparts. The state's competitiveness and economic growth depends on retaining talent of all ages in the workforce, upskilling and re-skilling workers, and developing cohesion in communities through a coordinated approach to age-inclusive employment practices.

GOVERNOR'S MANDATE:

Strengthen the direct care workforce, support family caregivers, and improve the economic wellbeing of older adults.

LRM IN ACTION:

- Senior Community Services Employment Program
- Maryland Caregiver Navigation Grant
- Governor's Workforce Development Board

Promote Economic Opportunity:
Objectives, Strategies, and Outcomes

Objective 1: Strengthen Maryland's ongoing commitment to family caregivers.

STRATEGIES:

- Increase the capacity of state agencies and the Maryland Commission on Caregiving to adopt actions within the National Strategy to Support Family Caregivers.
- Improve coordination between state-led caregiver support programs such as the National Family Caregiver Support Program, Kinship Care, and the Lifespan Respite Care Program, including through collaboration with the National Technical Assistance Center on Grandfamilies and Kinship Families and other technical assistance partners.
- Explore the recommendations within the 2024 Together in Care initiative, including the adoption of a coordinated statewide training initiative for paid and unpaid caregivers.
- Collaborate across state agencies to formulate policy that increases the opportunity for people to work more years with more flexibility, supporting family care across the lifespan.
- Expand the reach of existing caregiver support programs to underserved populations through targeted and culturally appropriate outreach in collaboration with federal, state, and local partners.
- Improve Maryland's No Wrong Door access to information and supports for family caregivers.
- Adopt policies for home- and community-based services and health care delivery that ensures the incorporation of caregivers in the care team, when appropriate.

Outcomes

SHORT TERM (1-3 YEARS)

- Enhance service delivery models to align with key national strategies
- Increase awareness of caregiving programs and benefits

MID TERM (4-6 YEARS)

- Develop collaborative data sharing and evaluation methods
- Advance training opportunities for caregivers

LONG TERM (7-10 YEARS)

- Increase the number of caregivers who access supportive resources

Objective 2: Improve the quality of direct care careers.

STRATEGIES:

- Explore opportunities to address the recruitment and retention of direct care workers by providing a living wage and access to benefits.
- Engage direct care workers as participating stakeholders in the design of relevant state policies to improve the quality of direct care careers.
- Identify and implement career pathways focused on skills-based job opportunities for direct care workers to utilize past lay experience and credentialed certifications to enter or re-enter the workforce.
- Explore the adoption of recommendations of the 2024 Together in Care initiative, including the development of direct care worker registries.

Outcomes

SHORT TERM (1-3 YEARS)

- Identify existing workforce development supports for direct care workers

MID TERM (4-6 YEARS)

- Expand training opportunities for the direct care workforce

LONG TERM (7-10 YEARS)

- Increase living wage and benefits for direct care workers

Promote Economic Opportunity:
Objectives, Strategies, and Outcomes

Objective 3: Increase the number of Maryland employers that promote sustainable career opportunities using age-inclusive policies and practices.

STRATEGIES:

- Evaluate the impact of the paid and unpaid older workforce on Maryland's economy.
- Evaluate age- and retirement-related policies and requirements and identify opportunities for modernization.
- Lead the effort to encourage Maryland employers to adopt age-inclusive policies and practices by implementing age-friendly employer certifications through the State of Maryland.
- Improve coordination and collaboration between Area Agencies on Aging and American Jobs Centers in providing access to supportive services and employment supports, including the Senior Community Services Employment Program (SCSEP).
- Support public- and private-sector employers in building their capacity to recruit, hire, and retain employees age 50 and over of all backgrounds and abilities.
- Create pathways for workers age 40 and over to upskill, reskill, and pursue career changes to in-demand occupations, such as health care, education, and information technology.

Outcomes

SHORT TERM (1-3 YEARS)

- Improve coordination between OAA programs
- Identify resources to evaluate the impact of older workers
- Receive age-friendly employer certification

MID TERM (4-6 YEARS)

- Create recruitment and retention resources for the older adult workforce
- Track employers using age-inclusive policies and practices

LONG TERM (7-10 YEARS)

- Increase employers using age-inclusive policies and practices

"Maryland's workforce is continually evolving. Appreciating the value, contributions, and needs of different generations of workers is essential to our ongoing economic growth. Multigenerational workplaces help businesses and communities thrive."

Portia Wu, Secretary of the Maryland Department of Labor

POTENTIAL MEASURES OF IMPACT:

- Improve the health, welfare, and financial stability of caregivers
- Increase wages, access to training, and workforce development programs for direct care workers
- Increase employment and opportunities for advancement for direct care and older adult workers

EPIC GOAL 3:
Prepare Marylanders to Afford Longevity

Improve economic security for the 100-year lifespan through affordable housing, financial literacy, and access to support services.

As we prepare for longer lives, Maryland communities must plan ahead to secure the financial stability of a growing number of older residents. Removing systematic barriers to key programs and services will help Marylanders save money and increase generational wealth while improving local economies.

Housing Costs

Rent increases for people age 65+ have outpaced Social Security income increases by 7% between 2018-2023.[20]

In-Home Care Costs

In-home care costs for a typical, older, middle-income family in Maryland is 63% of their annual income.[6]

Financial Literacy

Many experts recommend saving at least eight times your annual salary by age 60 to prepare for retirement.

AFFORDABLE HOUSING: Maryland has a housing shortage of more than 96,000 homes. By 2035, 1 in 3 households will be headed by someone 65 or older.[5] Access to housing programs and supports that meet the needs of a diverse range of older and multigenerational households will improve the ability to safely age in place, avoiding the expense associated with nursing home placement, and improving the economic security of Maryland communities.

FINANCIAL STABILITY: Older adults contribute significantly to the economy, providing tax revenue, creating jobs, and driving growth across many financial sectors. It's in the best interest of all of us to help keep Marylanders in Maryland as we age. Access to financial planning resources, supports for saving money, and education that helps protect wealth will improve financial security for Maryland families and their communities.

SERVICES AND BENEFITS: Access to key support services can reduce costs, improve health outcomes, and keep us connected to our communities as we age. Yet systematic barriers prevent a significant amount of older adults from being aware of low- and no-cost programs they may qualify for. To ensure all Marylanders have access to benefits and services that help save money and stay healthy and safe at home, we must adapt service delivery models that break down barriers and provide equitable access to care.

GOVERNOR'S MANDATE:

Recommend opportunities to improve the economic wellbeing of older adults.

LRM IN ACTION:

- Housing Expansion and Affordability Act
- Interagency Council on Homelessness
- CAPABLE Pilot
- Maryland Prescription Drug Affordability Board
- Maryland Access Point: No Wrong Door

Prepare Marylanders to Afford Longevity:
Objectives, Strategies, and Outcomes

Objective 1: Improve access to affordable, accessible housing options that support aging in place.

STRATEGIES:

- Through partnerships between the public and private sectors, invest in a variety of affordable housing developments, programs, and initiatives that are accessible to people of all ages and abilities.
- Improve access to housing options and resources by strengthening and expanding housing navigator networks.
- Commit funding to support a statewide initiative that prevents homelessness among older adults and provides housing supports for older adults who are homeless.
- Expand aging-in-place options by providing wraparound services that include health care, transportation, and social services in coordination with Area Agencies on Aging, Centers for Independent Living, Villages, and other community-based aging service providers.
- Increase access to home repair and modification programs that ensure safe and accessible home environments, such as HUBS, BCAUSE, CAPABLE, and Accessible Homes for Seniors.
- Increase access to any applicable state tax credits for income-limited households by lowering income thresholds, increasing property value limitations, and simplifying applications.
- Incentivize multigenerational living and expand access to intergenerational co-housing programs that match Marylanders to share housing costs.

Outcomes

SHORT TERM (1-3 YEARS)

- Expand the CAPABLE aging-in-place home modification pilot
- Convene state agencies on health, disabilities, housing, and aging to improve integration of services

MID TERM (4-6 YEARS)

- Commit funding to address older adult homelessness
- Increase access to affordable housing resources through enhanced navigators, integrated services, and tax credits

LONG TERM (7-10 YEARS)

- Increase the number of older adults enrolled in affordable housing programs

Objective 2: Assist Marylanders with long-term financial planning.

STRATEGIES:

- Provide age-appropriate financial literacy outreach to educate Marylanders across the lifespan about saving for the future.
- Increase awareness of and access to free financial planning resources that provide trusted and impartial information about savings and investment options.
- Provide targeted education to allow for financial stability through life transitions to assist in planning for a reduced income and access to available benefits.
- Provide outreach and education to inform older adults about ways to protect their savings from financial fraud and preserve generational wealth.
- Evaluate social and financial factors that impact the interest and ability of Marylanders to remain in the state as they transition away from full-time employment.
- Explore policies that provide support for people facing growing or unplanned long-term care costs, medical debt, tax burdens, housing costs, and other unforeseen expenses.

Outcomes

SHORT TERM (1-3 YEARS)

- Develop partnerships with organizations and institutions providing age-appropriate financial planning resources
- Map trusted and impartial financial planning resources

MID TERM (4-6 YEARS)

- Promote financial literacy education

LONG TERM (7-10 YEARS)

- Improve services that align with financial planning opportunities
- Identify long-term care insurance accessibility opportunities

Prepare Marylanders to Afford Longevity:
Objectives, Strategies, and Outcomes

Objective 3: Streamline access to public benefits and services.

STRATEGIES:

- Review and modernize state- and Medicaid-funded long-term services and supports to increase the number of people served, improve equitable service delivery statewide, and reduce administrative burden on providers.
- Improve referral pathways between acute care providers, Medicaid home- and community-based services, and aging network services to create a more streamlined continuum of home- and community-based supports.
- Incorporate programs targeting Marylanders across the lifespan, including older adults, adults with disabilities, and caregivers into the universal eligibility benefits application.
- Increase awareness and utilization of programs and resources to save for health care costs and increase self-determination, including Medicare Savings Plans, Health Savings Accounts, Advance Directives, end-of-life care, and others.
- Explore ways artificial intelligence can be leveraged to improve access to public benefits and programs.
- Increase access to prevention, screening and supportive services for people experiencing symptoms of dementia and their caregivers.
- Increase utilization of veteran benefits and resources while reducing disparities in access to benefits across hard-to-reach populations within the veteran community.
- Increase awareness of Social Security survivor benefits for non-married same-sex couples.

Outcomes

SHORT TERM (1-3 YEARS)

- Redesign state-funded pre-Medicaid long-term services and supports programming with AAAs
- Identify sustainable strategies to expand referrals between acute care and community-based providers

MID TERM (4-6 YEARS)

- Increase awareness of programs, benefits, and services that support healthy aging and help older adults save money

LONG TERM (7-10 YEARS)

- Improve coordination of aging network services with state- and Medicaid-funded home- and community-based services
- Improve coordination between systems of long-term care to increase access to home- and community-based services

> **"By working together across sectors through integrated, wrap-around referral systems, we can break down silos, identify individuals who are at-risk sooner, and deliver coordinated care that meets the full spectrum of needs—fostering healthier, more resilient communities."**
>
> ***Carnitra White,** Principal Deputy Secretary of the Maryland Department of Human Services*

POTENTIAL MEASURES OF IMPACT:

- Increase use of outreach and education programs that address financial literacy
- Increase the number of Marylanders saving for later life
- Increase assistance with accessing housing and aging-in-place services
- Expand reach and coordination of Maryland Access Point

EPIC GOAL 4:
Optimize Health, Wellness, and Mobility

Invest in programs that support healthier, more purposeful, and active lifestyles so Marylanders can enjoy longevity and reduce dependency.

Older Marylanders have a lot to look forward to. Ensuring we have access to proper nutrition, health literacy, outdoor spaces, and reliable transportation within our communities can help keep us active and socially connected throughout the lifespan.

Physical Activity

1 in 4 Marylanders age 65 and over meets federal physical activity guidelines.[10]

Nutrition

70 Maryland Food Deserts

Maryland has more than 70 geographic areas without adequate grocery sources.[1]

Staying Connected

The negative impact of social isolation is comparable to smoking 15 cigarettes a day.[21]

ACCESS TO EQUITABLE SYSTEMS OF CARE: All Marylanders deserve healthy, purposeful, and active lifestyles, with access to a spectrum of community-based services and supports that promote healthy lifespans. Yet the social determinants of health that impact health and wellbeing vary significantly from one Maryland community to the next. Adults in lower-income and rural communities are prone to social isolation risk factors that limit their access to healthy food, medical care, physical activity, and mental health services. The result is a higher risk of developing serious disabilities and chronic health conditions earlier in life. Holistic approaches that improve health outcomes for older adults require investments in nutrition, health literacy, outdoor spaces, public health, and transportation infrastructure across all Maryland communities. Overcoming challenges in creating collaborative systems of care will require agencies and organizations to work together to identify needs at the community level and find solutions that remove perceived barriers between sectors. Health care systems, community-based service providers, and state and local governments must invest in coordinated improvements to transportation systems, community infrastructure, digital literacy programs, and nutrition services that lead to holistic person-centered care in all Maryland communities.

GOVERNOR'S MANDATE:

Review current data and establish a comprehensive framework of policies and programs that seek to improve and support the health, wellbeing, and quality of life for older adults.

LRM IN ACTION:

- AHEAD Model
- Evidence-Based Health Promotion
- Maryland Equips
- Model Complete Streets

Optimize Health, Wellness, and Mobility:
Objectives, Strategies, and Outcomes

Objective 1: Improve equitable access to holistic health care that addresses physical, behavioral, emotional, and cognitive health.

STRATEGIES:

- Implement the AHEAD model to expand Maryland's focus on primary care, population health, prevention, and health equity across age groups.
- Explore policies that incentivize enhanced care delivery models in the home and community that collaborate with community-based organizations, care navigators, and community health workers, such as the Neighborhood Nursing model.
- Expand access to, and utilization of, community-based behavioral health services that address long-term care needs.
- Implement a person-centered, trauma-informed approach across publicly-funded programs to ensure older adults and adults with disabilities can effectively make decisions about their care and wellbeing.
- Leverage existing state infrastructure to target shortage areas for health providers and direct support professionals to increase access to care among older adults in underserved communities.
- Increase access to technology that will enhance the ability of all Marylanders to pursue their best life as they define it through the Technology First initiative by increasing access to the internet and providing resources for digital literacy education, accessible telecommunications equipment, telehealth, assistive technology, and durable medical equipment.
- Explore policy reform opportunities that incentivize small home alternatives to residential nursing institutions.
- Identify policy opportunities to incentivize equitable delivery of medical innovations that impact healthy aging.

Outcomes

SHORT TERM (1-3 YEARS)

- Launch the AHEAD model
- Identify and promote programs and policies that advance person-centered, trauma-informed care
- Advance awareness of assistive technology and digital access programs

MID TERM (4-6 YEARS)

- Improve systemic coordination to address social determinants of health
- Identify opportunities to incentivize enhanced care delivery models across state partners

LONG TERM (7-10 YEARS)

- Enhance holistic health of older adults through coordinated care and long-term services and supports

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Objective 2: Increase access to healthy food and physical activity.

STRATEGIES:

- Promote free and low-cost community wellness and fitness classes through targeted communications, partnerships with local organizations, and the utilization of public spaces.
- Engage communities in enhancing the safety and accessibility of community spaces through improvements to the built environment.
- Embrace a food-is-medicine approach by developing policies that support access to healthy food, home-delivered meals, and medically-tailored meals through cross-sector collaboration.
- Screen for and cross-promote food assistance programs, including SNAP, the Commodity Supplemental Food Program, The Emergency Food Assistance Program, Senior Farmers Market Nutrition Program, and locally-operated programs.

Outcomes

SHORT TERM (1-3 YEARS)

- Cross-promote food assistance programs
- Promote community-driven infrastructure, wellness, and fitness programs

MID TERM (4-6 YEARS)

- Implement a multisector food-is-medicine program
- Reduce malnutrition, and increase access to culturally appropriate and medically tailored meals

Optimize Health, Wellness, and Mobility:
Objectives, Strategies, and Outcomes

Objective 3: Increase investment in services and transportation infrastructure that promote safety, accessibility, and mobility.

STRATEGIES:

- Reassess the administration of state programs that fund human services transportation to better align resources focused on older adults and adults with disabilities, including Older Americans Act and Section 5310 grants.
- Analyze non-emergency human services transportation efforts in other states for consideration in Maryland, particularly those that have coordinated or consolidated funding programs administered by different agencies.
- Build out a sustained Model Complete Streets building initiative to improve connectivity between land use planning and community transportation, fill in gaps in active transportation networks, and support accessible and walkable communities.
- Leverage technology (e.g., ride-hailing services, self-driving cars) and community-based services to enhance transportation options and operability for older adults, especially in rural communities.
- Expand outreach and assistance to increase access to available transportation options.

Outcomes

SHORT TERM (1-3 YEARS)

- Publish the five-year human services transportation plan
- Improve cross-agency transportation services
- Increase awareness of mobility options

MID TERM (4-6 YEARS)

- Enhance coordination between land use and transportation planning

LONG TERM (7-10 YEARS)

- Increase innovative transportation options
- Increase walkable communities

Objective 4: Enhance a culture of social connection.

STRATEGIES:

- Promote policies that enhance social connection across sectors.
- Promote the adoption of health care screenings and referrals to programs that address social isolation and loneliness in partnership with community hubs.
- Reform state-funded social connection programming to better integrate with local programs and resources, including from AAAs, Villages, libraries, parks and recreation, and other community-based organizations.
- Infuse social connection into core programming using a person-centered approach, including ensuring home-delivered meal participants may participate in group meals and other in-person health and wellness activities when feasible and available.
- Educate the public about the prevention of, detection of, and response to negative health effects associated with social isolation.
- Promote innovative opportunities to connect Marylanders across all ages through technology, programming, and community spaces.
- Promote the adoption of initiatives that increase intergenerational connection to reduce age-related bias.

Outcomes

SHORT TERM (1-3 YEARS)

- Promote social connection programs and implement enhancements to state-funded programs

MID TERM (4-6 YEARS)

- Increase integration between national and local programs
- Integrate social isolation screening into clinical referral services

LONG TERM (7-10 YEARS)

- Increase awareness of risk factors of social isolation and benefits of social engagement

POTENTIAL MEASURES OF IMPACT:

- Increase healthier lifestyles for older adults
- Improve access to holistic health care across populations and geographic regions
- Increase participation in community-based services that promote healthy living
- Decrease the negative health effects associated with social isolation

LRM in Action:
Development and Implementation

With a strong foundation in place, LRM will be a continuous work in progress. We must be prepared for priorities to shift and new opportunities to develop along the way. Defined strategies will evolve to include more detail, accommodating partnership, program, and technology developments. Outcomes will be measured to inform fresh approaches and identify emerging needs. Methods for adaptation are an essential part of serving Maryland communities and are part of the implementation plan.

Work to Date

Data and Resource Mapping

Paving the way for a
Longevity Ready Maryland

Nowhere else is the opportunity to incorporate a longevity lens in the work we do more practical to implement and vital for success than through collecting and sharing age- and service-related data.

Data plays an essential role in the development of policies and programs that support longevity, and helps with the delivery of equitable access to services across diverse communities. Statistics that track social determinants of health increase capacity to make informed decisions about service needs. Resource mapping can connect essential services to the people who need them at the community level. Key LRM partnerships are developing improved data and resource mapping systems and resources that will inform program development and track the progress of LRM strategies in the years to come.

- **LRM DATA DASHBOARD** (MDOA AND MARYLAND DEPARTMENT OF PLANNING): An innovative resource to help service providers and policymakers identify needs, anticipate trends, and measure outcomes that impact longevity in Maryland, the LRM Data Dashboard provides information about life expectancy, population growth, and health and economic indicators across racial, age, and geographic breakdowns. Already an essential tool in developing LRM's objectives and strategies, the dashboard will continue to evolve to incorporate new data from state and local partners and play an important role across several phases of implementation.
- **MARYLAND ACCESS POINT** (MDOA AND MARYLAND DEPARTMENT OF HEALTH): In partnership with Maryland's AAAs, community service providers, and 211 Maryland, Maryland Access Point provides information, assistance, and referrals for long-term services and supports, hospital-to-home transition support, social service benefits, health care coverage, housing, dementia care, and other programs and services for older adults, people with disabilities, and their caregivers. Health and human service organizations can be included in this innovative resource mapping and referral service, free of charge.

Programs and Initiatives

While great strides have been made in the development of LRM's objectives and strategies, MDOA partners have also been hard at work implementing programs and initiatives to help pave the way for a Longevity Ready Maryland. Key examples of LRM in Action include:

- **AGE-FRIENDLY COMMUNITIES** (AARP/WHO): The development of inclusive programs and systems, often led by AAAs at the county level, that encourage best practices that make communities more livable for residents of all ages.
- **ASSISTANCE IN COMMUNITY INTEGRATION SERVICES PILOT** (MARYLAND DEPARTMENT OF HEALTH): A collaboration with MDOA and the departments of health, housing, and disabilities to reduce unnecessary institutionalization and homelessness among Medicaid participants guided through participation in the Housing and Services Partnership Accelerator.
- **CAPABLE PILOT** (MARYLAND DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT): A collaboration with MDOA and local aging and disability agencies to expand an evidence-based home modification model in rural communities.
- **EVIDENCE-BASED HEALTH PROMOTION** (MDOA AND MARYLAND DEPARTMENT OF HEALTH): A collaboration between public-private partnerships, state and local departments of aging and health, and the Maryland Living Well Center of Excellence to expand the capacity of local agencies, community-based organizations, and health care providers to provide evidence-based health promotion workshops.
- **HOUSING EXPANSION AND AFFORDABILITY ACT** (MOORE-MILLER ADMINISTRATION): Legislation that addresses the affordable housing crisis by bolstering supply. The Act removes local government barriers to the construction of affordable housing, promotes increased density where appropriate, and removes barriers to the use of manufactured housing statewide.
- **MARYLAND CAREGIVER NAVIGATION GRANT** (MDOA): A collaboration with the departments of human services, disabilities, and health, and the Maryland Commission on Caregiving to advance the implementation of the National Strategy to Support Family Caregivers through policy, outreach, and programming.
- **MARYLAND EQUIPS** (MDOA, MARYLAND DEPARTMENT OF DISABILITIES, AND MARYLAND DEPARTMENT OF HEALTH): A consolidated directory of free or low-cost medical and assistive technology, equipment, and service programs available to Maryland residents.
- **MODEL COMPLETE STREETS** (MARYLAND DEPARTMENT OF TRANSPORTATION): Policy guiding a deliberate approach to planning, designing, and constructing safer streets for residents of all ages and abilities.
- **SENIOR CALL CHECK AND SOCIAL CONNECTIONS** (MDOA): Adaptations to the Senior Call Check program will better address accessibility barriers that lead to social isolation through enhanced communications platforms and options that are more inclusive.
- **STATES ADVANCING ALL-PAYER HEALTH EQUITY APPROACHES AND DEVELOPMENT MODEL** (MARYLAND DEPARTMENT OF HEALTH): An approach intended to drive health care transformation by improving health care quality and controlling costs across all payers in partnership with the Health Services Cost Review Commission.
- **STRATEGIES TO REFRAME AGING** (MDOA AND NATIONAL CENTER TO REFRAME AGING): Training and technical assistance for aging services leaders to improve communication that advances a more equitable and complete understanding of the contributions of older Marylanders on our society.
- **SUPPORTING OLDER ADULT WITH RESOURCES (SOAR)** (MDOA): SOAR consolidates existing programs to improve efficiency and effectiveness of state-funded long-term care services and expand capacity.
- **SUPPORTIVE COMMUNITIES INITIATIVE** (MDOA): A collaboration with local governments, community-based organizations, Villages, and other community leaders to increase capacity of community-level supports that enable people to age in place.

Looking Ahead: Phases of Implementation

LRM is the result of hundreds of passionate Marylanders coming together with the goal of creating a more equitable society at all stages of life. To ensure LRM is actionable and sustainable, MDOA will continue to lead policy and program development for the aging services networks, while leveraging partnerships across sectors and governments to advance the opportunities and resources that others bring to the table. Recognizing that we can't create a longevity-ready state without investments in collaboration, LRM will serve as a catalyst for improved cross-sector coordination, policy planning, and service development that promotes longevity-readiness, and supports others in their respective and collective roles during implementation.

Stakeholder Engagement

Policy and Service Analysis

Policy and Service Development

Evaluation and Tracking

Stakeholder Engagement

- Engage Maryland communities through robust outreach efforts to create awareness of LRM, and invite community members and organizations to participate.
- Expand stakeholder advisory representation to be more inclusive of Maryland's diversity and key sectors.
- Meet regularly with stakeholders to work on key challenges, review progress, and inform next steps.
- Engage local organizations, community leaders, and residents throughout the state to share the plan, discuss opportunities for local implementation, and create collective impact from the community.
- Continue to engage AAAs as the local leaders in age-friendly and longevity supports, and build upon alignment between LRM and the State Plan on Aging to collect information about local-level collaboration through the next AAA Area Plans.
- Collaborate directly with partners throughout implementation to help identify resources that align LRM strategies with their work.
- Convene with state agency leadership to review progress and identify challenges and opportunities for state agency integration of LRM strategies.
- Partner with philanthropy networks to drive resources that advance LRM strategies.
- Maximize aging services representation across boards, commissions, and task forces to promote integration of the plan's strategies across existing state platforms.
- Develop strategies for serving target populations through partnerships with the Older Adults' Equity Collaborative, the Office of Minority Health and Health Disparities, the Maryland Commission on LGBTQIA+ Affairs, the Maryland Commission on Health Equity, the Governor's Commission on Asian Pacific American Affairs, and others to better serve those with the greatest social and economic need.
- Expand legislative presence and visibility by continuing to build relationships with elected officials, lobbyists, and key decision makers. Testify on key bills and legislation, providing data and using strategies that align with LRM, and partner with agencies whose policy platforms support its objectives and strategies.

Policy and Service Analysis

- Monitor participant demographics, person-centered strategies, and deployment of proactive methods to reach target populations.
- Promote the need for cross-sector data collection and integration with the LRM Data Dashboard.
- Advocate for incorporating a longevity lens in data collection by including age-specific data collection breakdowns and other longevity-related information.

LRM in Action: Development and Implementation

- Create consumer-focused service navigation journey maps and develop cross-agency metrics to monitor local and regional coordination among social services, AAAs, behavioral health providers, developmental disabilities administrations, local health departments, and others.
- Continually evaluate Maryland's longevity readiness, building upon our initial analysis of existing data, stakeholder engagement, and state agency initiatives to further assess opportunities and challenges in Maryland.

Policy and Service Development

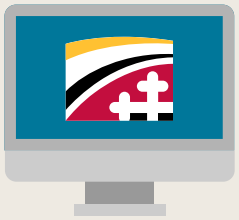
- In partnership with state and local organizations, execute LRM's strategies to guide partnership development, policy creation, and programmatic adaptations.
- Define calls to action on how LRM can be used at the state and local level to:
  - Identify and promote data-driven needs and opportunities;
  - Promote existing and new learning opportunities on developing best practices and evidence-informed models to advance LRM strategies;
  - Implement sector- and objective-specific opportunities for incorporating strategies;
  - Advance opportunities for advocacy, state and federal funding, and partnership building; and
  - Identify strategies for incorporating a longevity lens in the work partners are already doing.
- Develop digital platforms for information sharing to capture the needs, opportunities, and activities of partner programs, and help garner support for key initiatives throughout Maryland communities.
- Create a stakeholder directory by service area and geographical region as relationships with stakeholders, sectors, jurisdictions, and community groups across Maryland communities develop.
- Develop a longevity toolkit to help stakeholders implement program initiatives, engage communities, and advance equity for all ages, backgrounds, and abilities.
- Leverage opportunities to direct resources and improve service delivery to those with the greatest social and economic need through identified strategies within programs such as the Engaging Neighborhoods, Organizations, Unions, Governments and Households (ENOUGH) initiative.

Evaluation and Tracking

- Monitor the efficacy of programs that advance the equitable inclusion of older adults in planning, policy, resource allocation, and service delivery.
- Define measurable outcomes and track progress using validated data sources and program implementation.
- Provide stewardship and oversight to help aging networks meet OAA program requirements through holistic program management.
- Share ongoing progress through public-facing online platforms and annual reports to the legislature.

A Call to Action for Cross-Sector Collaboration

In The Collective Roles of State Agencies, we briefly identified the responsibilities other state agencies and program partners play in supporting longevity-readiness across the state. We cannot understate the importance of cross-sector cooperation throughout the implementation process, and how influential it has been in developing the plan, implementing LRM in Action items, and forging a path forward in strategy development. As the work continues, we will improve collaboration methods to scale impact, improve efficiency, and reduce administrative burden across sectors and stakeholders. We look to our partners at the state and local levels to help inform that process. By working together, we CAN become a state where all Marylanders lead healthy, financially secure, socially connected, and purposeful lives as we age.



Get involved! Visit **LRM.Maryland.gov** for ways everyone can help pave the way for a Longevity Ready Maryland.

Appendix A:
Older Americans Act State Plan Requirements

Attachment A: State Plan Assurances and Required Activities

Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the state Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a state to be eligible to participate in programs of grants to states from allotments under this title— . . .

(2) The state agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the state agency will take into account, in connection with matters of general policy arising in the development and administration of the State Plan for any fiscal year, the views of recipients of supportive services or nutrition services, or people using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older people with greatest economic need and older people with greatest social need (with particular attention to low-income older people, including low-income minority older people, older people with limited English proficiency, and older people residing in rural areas), and include proposed methods of carrying out the preference in the State Plan;

(F) provide assurances that the state agency will require use of outreach efforts described in section 307(a)(16); and

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older people and older people residing in rural areas;

(ii) provide an assurance that the state agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older people;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the state agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—...

(5) in the case of a state specified in subsection (b)(5), the state agency;

and shall provide assurance, determined adequate by the state agency, that the area agency on aging will have the ability to develop an Area Plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the state shall give preference to an established office on aging, unless the state agency finds that no such office within the planning and service area will have the capacity to carry out the Area Plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection (a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the state, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the state.

Note: states must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the state in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the state agency, prepare and develop an Area Plan for a planning and service area for a two-, three-, or four-year period determined by the state agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for Area Plans within the state prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older people in paid and unpaid work, including multigenerational and older person to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older people with low incomes residing in such area, the number of older people who have greatest economic need (with particular attention to low-income older people, including low-income minority older people, older people with limited English proficiency, and older people residing in rural areas) residing in such area, the number of older people who have greatest social need (with particular attention to low-income older people, including low-income minority older people, older people with limited English proficiency, and older people residing in rural areas) residing in such area, the number of older people at risk for institutional placement residing in such area, and the number of older people who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older people with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the state agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4)(A)(i) (I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with state policy, for providing services to older people with greatest economic need, older people with greatest social need, and older people at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older people, older people with limited English proficiency, and older people residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority people, older people with limited English proficiency, and older people residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority people, older people with limited English proficiency, and older people residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority people, older people with limited English proficiency, and older people residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older people in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older people; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify people eligible for assistance under this Act, with special emphasis on—

(I) older people residing in rural areas;

(II) older people with greatest economic need (with particular attention to low-income minority people and older people residing in rural areas);

(III) older people with greatest social need (with particular attention to low-income minority people and older people residing in rural areas);

(IV) older people with severe disabilities;

(V) older people with limited English proficiency;

(VI) older people with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such people); and

(VII) older people at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older people referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such people, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older people and older people residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older people with disabilities, with particular attention to people with severe disabilities, and people at risk for institutional placement, with agencies that develop or provide services for people with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the Area Plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older people within the community by (in cooperation with agencies, organizations, and people participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older people;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older people caring for relatives who are children, and respite for families, so as to provide opportunities for older people to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older people, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older people and people with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older people (including minority people and older people residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such people, representatives of older people, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the Area Plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other federal programs for older people at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the state agency and with the state agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older people who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such people in such area and shall inform such people of the availability of assistance under this Act;

(H) in coordination with the state agency and with the state agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the state agency to disseminate information about the state assistive technology entity and access to assistive technology options for serving older people;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older people and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older people and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older people at risk for institutional placement, to permit such people to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older people and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older people; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other federal and state programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older person seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each person described in clause (i) a statement specifying that the person has a right to make an independent choice of service providers and documents receipt by such person of such statement;

(iii) has case managers acting as agents for the people receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9)(A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other federal, state, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older people who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older people who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the Area Plan available, to the same extent as such services are available to older people within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other federal or federally assisted programs for older people at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the state agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older people; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the state, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older people;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older people as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older people, giving priority to older people identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and state emergency response agencies, relief organizations, local and state governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older people whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such people; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify people eligible for assistance under this Act, with special emphasis on those people whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the Area Plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older people during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older people in the planning and service area;

(B) an analysis of how such change may affect such people, including people with low incomes, people with greatest economic need, minority older people, older people residing in rural areas, and older people with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older people in the planning and service area; and

(D) an analysis of how the change in the number of people age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, state agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the state, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older people for—

(A) health and human services;

(B) land use;

(C) housing;

(D) transportation;

(E) public safety;

(F) workforce and economic development;

(G) recreation;

(H) education;

(I) civic engagement;

(J) emergency preparedness;

(K) protection from elder abuse, neglect, and exploitation;

(L) assistive technology devices and services; and

(M) any other service as determined by such agency.

(c) Each state, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the state agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a state where no such agency has been designated, the state agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of people receiving benefits under such Acts and older people participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older people and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a state agency finds that an area agency on aging has failed to comply with federal or state laws, including the Area Plan requirements of this section, regulations, or policies, the state may withhold a portion of the funds to the area agency on aging available under this title.

(2)(A) The head of a state agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the state agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3)(A) If a state agency withholds the funds, the state agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the state agency determines that the area agency on aging has not taken corrective action, or if the state agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the state agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or people that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each state, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a state Plan for a two, three, or four-year period determined by the state agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a state failed in 2 successive years to comply with the requirements under this title, then the state shall submit to the Assistant Secretary a State Plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the state is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the state agency for approval, in accordance with a uniform format developed by the state agency, an Area Plan meeting the requirements of section 306; and

(B) be based on such Area Plans.

(2) The plan shall provide that the state agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the state;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the state to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older people residing in rural areas—

(i) provide assurances that the state agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000...

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the state agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the state under this title and title VII, including evaluations of the effectiveness of services provided to people with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older people, older people with limited English proficiency, and older people residing in rural areas).

(5) The plan shall provide that the state agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on

aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the state agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, federal funds paid under this title to the state, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no person (appointed or otherwise) involved in the designation of the state agency or an area agency on aging, or in the designation of the head of any subdivision of the state agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the state agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the state agency or an area agency on aging in the state, unless, in the judgment of the state agency—

(i) provision of such services by the state agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such state agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such state agency or area agency on aging.

(B) Regarding case management services, if the state agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a state program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the state agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the state agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the state agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the state agency pursuant to section 712 shall be used to supplement and not supplant other federal, state, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older people residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older people on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older people with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on people with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the state agency will provide for the coordination of the furnishing of legal assistance to older people within the state, and provide advice and technical assistance in the provision of legal assistance to older people within the state and support the furnishing of training and technical assistance for legal assistance for older people;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older people being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older people; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the state desires to provide for a fiscal year for services for the prevention of abuse of older people —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant state law and coordinated with existing state adult protective service activities for—

(i) public education to identify and prevent abuse of older people;

(ii) receipt of reports of abuse of older people;

(iii) active participation of older people participating in programs under this Act through outreach, conferences, and referral of such people to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the state will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each state will assign personnel (one of whom shall be known as a legal assistance developer) to provide state leadership in developing legal assistance programs for older people throughout the state.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older people in the state, including the number of low-income minority older people with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older people described in subparagraph (A), including the plan to meet the needs of low- income minority older people with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older people residing in any planning and service area in the state are of limited

English-speaking ability, then the state will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older people who are of limited English-speaking ability; and

(B) to designate an person employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older people who are of limited English-speaking ability in order to assist such older people in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to people engaged in the delivery of supportive services under the Area Plan involved to enable such people to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the state agency will require outreach efforts that will—

(A) identify people eligible for assistance under this Act, with special emphasis on—

(i) older people residing in rural areas;

(ii) older people with greatest economic need (with particular attention to low-income older people, including low-income minority older people, older people with limited English proficiency, and older people residing in rural areas);

(iii) older people with greatest social need (with particular attention to low-income older people, including low-income minority older people, older people with limited English proficiency, and older people residing in rural areas);

(iv) older people with severe disabilities;

(v) older people with limited English-speaking ability; and

(vi) older people with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such people); and

(B) inform the older people referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such people, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older people with severe disabilities, assurances that the state will coordinate planning, identification, assessment of needs, and service for older people with disabilities with particular attention to people with severe disabilities with the state agencies with primary responsibility for people with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older people with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older people who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the state agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the state agency will pursue activities to increase access by older people who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the state agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the state agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other state services that benefit older people; and

(B) to provide multigenerational activities, such as opportunities for older people to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the state will coordinate public services within the state to assist older people to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the state has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27)(A) The plan shall include, at the election of the state, an assessment of how prepared the state is, under the state's statewide service delivery model, for any anticipated change in the number of older people during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older people in the state;

(ii) an analysis of how such change may affect such people, including people with low incomes, people with greatest economic need, minority older people, older people residing in rural areas, and older people with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the state can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older people in the state; and

(iv) an analysis of how the change in the number of people age 85 and older in the state is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the state will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, state agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the state agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the state shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older people whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such people; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a state under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the state under this paragraph will be used to hire any person to fill a job opening created by the action of the state in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY.—In order to be eligible to receive an allotment under this subtitle, a state shall include in the State Plan submitted under section 307—

(1) an assurance that the state, in carrying out any chapter of this subtitle for which the state receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the state will hold public hearings, and use other means, to obtain the views of older people, area agencies on aging, recipients of grants under title VI, and other interested people and entities regarding programs carried out under this subtitle;

(3) an assurance that the state, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older people have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the state will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any federal or state law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the state will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the state agency will conduct a program of services consistent with relevant state law and coordinated with existing state adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older people participating in programs under this Act through outreach, conferences, and referral of such people to other social service agencies or sources of assistance if appropriate and if the people to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

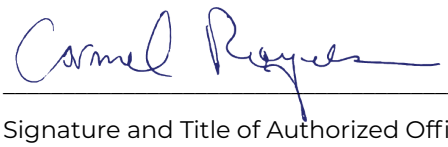
(B) the state will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order...



Signature and Title of Authorized Official

June 26, 2025

Date

Attachment B: Information Requirements

Except as indicated where optional or only applicable to states with multiple planning and service areas, the State Plan must state how the following provision(s) will be met:

Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (d) requires each State Plan must include a description of how greatest economic need and greatest social need are determined and addressed by specifying:

> (1) How the state agency defines greatest economic need and greatest social need, which shall include the populations as set forth in the definitions of greatest economic need and greatest social need, as set forth in 45 CFR § 1321.3; and
>
> (2) The methods the state agency will use to target services to such populations, including how OAA funds may be distributed to serve prioritized populations in accordance with requirements as set forth in 45 CFR § 1321.49 or 45 CFR § 1321.51, as appropriate.

"Greatest economic need" means "the need resulting from an income level at or below the federal poverty level and as further defined by state and Area Plans based on local and individual factors, including geography and expenses" (45 CFR § 1321.3).

"Greatest social need" means the need caused by the following noneconomic factors as defined in 45 CFR § 1321.3.

A state agency's response must establish how the state agency will:

> (1) identify and consider populations in greatest economic need and greatest social need;
>
> (2) describe how they target the identified the populations for service provision;
>
> (3) establish priorities to serve one or more of the identified target populations, given limited availability of funds and other resources;
>
> (4) establish methods for serving the prioritized populations; and
>
> (5) use data to evaluate whether and how the prioritized populations are being served.

RESPONSE:

The MDOA and its network of Area Agencies on Aging continually strive to serve those with greatest social and economic need. The state's Intrastate Funding Formula (IFF) is based on the population of older adults (60 and older) and also emphasizes the proportion of older adults below the federal poverty level and minority older adults below the federal poverty level. The methodology for allocating the funding to the AAAs is based on establishing a final funding ratio for each AAA. The mathematical formula ensures that AAAs with jurisdictions that have the greatest economic and social need receive adequate funding. The Department will be working with AAAs during the OAA State Plan term to determine whether and how to best update the IFF to ensure effective allocation of resources across the state to those in the greatest social and economic need.

MDOA has established a policy to ensure AAAs prioritize services to people with greatest economic need and greatest social need, paying particular attention to low-income older people, including low-income minority people, people with Limited English Proficiency (LEP), and older people living in rural areas. Based on the funding formula and the limited availability of funds, the priority target populations for the current plan are older adults in poverty and minorities. The MDOA policy directs the AAA to create a policy defining greatest economic need and greatest social need that aligns with MDOA's definition and utilize the definition to guide the provision of services. It also identifies that MDOA shall annually monitor AAA service provision to ensure that service units, unduplicated people, and program expenditures align with the percentage of clients identified as having the greatest economic need and greatest social need. MDOA currently uses Older Americans Act Performance System (OAAPS) data to evaluate whether priority populations are being served and is working to review and update its monitoring tools to improve programmatic and fiscal accountability and alignment with Older Americans Act regulations.

Specific programmatic policies also include a focus on effectively targeting services. For example, in the Home-Delivered Meals program, a Priority Screening Tool is used to assist AAAs in evaluating recipients to best serve those in greatest need. The statewide Maryland Access Point aging and disability resource center conducts priority screening during all calls coming into AAAs. And, the Department's statewide Medicare Improvements for Patients and Providers Act (MIPPA) program provides savings to Medicare beneficiaries based on income eligibility.

In addition to ongoing programmatic monitoring, MDOA reviews Area Plans to ensure AAAs are identifying their target populations and core strategies to facilitate an effective reach of their services to people representing the greatest social and economic need. AAAs submit a four-year Area Plan and on an annual basis AAAs update their Area Plan to represent any changes, provide programmatic data, and submit their budgets for Older Americans Act funds. As outlined in the Area Plans, AAAs employ a variety of strategies to meet the greatest social and economic need, including the engagement of trusted community partners such as multicultural and faith-based organizations, hiring of bilingual and culturally-representative staff, translation services, and staff training on effective inclusion. AAAs that do not provide sufficient detail on their target populations, demographics, services levels and strategies for effective outreach and engagement are required to provide such detail before the plan can be approved.

MDOA has partnered with the Maryland Department of Planning to develop a data dashboard tool using verified core data sets and geomapping to identify areas of need and facilitate planning at the state and local level. This tool will extend the benefits some Area Agencies on Aging are already experiencing from access to targeted data, such as the Montgomery County CountyStat performance management and data analytics tool and the Baltimore County Social Determinants of Health Data Library. As MDOA further develops the data dashboard tool, we envision the opportunity to integrate service provision data, allowing us to understand reach potential as compared to actual reach.

As part of our commitment to improving the reach of services to those with the greatest social and economic need, MDOA has identified a staff lead responsible for the provision of training, technical assistance, and the sharing of best practices related to serving those with the greatest social and economic need among state and local program managers.

Native Americans: Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (g):

Demonstration that the determination of greatest economic need and greatest social need specific to Native American people is identified pursuant to communication among the state agency and Tribes, Tribal organizations, and Native communities, and that the services provided under this part will be coordinated, where applicable, with the services provided under Title VI of the Act and that the state agency shall require area agencies to provide outreach where there are older Native Americans in any planning and service area, including those living outside of reservations and other Tribal lands.

RESPONSE:

The State of Maryland has no federally recognized Native American tribes. However, according to the 2023 American Community Survey one-year estimates of population 60 and over in Maryland, there are nearly 3,000 older Marylanders that identify as American Indian or Alaska Native. Accordingly, the state will work to identify and engage community leaders that can assist us in effectively reaching native elders to ensure access to all aging programs and benefits provided by the Department. As a starting point, the Department will engage The Maryland Commission on Indian Affairs to request guidance on connecting with local communities. The Commission is part of the Governor's Office of Community Initiatives and assists state, local, and private agencies to provide resources to address the educational, social, and economic needs of Native American Communities in Maryland. The state will also work with specific AAA jurisdictions with Native American population presence, to assure the pursuit to inform and provide access by Native American Marylanders to all aging programs and benefits provided through the AAA. The Area Plans for AAAs will be monitored to reflect this planning. And, finally, the state will seek and follow the guidance of ACL's Regional Administrator for the inclusion of best practices and opportunities to implement new approaches in Maryland.

Activities to Increase Access and Coordination for Native American Older Adults

OAA Section 307(a)(21): The plan shall —

. . .

(B) provide an assurance that the state agency will pursue activities to increase access by older people who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the state agency intends to implement the activities.

45 CFR § 1321.53:

(a) For states where there are Title VI programs, the state agency's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in § 1322.13(a), must explain how the state's aging network, including area agencies and service providers, will coordinate with Title VI programs to ensure compliance with sections 306(a)(11)(B) (42 U.S.C. 3026(a)(11)(B)) and 307(a)(21)(A) (42 U.S.C. 3027(a)(21)(A)) of the Act. state agencies may meet these requirements through a Tribal consultation policy that includes Title VI programs.

(b) The policies and procedures set forth in (a) of this provision must at a minimum address:

(1) How the state's aging network, including area agencies on aging and service providers, will provide outreach to Tribal elders and family caregivers regarding services for which they may be eligible under Title III and/or VII;

(2) The communication opportunities the state agency will make available to Title VI programs, to include Title III and other funding opportunities, technical assistance on how to apply for Title III and other funding opportunities, meetings, email distribution lists, presentations, and public hearings;

(3) The methods for collaboration on and sharing of program information and changes, including coordinating with area agencies and service providers where applicable;

(4) How Title VI programs may refer people who are eligible for Title III and/or VII services;

(5) How services will be provided in a culturally appropriate and trauma-informed manner; and

(6) Opportunities to serve on advisory councils, work groups, and boards, including area agency advisory councils, as set forth in § 1321.63.

RESPONSE:

As identified above, the State of Maryland has no federally recognized Native American tribes and also does not have any Title VI programs. The state provides assurance that the state agency will pursue activities to increase access by older people who are Native Americans to all aging programs and benefits provided by the Department. This includes programs and benefits provided under this title through engagement of Native American Tribes on the state and local level for planning, outreach, and technical assistance in collaboration with Native American leaders, and by monitoring AAAs for such engagement and service provision.

Low Income Minority Older Adults

OAA Section 307(a)(14):

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older people in the state, including the number of low income minority older people with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older people described in subparagraph (A), including the plan to meet the needs of low- income minority older people with limited English proficiency.

RESPONSE:

Based on the US Census Bureau, American Community Survey, 2022 Maryland has 57,635 minority older adults in poverty (5.71% of Maryland's total older adult population) and 38,308 older adults with limited

English proficiency (3.67% of Maryland's total older adult population). Of the 38,308 older adults with limited English proficiency, 5,470 are low income, minority older adults. Low income is defined as at or below the Federal Poverty Level.

As identified in the response related to greatest social and economic populations, MDOA utilizes data capture tools and policies to support and monitor local programmatic reach. MDOA recognizes that each AAA has a unique landscape of minority, low income minority, and populations with different language requirements and develops strategies to target and serve minority populations based on community makeup and needs. Some examples of targeted activities by AAAs include contracting for culturally appropriate congregate and home-delivered meals, dedicated senior center activities that celebrate culturally focused traditions, partnerships with trusted faith based and multicultural organizations to deliver health promotion programming, including evidence-based health promotion workshops in Spanish, Korean, and Chinese, and conducting enrollment seminars for Medicare savings

programs and state programs in affordable housing buildings with high numbers of low Income minority older residents; and utilizing bilingual staff and language lines to deliver Maryland Access Point information, referral, and assistance.

Rural Areas – Hold Harmless

OAA Section 307(a)(3):

The plan shall—

(B) with respect to services for older people residing in rural areas—

(i) provide assurances the state agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:

The MDOA will spend in each fiscal year between FY 2026-2030 at least the amount expended for services for older people in rural areas for fiscal year 2000. Maryland's Older Americans Act IFF now includes a rural factor and other non-Older Americans Act grants include such a factor to better ensure sufficient resources are available to meet the needs of older adults residing in rural areas.

The Department projects costs of providing such services:

Service	2026-2030 Projected Title III Costs per Year	Service	2026-2030 Projected Title III Costs per Year
Personal Care	$15,220	Nutrition Education & Counseling	$7,033
Homemaker	$37,930	Information and Assistance	$324,433
Chore	$10,089	Health Promotion: Evidence & Non-Evidence Based	$121,882
Home-Delivered Nutrition	$671,122	Caregiver Counseling/Support Groups/Training	$38,965
Adult Day Care/Health	$6,709	Caregiver Respite Care	$146,615
Case Management	$85,550	Caregiver Supplemental Services	$62,734
Assisted Transportation	$12,219	Caregiver Information & Assistance	$62,077
Congregate Nutrition	$1,041,745	Caregiver Information Services	$47,411
Transportation	$65,853	Caregiver Case Management	$51,186
Legal Assistance	$66,255	Other Services	$219,782
Grand Total Each Year $3,094,811			
MDOA projects costs for services to rural customers will remain static over the four years of this plan.			

As part of the preparation for developing a strategic Area Plan, each AAA conducts public hearings and a needs assessment to determine where gaps exist in the planning and service area. The information and interventions are included in their Area Plans, which are reviewed by the Department.

Rural Areas – Needs and Fund Allocations

OAA Section 307(a)(10):

The plan shall provide assurance that the special needs of older people residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

RESPONSE:

Maryland's geographically diverse AAA Network serves multiple populations including older adults and caregivers residing in rural areas. To ensure lesser populated jurisdictions can serve their older residents, the Department's Older Americans Act IFF includes a base allocation. The Department will be working with AAAs during the OAA State Plan term to determine whether and how to best update the IFF, which includes consideration of a rural factor. Certain non-Older Americans Act programs include a rural factor in their formulas in recognition of the additional costs local agencies may incur to effectively reach and serve Marylanders in rural communities.

Assistive Technology

OAA Section 306(a)(6)(I):

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the area agency will, to the extent feasible, coordinate with the state agency to disseminate information about the state assistive technology entity and access to assistive technology options for serving older people;

RESPONSE:

In 2024, Maryland launched the "Maryland Equips" partnership between the MDOA, the Maryland Department of Disabilities and the Maryland Department Health, providing free durable medical equipment and assistive technology to Marylanders with any disability, illness, or injury who need support to remain comfortable and connected. This initiative recognizes the important role of assistive technology in keeping Marylanders safe and independent and improves access to resources through a single source of information on our website, as well as by consolidating and standardizing the outreach and referral processes for these programs. Maryland's AAAs work in collaboration with state agencies and Centers for Independent Living to improve access to equipment and resources provided by the Maryland Assistive Technology Program, partnerships established over a decade ago with support from the Administration for Community Living.

MDOA conducts a review of all Area Plans annually. The full narrative, completed every four years, includes requirements to outline how the AAA provides information about assistive technology options through the Maryland Access Point aging and disability resource center. On an annual basis, AAAs update their Area Plan to represent any changes and to provide programmatic data, which includes data on the number of Maryland Access Point contacts associated with assistive technology. AAAs must address this information before the plan is approved by the state. Moving forward AAAs will be asked to utilize the Maryland Equips initiative to streamline access to information about assistive technology options for older adults.

Minimum Proportion of Funds

OAA Section 307(a)(2):

The plan shall provide that the state agency will —...

(C) specify a minimum proportion of the funds received by each area agency on aging in the state to carry out part B that will be expended (in the absence of a waiver under sections 306 or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). (Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)

RESPONSE:

- Access Services: 15% of the initial Title III-B allocation
- In-home Services: 10% of the initial Title III-B allocation
- Legal Assistance: 5% of the initial Title III-B allocation

Assessment of Statewide Service Delivery Model

OAA Section 307(a)(27):

(A) The plan shall include, at the election of the state, an assessment of how prepared the state is, under the state's statewide service delivery model, for any anticipated change in the number of older people during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older people in the state;

(ii) an analysis of how such change may affect such people, including people with low incomes, people with greatest economic need, minority older people, older people residing in rural areas, and older people with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the state can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older people in the state; and

(iv) an analysis of how the change in the number of people age 85 and older in the state is expected to affect the need for supportive services

RESPONSE:

Through the Longevity Ready Maryland initiative the state is committed to planning ahead to understand the potential impact, leverage the opportunities, and address the challenges of demographic change. An analysis of the projected population growth of the older population, impact on Maryland communities, and the challenges and opportunities can be found in the plan's Where Maryland Stands: Opportunities and Challenges section.

There is significant opportunity to improve the programs, policies, and services within the state to greater prepare Maryland communities for an aging society and meet the needs of the growing older adult population. This plan established a myriad of strategies that will guide multisector collaboration that leverages and builds upon the existing aging services network services and programming that supports healthy aging across the lifespan through a variety of sectors, including health, transportation, labor, and human services. By using these strategies to break down the silos that traditionally limit our ability to efficiently collect data, allocate resources, outreach to communities, and ensure access to the supports necessary for healthy long lives, Maryland can improve the reach and efficacy of services that support residents to age in community settings, even as the population grows.

Many AAAs are already guiding the process of shared decision making and resource allocation through extensive cross-sector collaboration at the local level. For example, the plan includes a strategy to advance partnership through local adoption of the Age Friendly Communities model, based on the success of existing collaborations in Baltimore, Calvert, Carroll, Howard, and Montgomery County, all of which are led by the AAA in the jurisdiction. In Montgomery, Prince George's, and more recently Baltimore County, the Village neighbor-to-neighbor model is creating communities more prepared to support their neighbors to age in place. The Longevity Ready Maryland initiative provides a vehicle to learn from these communities and provide guidance that effectively promotes the adoption of such collaborative partnership and community-driven change to enhance aging infrastructure and programming throughout the state.

While our traditional funding resources are not anticipated to grow, Maryland is working to ensure that the distribution of resources better meets community need. Acknowledging the importance of stewardship and oversight of resources, MDOA has been working to develop policies and procedures that assess whether and how Older Americans Act resources are utilized to the best and highest use to meet the needs of local communities. This includes adjustments to the IFF, the establishment of clear policy directives, and modification to the monitoring procedure to better review and address missing data or lack of reach among populations with the greatest social and economic need. Such efforts, in combination with a greater focus on cross-sector collaboration and data-driven decision making with the help of the LRM Data Dashboard, will better prepare Maryland to understand needs and adjust our planning and implementation of policy and programming accordingly.

Shelf Stable, Pick-Up, Carry-Out, Drive-Through, or Similar Meals Using Title III Congregate Nutrition (C-1) Service Funding (Optional, only for states that elect to pursue this activity)

45 CFR § 1321.87(a)(1)(ii):

Title III C-1 funds may be used for shelf-stable, pick-up, carry-out, drive-through, or similar meals, subject to certain terms and conditions:

(A) Such meals must not exceed 25 percent of the funds expended by the state agency under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(B) Such meals must not exceed 25 percent of the funds expended by any area agency on aging under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(iii) Such meals are to be provided to complement the congregate meal program:

(A) During disaster or emergency situations affecting the provision of nutrition services;

(B) To older people who have an occasional need for such meal; and/or

(C) To older people who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need; and

45 CFR § 1321.27 (j):

If the state agency allows for Title III, part C-1 funds to be used as set forth in §1321.87(a)(1)(i), the state agency must include the following:

(1) Evidence, using participation projections based on existing data, that provision of such meals will enhance and not diminish the congregate meals program, and a commitment to monitor the impact on congregate meals program participation;

(2) Description of how provision of such meals will be targeted to reach those populations identified as in greatest economic need and greatest social need;

(3) Description of the eligibility criteria for service provision;

(4) Evidence of consultation with area agencies on aging, nutrition and other direct services providers, other stakeholders, and the general public regarding the provision of such meals; and

(5) Description of how provision of such meals will be coordinated with area agencies on aging, nutrition and other direct services providers, and other stakeholders.

RESPONSE:

MDOA will permit Title III C-1 funds to be used for Grab-and-Go meals as outlined in 45 CFR 1321.87(a)(2) within the State Plan on Aging. A Grab-and-Go meal is a meal a non-homebound participant picks up at a congregate location but eats elsewhere. These meals can be provided during disasters or emergencies, for people with occasional needs, or for those with regular needs based on an individualized assessment. Options for receiving these meals include pick-up, carry-out, or drive-through. This allowance was determined through consultation with AAAs and other state and national partners and is communicated through policy issuance to AAAs.

Grab-and-Go meals must meet dietary guidelines for Americans and dietary reference Intakes as set forth in section 339 of the Older American Act (42 U.S.C. 3030g-21) provided under Title III, part C-1 by a qualified nutrition service provider. AAAs must indicate whether they plan to utilize Grab-and-Go meals in the Area Plan, starting with the FY 2027 annual update. If the agency chooses to offer Grab-and-Go meals, up to 25 percent of Title III C-1 funds may be allocated for the service.

AAAs that choose to provide Grab-and-Go meals must detail in the Area Plan how the grab-and-go meal options will enhance their existing Congregate Nutrition Program. The AAA shall provide a written justification to include:

- Evidence, using participation projections based on existing data, that provision of such meals will enhance and not diminish the congregate meals program, and a commitment to monitor the impact on congregate meals program participation.
- Description of how the provision of such meals will be targeted to reach those populations identified as in greatest social and greatest economic need, in alignment with state and local policy.
- Description of the eligibility criteria and prioritization for service provision.
- Evidence of consultation with internal nutrition expertise and contractual providers the public, and other interested parties, as applicable, regarding the need for and provision of such meals.
- Description of how the provision of such meals will be coordinated with nutrition and other direct service program providers, as well as other stakeholders.
- Situations in which the Grab-and-Go meals will be offered.

- Description of the system for tracking funding to ensure that no more than 25% of Title III C-1 funds are allocated to Grab-and-Go meals.

To ensure the program's effectiveness, MDOA will:

- Utilize the provided justification and available demographic and service data to assess the impact on congregate nutrition program participation to understand any shifts or effects.
- Ensure that the eligibility criteria provided in the Area Plan effectively support the congregate program as part of the review process.
- Review the Grab-and-Go meal provision through AAA program monitoring to ensure compliance and work with the AAA to create and implement a corrective action plan to come into compliance, when necessary.

Funding Allocation – Ombudsman Program

45 CFR Part 1324, Subpart A:

How the state agency will coordinate with the State Long-Term Care Ombudsman and allocate and use funds for the Ombudsman program under Title III and VII, as set forth in 45 CFR part 1324, subpart A.

RESPONSE:

The Maryland Long Term Care Ombudsman is embedded in the MDOA and receives an allocation at the state and local level, as identified in the Intrastate Funding Formula (Attachment C). Funds are used to support two state level positions and staffing across the 19 Area Agencies on Aging, as well as outreach, education, and material costs. The Ombudsman Program IFF was revised in Federal Fiscal Year 2024 to utilize the FFY19 base year spending per the Administration on Community Living requirements. To meet or exceed the minimum spending requirements of 2019, MDOA changed the allocation formula for Title VII Ombudsman, Title VII Elder Abuse, and the Title IIIB Ombudsman grants to include a base level of funding to match FFY2019 for each planning service area. Once the 2019 base level is allocated, the remaining funds are allocated based on the IFF.

Funding Allocation – Elder Abuse, Neglect, and Exploitation45 CFR § 1321.27 (k):

How the state agency will allocate and use funds for prevention of elder abuse, neglect, and exploitation as set forth in 45 CFR part 1324, subpart B.

RESPONSE:

The MDOA allocates and uses Title IIIB Ombudsman and Title VII funding for the prevention of elder abuse, neglect, and exploitation. The State Long Term Care Ombudsman, local representatives, volunteers, and other AAA staff, utilize a person-centered approach to conduct outreach and education across all twenty-four planning service areas. Ombudsmen empower residents of assisted living and nursing homes by providing education on resident rights, through individual advocacy, by attending resident and family council meetings and by providing information and assistance. Ombudsmen also provide training to long-term care staff on resident rights and person-centered approaches. The ombudsman program works closely with providers to advocate with and on the behalf of residents. Additionally, the ombudsman program works closely with the Maryland Access Point, receiving referrals, providing information and assistance, and linking Marylanders to vital services and resources. Ombudsmen participate in statewide taskforces, work groups, and commissions to increase awareness of elder justice issues. Lastly, the ombudsman program works across sectors and establishes strategic partnerships and collaboration to plan and execute statewide abuse, neglect, and exploitation events such as World Elder Abuse Awareness Day (WEAAD) on an annual basis, Health Care Decisions Day, and Older Americans Month celebrations.

Monitoring of Assurances

45 CFR § 1321.27 (m):

Describe how the state agency will conduct monitoring that the assurances (submitted as Attachment A of the State Plan) to which they attest are being met.

RESPONSE:

MDOA's annual compliance monitoring tool incorporates the assurances. AAAs complete the pre-monitoring tool and meet with MDOA program managers and program monitor during a single day to review the monitoring

tool and provide additional context and information. The pre-monitoring tool reviews multiple aspects of the required assurances, including but not limited to: specific resources being provided, outreach efforts, services provided to populations specified within the requirements of the assurances, allocations for legal assistance, efforts for community-wide collaborative services, provision of an advisory council, services for caregivers, preventing duplication of benefits and much more. The state program monitor collects and verifies programmatic and contract documentation. Monitoring is completed with all aspects of the programmatic areas. During the monitoring session, MDOA staff, including Program Managers and monitoring staff, will meet with various representatives of the AAA staff, including appropriate front-line services staff and supervisory staff. Corrective action plans are implemented when assurances are not met or insufficient documentation is available. Corrective Action plan follow-up will be provided at appropriate intervals throughout the year. Technical assistance related to the OAA Assurances is also available year-round from the State Program Monitor.

State Plans Informed By and Based on Area Plans

45 CFR § 1321.27 (c):

Evidence that the State Plan is informed by and based on Area Plans, except for single planning and service area states.

RESPONSE:

The MDOA conducted a detailed analysis of the AAA four-year Area Plans to guide the development of the statewide plan. The analysis can be found in Appendix D. As outlined in the analysis, the overarching themes identified within the AAA Area Plans included:

1. Enhanced Service Delivery and Accessibility: Ensure that services are widely accessible, affordable, and comprehensive, addressing both immediate needs and long-term wellness.
2. Community-Based Care and Independence: Provide care and services within communities to minimize the need for institutionalization and support aging in place.
3. Equity and Inclusive Aging: Ensuring that all older adults, regardless of race, income, or geographic location, have access to necessary services.
4. Caregiver Support and Wellbeing: Recognizing the crucial role of family caregivers in helping older adults age in place, ensure the provision of necessary supports and resources to manage the challenges of caregiving.
5. Strategic Partnerships and Collaboration: Foster strong, multi-sector partnerships between various stakeholders to enhance service coordination, improve efficiency, and avoid gaps in care.

The analysis was used in reviewing and modifying the recommended goals, objectives, and strategies to develop the final version included in the plan.

Public Input and Review

45 CFR § 1321.29:

Describe how the state agency considered the views of older people, family caregivers, service providers and the public in developing the State Plan, and how the state agency considers such views in administering the State Plan. Describe how the public review and comment period was conducted and how the state agency responded to public input and comments in the development of the State Plan.

RESPONSE:

As identified in the plan and included in Appendix D, MDOA conducted extensive community engagement through attendance at community events, meetings and conferences; targeted discussions with specific population groups; and the formal convening of stakeholder work groups to guide the development of the plan. Engagement included extensive involvement of older people, family caregivers, service providers, and the public.

The plan was made available for public comment in March 2025 and comments were submitted through an online portal in writing, by uploading a communication, leaving a voicemail, or attending a virtual or in-person town hall. A toolkit was developed to facilitate public comment from community groups and organizations. Feedback was reviewed for consideration on a rolling basis and an analysis of all submitted comments was completed upon the

closure of the public comment period. The feedback received informed several updates to the plan to address errors, challenges, and opportunities identified by members of the public.

Program Development and Coordination Activities (Optional, only for states that elect to pursue this activity)

45 CFR § 1321.27 (h):

Certification that any program development and coordination activities shall meet the following requirements:

(1) The state agency shall not fund program development and coordination activities as a cost of supportive services under Area Plans until it has first spent 10 percent of the total of its combined allotments under Title III on the administration of Area Plans;

(2) Program development and coordination activities must only be expended as a cost of State Plan administration, Area Plan administration, and/or Title III, part B supportive services;

(3) State agencies and area agencies on aging shall, consistent with the Area Plan and budgeting cycles, submit the details of proposals to pay for program development and coordination as a cost of Title III, part B supportive services to the general public for review and comment; and

(4) Expenditure by the state agency and area agency on program development and coordination activities are intended to have a direct and positive impact on the enhancement of services for older people and family caregivers in the planning and service area.

RESPONSE:

MDOA certifies the requirements listed above for all program development and coordination of activities. These requirements are incorporated into the Area Plan and monitoring processes.

Legal Assistance Developer

45 CFR § 1321.27 (l):

How the state agency will meet responsibilities for the Legal Assistance Developer, as set forth in part 1324, subpart C.

RESPONSE:

MDOA is still developing its plan to comply with the Legal Assistance Developer (LAD) responsibilities, but intends to enter into a contract with a legal assistance organization or person with sufficient knowledge and expertise to meet the requirements of this role. This person will be responsible for ensuring that legal services providers and other support services are responsible in securing and maintaining the legal rights of older adults including that of guardianship avoidance. Through the state's capacity the LAD will provide training, technical assistance and supportive functions to our AAAs, Long Term Care Ombudsman Program, legal services providers and other programs, services and providers under the OAA with a focus on elder rights. The LAD will help to ensure Guardianship avoidance is part of the AAA process to provide services in the community, prioritizing those with greatest economic and greatest social need and protect against conflicts of interest.

Emergency Preparedness Plans – Coordination and Development

OAA Section 307(a)(28):

The plan shall include information detailing how the state will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, state agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

The Maryland Department of Emergency Management (MDEM) is the lead agency for emergency preparedness and response for the State of Maryland. Each state agency's role in emergency management is identified by the MDEM and agencies participate in coordinated planning and response activities as assigned by MDEM depending on the emergency situation. All state agencies are responsible for developing and maintaining a Continuity of

Operations plan to ensure the continued performance of critical business and government functions during a wide range of potential emergencies. Local counties have a similar structure, working through the county-identified lead emergency management agency. Each county's identified representative participates in state emergency management calls and operations, led by MDEM. MDOA works with state and local partners to identify and share information relevant to emergency management and response proactively to ensure that the needs of older Marylanders are considered and addressed through the state's coordinated action.

As part of the annual monitoring process, the Secretary of Aging's designee ensures each AAA has active and coordinated emergency preparedness and response plans that align with state and local guidance. The Secretary of Aging, through a designated team member at MDOA, proactively ensures AAAs are interacting with their local emergency operations leads as well as with the MDOA and state agencies before, during, and after an emergency. AAAs are routinely informed of national and state training opportunities.

Emergency Preparedness Plans – Involvement of the head of the state agency

OAA Section 307(a)(29):

The plan shall include information describing the involvement of the head of the state agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE:

The Maryland Department of Emergency Management (MDEM) is the lead agency for emergency preparedness and response for the State of Maryland. MDEM collaborates with all state agencies to ensure appropriate planning and response to a range of emergency situations, including the Maryland Department of Health's Office of Preparedness and Response for health-related emergency planning. The Secretary of Aging leads MDOA's collaboration with MDEM through two departmental designees in the form of an Emergency Coordinator and State Emergency Operations Center representative. MDOA follows the guidance of its state agency lead and partners and is called upon to provide guidance on emergency preparedness and response specific to older adults and the aging services network. For example, MDOA was a key collaborator on emergency food response efforts led by the Maryland Department of Human Services during the start of the COVID-19 pandemic.

Attachment C: Intrastate Funding Formula

Requirements Applicable to IFF Revisions:

Definition: Jurisdiction: There are 24 jurisdictions in the State of Maryland, including 23 counties and Baltimore City.

FUNDING FORMULA - TITLES IIIB, IIIC1, IIIC2, AND IIIE

In allocating the Older Americans Act Title IIIB, IIIC1, IIIC2, and IIIE funds to the state's 19 AAAs, the MDOA utilizes American Community Survey (ACS) Special Tabulations charts, which are updated yearly and located at: https://www.census.gov/programs-surveys/acs/data.html. The Department uses the factors and the assigned weights as follows:

Factors	Weight
ACS Population 60+	45%
ACS Population 60+ and Below Poverty Line	45%
ACS Population 60+ Below Poverty and Minority	10%

The methodology for allocating the funding to the AAAs is based on establishing a final funding ratio for each AAA. The mathematical formula ensures that AAAs with jurisdictions that have the greatest economic and social need receive adequate funding. For AAAs with jurisdictions that fall below the established minimum funding ratio, those ratios are increased to the minimum ratio. If the ratio is above the minimum ratio, a formula is used to reduce the rate to keep the overall funding level at 100%. No AAA receives funding less than the minimum funding ratio for each of its jurisdiction(s). AAAs serving multiple jurisdictions determine how to allocate the funding awarded to it through the IFF among the various jurisdictions in its service area.

The state receives its allocation for each grant through Notices of Award from ACL. The state retains a percentage of the total allocations for Title IIIB, IIIC1, IIIC2, IIID, and IIIE for state plan administration. Additionally, funding is reduced from Title IIIB to be allocated as Title IIIB Ombudsman funding to support the Long-Term Care Ombudsman Program. The amount for each grant after those reductions is allocated to the AAAs.

The following formula is used to determine the minimum funding ratio:

- The amount of $125,000 is divided by the total of the AAA allocations for Title IIIB, IIIC1, IIIC2, and IIIE. This calculation becomes the minimum funding ratio (M).

  $$M = \frac{\$125{,}000}{(N + O + P + Q)}$$

  M = Minimum funding ratio
  N = Title IIIB AAAs allocation
  O = Title IIIC1 AAAs allocation
  P = Title IIIC2 AAAs allocation
  Q = Title IIIE AAA allocation

The following steps are used to calculate each AAA's final funding ratio:

1) a. For each factor, the jurisdiction's percentage of that factor is calculated as follows:
   - Each jurisdiction's ACS Population 60+ (A) is divided by the state's total 60+ population (A1), then multiplied by the respective weight of 45%
   - Each jurisdiction's ACS Population 60+ and Below Poverty Line (B) is divided by the state's total low-income elderly population (B1), then multiplied by the respective weight of 45%
   - Each jurisdiction's ACS Population 60+, Below Poverty and Minority (C) is divided by the state's total low-income, minority population (C1), then multiplied by the respective weight of 10%

   b. The jurisdiction's percentage for the three factors are combined to establish the jurisdiction's initial funding ratio (D) before determining any ratio adjustments.

   $((A/A1) * 45\%) + ((B/B1) * 45\%) + ((C/C1) * 10\%) = D$

A = jurisdiction's ACS Population 60+
A1 = state's ACS Population 60+
B = jurisdiction's ACS Population 60+ and Below Poverty Line
B1 = state's ACS Population 60+ and Below Poverty Line
C = jurisdiction's ACS Population 60+, Below Poverty and Minority
C1 = state's ACS Population 60+, Below Poverty and Minority
D = jurisdiction's initial funding ratio

2) For any jurisdiction whose initial funding ratio is below the calculated minimum funding ratio, that jurisdiction's funding ratio is increased to the minimum funding ratio and becomes that jurisdiction's final funding ratio. The total of all jurisdictions initial funding ratios will then be above 100% and must be reduced.

3) For any jurisdiction whose initial funding ratio is above the calculated minimum funding ratio, that jurisdiction's initial funding ratio is decreased to ensure overall funding does not exceed 100% as follows:

a. Subtract from each jurisdiction's initial funding ratio (D) the calculated minimum funding ratio (M).

b. That difference is then divided by the aggregate of the differences for all jurisdictions (E) and multiplied by the percentage over 100% (F) to determine the amount to reduce from each jurisdiction's initial funding ratio (G)

$$\frac{(D - M)}{E} * F = G$$

D = jurisdiction's initial funding ratio
E = aggregate of the differences for all jurisdictions
F = percent of combined initial funding ratios over 100%
G = Amount to reduce from the initial funding ratio

c. Subtract from each jurisdiction's initial funding ratio (D) the amount calculated in step b (G) to determine the final funding ratio for each jurisdiction (H).

D - G = H
D = jurisdiction's initial funding ratio
G = Amount to reduce from the initial funding ratio
H = jurisdiction's final funding ratio

4) The final funding ratio for each AAA is that of the jurisdiction(s) it represents. For AAAs that represent multiple jurisdictions, the final funding ratio of those jurisdictions are totaled and become the final funding ratio for that AAA (I).

I = the sum total of the final funding ratios for the jurisdictions the AAA represents

To calculate each AAA's grant allotment, the AAA's final funding ratio (I) is multiplied by the total AAA allocation for each grant. This is done separately for Title IIIB, Title IIIC1, Title IIIC2, and Title IIIE.

I * N = Title IIIB allocation for each AAA
I * O = Title IIIC1 allocation for each AAA
I * P = Title IIIC2 allocation for each AAA
I * Q = Title IIIE allocation for each AAA

FUNDING FORMULA - TITLE IIID

In allocating the Older Americans Act Title IIID funds to the state's 19 AAAs, the MDOA utilizes American Community Survey (ACS) Special Tabulations charts, which are updated yearly and located at: https://www.census.gov/programs-surveys/acs/data.html. The Department uses the factors and the assigned weights as follows:

Factors	Weight
ACS Population 60+	45%
ACS Population 60+ and Below Poverty Line	45%
ACS Population 60+ Below Poverty and Minority	10%

The methodology for allocating the funding to the AAAs is based on establishing a final funding ratio for each AAA.

The mathematical formula ensures that AAAs with jurisdictions that have the greatest economic and social need receive adequate funding. For AAAs with jurisdictions that fall below the established minimum funding ratio, those ratios are increased to the minimum ratio. If the ratio is above the minimum ratio, a formula is used to reduce the rate to keep the overall funding level at 100%. No AAA receives funding less than the minimum funding ratio for each of its jurisdiction(s). AAAs serving multiple jurisdictions determine how to allocate the funding awarded to it through the IFF among the various jurisdictions in its service area. MDOA has determined that this formula gives priority to areas of the state that are medically underserved and in which there are large numbers of people who have the greatest need for such services.

The state receives its allocation for Title IIID through Notices of Award from ACL. The state retains a percentage of the total allocations for Title IIIB, IIIC1, IIIC2, IIID, and IIIE for State Plan administration. The amount for each grant after those reductions is allocated to the AAAs.

The following formula is used to determine the minimum funding ratio:

- The amount of $9,000 is divided by the aggregate Title IIID to be allocated to the AAAs (U). This calculation becomes the minimum funding ratio (M).

$$M = \frac{\$9{,}000}{U}$$

M = Minimum funding ratio U = Title IIID AAAs allocation

The following steps are used to calculate each AAA's final funding ratio:

1) a. For each factor, the jurisdiction's percentage of that factor is calculated as follows:
   - Each jurisdiction's ACS Population 60+ (A) is divided by the state's total 60+ population (A1), then multiplied by the respective weight of 45%
   - Each jurisdiction's ACS Population 60+ and Below Poverty Line (B) is divided by the state's total low-income elderly population (B1), then multiplied by the respective weight of 45%
   - Each jurisdiction's ACS Population 60+, Below Poverty and Minority (C) is divided by the state's total low-income, minority population (C1), then multiplied by the respective weight of 10%

   b. The jurisdiction's percentage for the three factors are combined to establish the jurisdiction's initial funding ratio (D) before determining any ratio adjustments.

   ((A/A1) * 45%) + ((B/B1) * 45%) + ((C/C1) * 10%) = D

   A = jurisdiction's ACS Population 60+
   A1 = state's ACS Population 60+
   B = jurisdiction's ACS Population 60+ and Below Poverty Line
   B1 = state's ACS Population 60+ and Below Poverty Line
   C = jurisdiction's ACS Population 60+, Below Poverty and Minority
   C1 = state's ACS Population 60+, Below Poverty and Minority
   D = jurisdiction's initial funding ratio

2) For any jurisdiction whose initial funding ratio is below the calculated minimum funding ratio, that jurisdiction's funding ratio is increased to the minimum funding ratio and becomes the jurisdiction's final funding ratio. The total of all jurisdictions initial funding ratios will then be above 100% and must be reduced.

3) For any jurisdiction whose initial funding ratio is above the calculated minimum funding ratio, that jurisdiction's initial funding ratio is decreased to ensure overall funding does not exceed 100% as follows:

   a. Subtract from each jurisdiction's initial funding ratio (D) the calculated minimum funding ratio (M).

   b. That difference is then divided by the aggregate of the differences for all jurisdictions (E) and multiplied by the percentage over 100% (F) to determine the amount to reduce from each jurisdiction's initial funding ratio (G).

$$\frac{(D - M)}{E} * F = G$$

D = jurisdiction's initial funding ratio
E = aggregate of the differences for all jurisdictions
F = percent of combined initial funding ratios over 100%
G = Amount to reduce from the initial funding ratio

c. Subtract from each jurisdiction's initial funding ratio (D) the amount calculated in step b (G) to determine the final funding ratio for each jurisdiction (H).

D - G = H

D = jurisdiction's initial funding ratio
G = Amount to reduce from the initial funding ratio
H = jurisdiction's final funding ratio

4) The final funding ratio for each AAA is that of the jurisdiction(s) it represents. For AAAs that represent multiple jurisdictions, the final funding ratio of those jurisdictions are totaled and become the final funding ratio for that AAA (I).

I = the sum total of the final funding ratios for the jurisdictions the AAA represents

To calculate each jurisdiction's AAA's grant allotment for Title IIID, the AAA's final funding ratio (I) is multiplied by the AAA allocation for Title IIID (U).

I * U = Title IIID allocation for each AAA

FUNDING FORMULA - TITLE VII AND TITLE IIIB OMBUDSMAN

The Department utilizes the following formula to calculate the Older Americans Act Title VII grants and the Title IIIB Ombudsman grant. The formula is the ratio of the AAA's sum relative to the state's sum of the following factors:

- 1 point for the AAA's square miles of the planning and service area (A)
- 2 points for each of the AAA's number of skilled nursing facilities (B)
- 2 points for each of the AAA's number of assisted living facilities (C)
- 7 points for the long term care beds (the total license capacity of the skilled nursing facilities and assisted living facilities) (D)

The following steps are followed to calculate each AAA's allocation:

1) The prior year's reported count of skilled nursing facilities, assisted living facilities, and the license capacity for each is utilized to calculate the formula.

2) This formula is used to calculate each AAA's total points:

(A*1) + (B*2) + (C*2) + (D*7) = a AAA's total points (E)

A = square miles
B = skilled nursing facilities
C = assisted living facilities
D = long term care beds

3) The AAAs' total points (E) are added together to calculate the total points for the state (F).

4) Each AAA's total points is divided by the total points for the state to establish each AAA's funding ratio (G).

E / F = G

5) For the Title VII Ombudsman grant, the state retains a portion of funding at the state level for direct program costs. That amount is deducted from the state allocation to determine the amount to be allocated to the AAAs. No deductions are taken from Title VII Elder Abuse Prevention or Title IIIB Ombudsman.

6) Each AAA's funding ratio (G) is multiplied by the AAA allocation to determine each AAA's allocation of funds. This calculation is done separately for Title VII Ombudsman, Title VII Elder Abuse Prevention, and Title IIIB Ombudsman.

7) Title VII Ombudsman: Each AAA receives a base allocation of $291,377, determined by actual spending in FY19. The remaining funds are distributed according to a funding formula that assigns points to AAAs based on the following criteria:

- Square miles covered – 1 point
- Total skilled nursing facilities – 2 points
- Total assisted living facilities – 2 points
- Total available beds – 7 points

The total points are aggregated, and the remaining funds (beyond the base allocation) are distributed proportionally based on each AAA's percentage share of the total points.

8) Title IIIB Ombudsman: The Title IIIB Ombudsman funding follows the same points-based formula used for Title VII Ombudsman. A total of $125,000 in Title IIIB funds is allocated based on this formula.

However, no Area Agency on Aging (AAA) may receive less than their FY19 expenditure level. If an AAA's formula-based allocation results in funding below their FY19 expenditure amount, they will receive a supplemental award to meet that level. This supplemental funding is derived from their IIIB allocation.

FUNDING FORMULA - NSIP

The Department utilizes a formula for NSIP which is based on the ratio of each AAA's prior year's reported meal counts relative to the total meals served throughout the state.

The following steps are used to calculate each AAA's NSIP allocation:

1) Each AAA's prior year's home-delivered meals and congregate meals served are totaled.

2) All AAAs' meal counts are added to total the number of meals served in the state.

3) The total meal count for each AAA is divided by the total meal count for the state to establish each AAA's funding ratio.

4) Each AAA's funding ratio is multiplied by the state's NSIP allocation to determine each AAA's NSIP allocation.

FY 2026 OLDER AMERICANS ACT FUNDING RATIO: TITLES IIIB, IIIC AND IIIE

AAA	2022 ACS Population 60+ (AGID MDs21003)	2022 ACS Population 60+ and Below Poverty Line (MDs21055)	2017-2021 ACS Population 60+, Below Poverty and Minority (MDs21040)
Allegany	18,778	1,704	64
Anne Arundel	134,034	5,795	1,840
Baltimore City	125,258	23,310	18,530
Baltimore County	213,020	16,125	5,930
Calvert	22,320	885	375
Carroll	44,310	1,814	74
Cecil	25,900	1,814	249
Charles	34,487	2,385	1,470
Frederick	62,607	2,900	490
Garrett	9,380	618	8
Harford	64,875	3,740	800
Howard	72,163	3,325	1,710
MAC	60,436	4,260	1,627
Montgomery	247,829	15,315	9,375
Prince George's	206,095	14,305	12,170
Queen Anne's	14,866	895	260
St. Mary's	23,591	1,550	262
Upper Shore	30,039	2,047	702
Washington	38,674	3,085	475
Total	**1,448,912**	**105,872**	**56,582**

Source: 2022 American Community Survey, Special Tabulation on Aging – Population Characteristics prepared by the U.S. Census Bureau

FY 2026 FEDERAL OLDER AMERICANS ACT AWARD ALLOCATIONS

Estimated* as of April 8, 2025

AAA	IIIB (6501)	IIIC1 (6502)	IIIC2 (6503)	IIID (6506)	IIIE (6520)	IIIB Ombs. (6521)	VII Ombs. (6507)	VII Elder Abuse (6509)	NSIP (6505)**
Allegany	$84,411	$120,893	$82,445	$9,000	$42,013	$2,684	$8,464	$1,671	$49,683
Anne Arundel	$444,865	$637,137	$434,503	$27,520	$221,419	$9,864	$28,461	$6,029	$59,453
Baltimore City	$1,092,630	$1,564,868	$1,067,180	$65,076	$543,827	$14,978	$48,735	$10,223	$317,184
Baltimore County	$929,111	$1,330,676	$907,470	$55,595	$462,440	$53,487	$66,783	$12,882	$103,678
Calvert	$72,691	$104,108	$70,997	$9,000	$36,180	$15,474	$3,476	$658	$19,375
Carroll	$138,264	$198,022	$135,043	$9,743	$68,817	$48,782	$13,587	$2,586	$26,693
Cecil	$103,651	$148,450	$101,237	$9,000	$51,590	$1,582	$5,162	$974	$18,639
Charles	$150,061	$214,918	$146,566	$10,427	$74,689	$2,830	$7,748	$1,787	$26,394
Frederick	$208,878	$299,155	$204,012	$13,837	$103,963	$4,885	$14,626	$3,150	$55,132
Garrett	$35,557	$50,925	$34,729	$9,000	$17,697	$1,079	$3,435	$656	$26,976
Harford	$239,741	$343,358	$234,157	$15,627	$119,325	$4,001	$11,742	$2,423	$29,989
Howard	$253,231	$362,678	$247,332	$16,409	$126,039	$5,644	$16,997	$3,563	$37,945
MAC	$259,002	$370,943	$252,969	$36,000	$128,911	$5,211	$16,519	$3,254	$73,473
Montgomery	$1,015,230	$1,454,015	$991,583	$60,588	$505,303	$57,333	$64,360	$13,573	$220,669
Prince George's	$936,418	$1,341,141	$914,607	$56,019	$466,076	$49,139	$41,127	$8,446	$143,419
Queen Anne's	$56,846	$81,415	$55,522	$9,000	$28,294	$592	$1,806	$391	$9,250
St. Mary's	$92,028	$131,802	$89,884	$9,000	$45,804	$2,028	$6,305	$1,254	$37,935
Upper Shore	$123,364	$176,682	$120,490	$27,000	$61,401	$2,637	$9,117	$1,819	$40,923
Washington	$166,171	$237,990	$162,300	$11,361	$82,707	$4,401	$13,344	$2,746	$23,389
Total	**$6,402,149**	**$9,169,175**	**$6,253,027**	**$459,203**	**$3,186,494**	**$286,631**	**$381,794**	**$78,087**	**$1,320,198**

** FY26 estimated allocations are based on the ACS five-year tabulation 2017-2021 or 2022 data. Funding levels are based on the total funding received for FY24.*

*** NSIP calculations are based on FY24 NSIP meal counts for the purpose of this allocation.*

FY 2026 AREA PLAN STATE GRANTS AWARD ALLOCATIONS

Rounded totals, as of April 8, 2025

AAA	State Guardianship	State I&A	State Support to MAC	State VEPI	State Ombudsman	State Nutrition	Senior Care	SALS
Allegany	$20,789	$106,884	$-	$6,314	$24,089	$31,710	$173,919	$85,682
Anne Arundel	$32,986	$288,434	$-	$33,280	$88,521	$132,915	$880,273	$515,117
Baltimore City	$177,104	$743,784	$-	$81,740	$134,422	$386,750	$2,149,648	$753,266
Baltimore County	$118,186	$610,938	$-	$69,507	$189,720	$312,695	$1,829,213	$901,105
Calvert	$4,299	$87,599	$-	$5,437	$11,232	$20,960	$160,000	$-
Carroll	$23,538	$126,145	$-	$10,343	$38,669	$42,447	$279,451	$221,749
Cecil	$9,796	$114,344	$-	$7,753	$14,193	$35,869	$211,623	$142,013
Charles	$4,127	$134,877	$-	$11,225	$25,400	$47,315	$302,569	$131,638
Frederick	$15,808	$166,456	$-	$15,625	$43,838	$64,918	$417,827	$-
Garrett	$2,000	$72,278	$-	$2,659	$9,680	$12,419	$160,000	$-
Harford	$38,482	$190,017	$-	$17,934	$35,904	$78,053	$478,308	$282,426
Howard	$22,164	$183,767	$-	$18,943	$50,656	$74,568	$504,743	$222,035
MAC	$20,446	$201,018	$131,800	$19,214	$46,768	$84,185	$695,216	$236,689
Montgomery	$46,384	$611,932	$-	$75,949	$198,099	$313,249	$1,997,973	$568,093
Prince George's	$74,555	$558,598	$-	$70,053	$123,935	$283,518	$1,843,532	$585,496
Queen Anne's	$2,000	$83,084	$-	$4,252	$5,314	$18,443	$160,000	$41,828
St. Mary's	$9,452	$105,916	$-	$6,884	$18,197	$31,170	$188,845	$-
USA	$8,765	$122,945	$-	$9,212	$23,669	$40,664	$480,000	$61,912
Washington	$10,311	$155,984	$-	$12,431	$39,495	$59,081	$334,137	$168,781
TOTAL	**$641,192**	**$4,665,000**	**$131,800**	**$478,755**	**$1,121,801**	**$2,070,929**	**$13,247,277**	**$4,917,832**

Attachment D: Planning and Service Areas and AAA Designation

01. **Human Resources Development Commission**
Allegany County
125 Virginia Avenue
Cumberland, MD 21502

02. **Department of Aging and Disabilities**
Anne Arundel County
2666 Riva Road
Annapolis, MD 21401

03. **Division of Aging and Care Services**
Baltimore City
417 E. Fayette Street, 6th Floor
Baltimore, MD 21202

04. **Department of Aging**
Baltimore County
611 Central Avenue
Towson, MD 21204

05. **Office on Aging**
Calvert County
450 West Dares Beach Road
Prince Frederick, MD 20678

06. **Bureau of Aging and Disabilities**
Carroll County
125 Stoner Avenue
Westminster, MD 21157

07. **Aging and Disability Services**
Cecil County
200 Chesapeake Blvd., Ste: 2550
Elkton, MD 21921

08. **Aging and Human Services**
Charles County
8190 Port Tobacco Road
Port Tobacco, MD 20677

09. **Division of Aging and Independence**
Frederick County
1440 Taney Avenue
Frederick, MD 21702

10. **Area Agency on Aging**
Garrett County
104 East Center Street
Oakland, MD 21550

11. **Office on Aging**
Harford County
145 North Hickory Avenue
Bel Air, MD 21014

12. **Office on Aging and Independence**
Howard County
9830 Patuxent Woods Drive
Columbia, MD 21046

13. **MAC, Inc.**
Dorchester County
Somerset County
Wicomico County
Worcester County
909 Progress Circle
Salisbury, MD 21804

14. **Commission on Aging**
Montgomery County
401 Hungerford Drive, 3rd Floor
Rockville, MD 20850

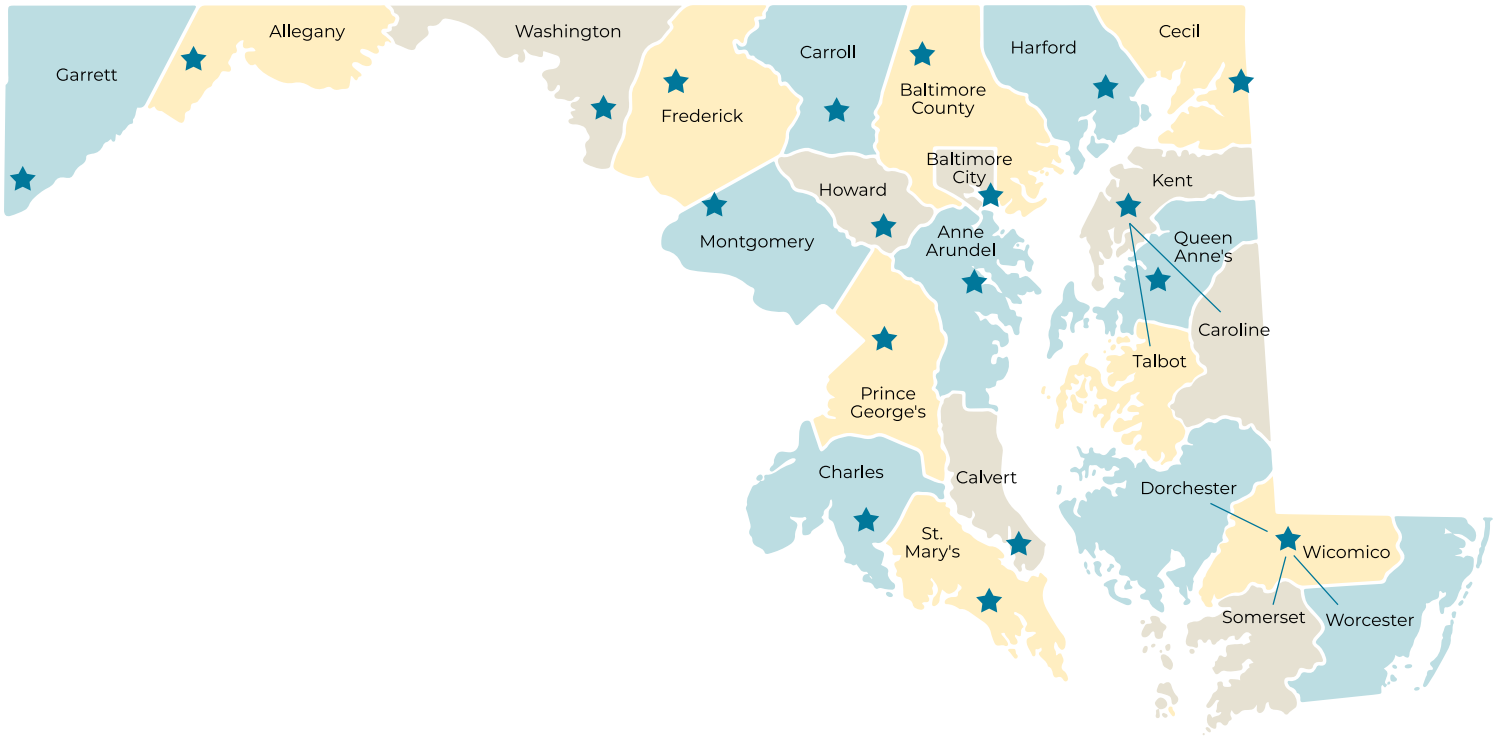
15. **Aging and Disabilities Services Division**
Prince George's County
6420 Allentown Road
Camp Springs, MD 20748

16. **Area Agency on Aging**
Queen Anne's County
104 Powell Street
Centerville, MD 21617

17. **Department of Aging and Human Services**
St. Mary's County
41780 Baldridge Street
Leonardtown, MD 20650

18. **Upper Shore Aging, Inc.**
Caroline County
Kent County
Talbot County
100 Schauber Road
Chestertown, MD 21620

19. **Commission on Aging, Inc.**
Washington County
535 E. Franklin Street
Hagerstown, MD 21740



Attachment E: Evidence of Providing the Minimum Public Comment Period

The State Plan must include information that demonstrates the SUA's compliance with the minimum time period (i.e., at least thirty (30) calendar days, absent a waiver from the ASA) for public review and comment on the new State Plan, pursuant to 45 CFR § 1321.29(c).

Outreach

The draft plan became available on March 17, 2025. Outreach on the public review period and plan availability began immediately and continued until April 20, 2025 through a series of more than 20 emails to more than 43,000 contacts and 20 social media posts to over 15,000 followers.

Town Halls

SALISBURY

- March 18, 2025 from 1:00pm - 3:00pm
- Salisbury University
- 108 registered for 135 reservations

ALLEGANY

- Mar 25, 2025 from 1:00pm - 3:00pm
- Allegany County Fairgrounds
- 74 registered for 94 reservations

VIRTUAL TOWN HALL WITH MARYLAND NONPROFITS

- April 3, 2025 from 1:00pm - 2:30pm
- 336 in attendance

BALTIMORE CITY

- April 8, 2025 from 1:00pm - 3:00pm
- Enoch Pratt Free Library
- 63 registered for 100 reservations

VIRTUAL TOWN HALL WITH AARP

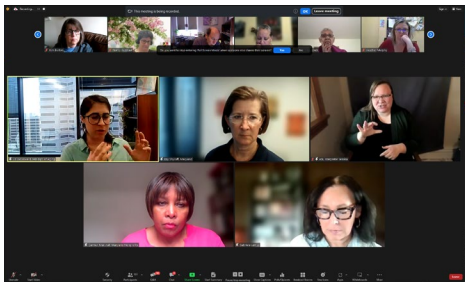
- April 14th, 2025 from 10:00am - 11:00am
- 3,323 members on the call
- 479 attended via Facebook
- Audio of Town Hall is available here.

Salisbury Town Hall

Allegany Town Hall

Baltimore Town Hall

Virtual Town Hall Maryland Nonprofits



Town Hall Invitation

Social Media Post

Attachment F: Service Data

This State Performance Report data is collected as part of the OAA Performance System and submitted annually to the Administration for Community Living to ensure accountability for OAA services. OAA programs help older adults remain at home for as long as possible, promote the rights of older people, and advocate for people who live in long-term care facilities.

Consumer Summary	2023	2024
Total Clients	**196,778**	**292,062**
Total Registered Clients	41,623	49,394
% Minority Clients	46.97%	46.10%
% Rural Clients	7.32%	7.45%
% Clients Below Poverty	29.21%	32.64%
# Clients with 3+ ADLs	5,716	6,584
# of People Served at High Nutrition Risk	10,465	12,562
Units of Service		
Personal Care	15,242	20,783
Homemaker	14,751	20,185
Home-Delivered Meals	2,011,645	2,124,711
NSIP Home-Delivered Meals	1,976,743	2,080,141
Adult Day Care	7,627	28,578
Case Management	12,732	53,851
Assisted Transportation	32,060	31,660
Congregate Meals	835,663	880,899
Transportation	101,848	127,206
Legal Assistance	27,285	31,786
Other Services	187,422	186,389
Health Promotion - Evidence Based	8,339	7,810
Health Promotion - Non-Evidence Based	55,695	56,442
Caregivers		
Serving Elderly People	62,273	107,424
Elderly Caregivers Serving Children	2,167	3,068

Appendix B:
State Government Resources for Older Marylanders

Relevant State Agencies, Programs, and Initiatives

State Department	Initiative/Programs
Governor's Workforce Development Board	■ Planning, coordination, and monitoring of state programs and services for workforce development and advising the Governor on the development, implementation, and modification of the four-year State Plan.
Governor's Office for Children	■ Engaging Neighborhoods, Organizations, Unions, Governments and Households (ENOUGH): community-driven, place-based strategy to fight poverty
Maryland Attorney General	■ Oversight of legal business of the state and representative of major agencies, various boards, commissions, officials and institutions of state government ■ Maryland Equitable Justice Collaborative ■ Consumer Guides for Marylanders to avoid scams and fraud, learn about long-term care, learn about advance directives, and more
Maryland Comptroller	■ Education and resources for financial planning ■ Tax processing and tax credit management ■ Free income tax filing assistance and problem solving available at 12 Comptroller office locations around the state ■ Research and reporting on Maryland's economy
Maryland Department of Aging	■ Planning, policy, advocacy, and legislation to support healthy long lives ■ Oversees Maryland's AAAs, which provide all services locally, including: ◆ Older Americans Act Services (Title IIIB: Supportive Services: Chore, Assisted Transportation, Transportation, Homemaker, Personal Care; Title IIIC Senior Nutrition Program: Home-Delivered Meals and Congregate Dining; Title IIID: Evidence-Based Health Promotion; Title IIIE: National Family Caregiver Program; Title VII: Long-term Care Ombudsman Program, Elder Abuse, Neglect, and Exploitation Prevention, and Legal Services) ◆ Maryland Access Point: aging and disability resource centers providing information, referral, assistance, and person-centered options counseling, including access to Medicaid home- and community-based services, and transitions from institutions to community-based settings ◆ State Health Insurance Assistance Program: Medicare counseling and Medicare fraud and abuse prevention through the Senior Medicare Patrol ◆ Pre-Medicaid long-term services and supports ■ Resources and technical assistance to build the capacity of hyperlocal organizations, such as neighbor-to-neighbor Village models through Supportive Communities Initiative and Aging-in-Place Grants ■ Reframe Aging: challenging age-related bias and reframing the aging narrative through education and awareness ■ Maryland Durable Medical Equipment Re-Use Program: providing free equipment to all Marylanders, regardless of age, illness, income, or ability ■ Senior Call Check and Social Connections: automated daily check-in calls ■ Licensing and regulation of Continuing Care Retirement Communities
Maryland Department of Emergency Management	■ Information, programmatic activities, and leadership for emergency risk reduction and consequence management

State Department	Initiative/Programs
Maryland Department of Health	■ Maryland Medicaid including home- and community-based services for older adults ■ States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model to curb growth in health care cost and spending, improve population health, and advance health equity ■ Maryland Public Health Services Administration: infectious disease control and prevention, environmental health, maternal, child, and family health, food safety, health care quality, vital records, Office of the Chief Medical Examiner, State Anatomy Board, and oversight of the 24 local health departments in the state ■ Maryland Primary Care Program: funding and support for the delivery of advanced statewide primary care ■ Office of Health Care Quality: licensing and oversight of long-term care facilities, adult day care, and assisted living programs ■ Minority Health and Health Disparities: consultation, education, and policy development ■ Behavioral Health Administration: peer support, behavioral health assisted living, mental health outreach, older adult behavioral health preadmission screening, and resident review ■ Maternal and Child Health Bureau: programs and services connect birthing people and families to services and information to support a lifetime of health and wellbeing ■ Interactive data dashboards: data visualizations on overdose, firearm violence, and women's health
Maryland Department of Housing and Community Development	■ Homeownership information, resources, and programs, including the Maryland Mortgage Program ■ Whole Home Energy and Repairs programs and services ■ Homelessness prevention services, including renter assistance, shelter management and Continuum of Care organizations ■ HUD-funded pilot of the CAPABLE model, a home modification, occupational therapy, and behavioral counseling program for aging in place ■ Interagency Council on Homelessness: examining statewide initiatives and recommending policy solutions to end homelessness in Maryland ■ Connect Maryland digital access services
Maryland Department of Human Services	■ In-home care, respite, adult foster care, and kinship care ■ Adult Protective Services and Child Protective Services ■ Benefits access including food and cash assistance, medical assistance, and housing and energy assistance
Maryland Department of Juvenile Services	■ Foster Grandparent Program: connecting adults age 55+ with at-risk youth for mentoring and tutoring assistance ■ Managing, supervising, and treating youth who are involved in the juvenile justice system in Maryland
Maryland Department of Labor	■ American Job Centers: assistance with resume writing, job searching, and providing paid training opportunities for workers ■ Senior Community Service Employment Program: community service and work-based job training program for low-income, unemployed older adults
Maryland Department of Planning	■ Assisting counties and cities with land use and planning ■ Data, research help, policy advice, and support to local governments, communities, businesses, and other groups ■ Maryland Sustainable Growth Subcabinet

State Department	Initiative/Programs
Maryland Department of Service and Civic Innovation	■ Service Year Option for young adults and Maryland Corps volunteer programs ■ Volunteer recognition services
Maryland Department of Transportation	■ Transportation infrastructure and programming ■ State Coordinating Committee for Human Services Transportation ■ Public transportation, including Mobility specialized transit and 5310 grants for aging and disability transportation operating expenses ■ Inclusive design and active transportation planning, including the Model Complete Streets Initiative, a multi-pronged approach for safe and accessible travel options for all, and the Pedestrian Safety Action Plan
Maryland Department of Veterans and Military Families	■ Assisting veterans, active duty service members, their families and dependents to secure benefits earned through military service ■ Assisting with access to the Maryland Veterans Trust Fund, State Military Retirement Pay and Pension Tax Benefits, Maryland VA Medical Centers, and Charlotte Hall Veterans Home ■ Veterans Service Specialist Program, embedding liaisons throughout state government agencies
Maryland Health Care Commission	■ Education and resources, including on long-term care and advanced planning ■ Quality reporting and directory of long-term care and health care facilities
Maryland Health Services Cost Review Commission	■ Regulating hospital cost management to promote cost containment, access to care, equity, financial stability, and hospital accountability
Maryland Insurance Administration	■ Ensuring fair treatment for consumers, regulating availability of insurance coverage, and support in settlement practices
Maryland Public University System	■ Aging expertise embedded throughout university system, including: ◆ University of Maryland Baltimore Geriatrics and Gerontology Education and Research Program, Age Friendly University ◆ University of Maryland Baltimore County Erickson School of Aging Studies ◆ University of Maryland Extension Marylanders Online
Maryland State Department of Education	■ Blueprint for Maryland's Future to improve student experiences and outcomes ■ Strategic direction, policymaking, resources, and oversight of the Maryland school system, and financial literacy resources
Maryland State Library Agency	■ Strategic leadership and guidance to Maryland's 190 public library branches
Maryland State Police	■ Crime prevention and investigation, and support for allied law enforcement agencies
State Commissions, Committees, Task Forces, and Advisory Boards	■ Planning, collaboration, and guidance for the state on specific topics, including preventing and countering elder abuse, caregiver services, health and wellness, and more

Key Reports, Strategic Plans, and Recommendations

- Blueprint for Maryland's Future (Maryland State Department of Education)
- Building a Healthier Maryland: State Health Improvement Plan (2024, Maryland Department of Health)
- Building the Next Generation of Empowering Eldercare Communities (2024, Center for Innovation)
- Challenges and Opportunities Facing LGBTQIA+ Marylanders: 2024 Policy Priorities, Recommendations and Best Practices (2024, Maryland Commission on LGBTQIA+ Affairs)
- Investing in Maryland's Behavioral Health Talent (2024, Maryland Health Care Commission)
- Maryland Age-Friendly Community Strategic Plans
- Maryland Department of Transportation Model Complete Streets Policy (2024)
- Maryland Housing Needs Assessment & 10-Year Strategic Plan (2020, National Center for Smart Growth and Enterprise Partners, Inc.)
- Maryland State Plan to Address Alzheimer's Disease and Related Dementias: 2022-2026 (2022, Virginia I. Jones Alzheimer's Disease and Related Disorders Council)
- Maryland Transforms: A Strategic Plan for Marylanders by Marylanders (2023, Maryland State Department of Education)
- Maryland's Climate Pollution Reduction Plan (2023, Maryland Department of the Environment)
- Maryland WIOA State Plan (2020-2024, Maryland Department of Labor)
- MD Total Cost of Care Model Progress Report (2022, Centers for Medicare and Medicaid)
- Moore-Miller Administration State Plan (2024)
- Report of the Commission on Behavioral Health Care Treatment Access (2023, Maryland Department of Health)
- State Managing for Results Strategic Plans (2024, Maryland Department of Budget and Management)
- State of Maryland Statewide Digital Equity Plan (2024, Maryland Department of Housing and Community Development)
- State of the Economy (2023, Office of the Comptroller of Maryland)
- Final Report (2024, Task Force on Preventing and Countering Elder Abuse)
- The Development of Cognitive Health Plan for Maryland's Aging Population (2021, Maryland Departments of Health and Aging)
- The Playbook: Maryland Transportation Plan (2050, Maryland Department of Transportation)

Key Research and Data

- Age-wise Distribution of Maryland Household Incomes: Comparative Analysis Across 16 Income Brackets (2024)
- America's Health Rankings Maryland - 2022 Senior Report; 2024 Values and Rankings
- Comptroller of Maryland State of the Economy Series: Immigration and The Economy (2024)
- Gross Domestic Product in Maryland (2023)
- Livability Index Maryland Profile (2023)
- Longevity Economy Outlook for Maryland (2019)
- LRM Data Dashboard (2024)
- Maryland Area Agencies on Aging State Data Report 2022 Profile
- Maryland Grandfamilies Fact Sheet (2021)
- Maryland Long-Term Services and Supports Fact Sheet (2023)
- Maryland Long-Term Services and Supports Scorecard (2023)
- Maryland Vital Statistics Annual Report (2020)
- Overview: Maryland State Retirement and Pension System (2024)
- Pensionomics: Measuring the Economic Impact of DB Pension Expenditures (2025)
- Profile of Older Americans (2023)

Appendix C:
Glossary of Terms

- **Advocacy Groups:** Organizations that promote the rights and wellbeing of older adults, often working to prevent abuse, fraud, and victimization, and to influence policies and legislation that protect older adults.
- **Affordable Housing:** Housing options that are affordable for low-income residents, typically defined as costing no more than 30% of a person's monthly income.
- **Age-Friendly Communities:** A global movement to create communities that are inclusive and supportive of people of all ages. In Maryland, this includes local programs that incorporate perspectives from older residents in the development of age-friendly policies.
- **Age in Place:** The ability of older adults to live in their own homes and communities, with the support and services they need, for as long as possible rather than moving to institutional care settings.
- **Aging Services Network:** Federal, state, local, and nonprofit providers of programs, services, and supports for the aging population.
- **Add Area Agency on Aging:** A network of state-level service providers that administer OAA programs and services at the local level.
- **Birth Rates:** The number of live births per 1,000 people in a given year.
- **Capacity Building:** The process of increasing the ability of organizations or systems to effectively serve their target populations. For aging services, capacity building might involve increasing the availability of trained caregivers, expanding service offerings, or improving infrastructure.
- **Caregivers:** People who provide care to grandchildren, people with disabilities, or older adults. Care may include medical, health, and personal care either as professionals (paid) or family and friends (unpaid).
- **Care Services:** Services that provide personal care and support, ranging from in-home assistance to medical and health care services.
- **Care Workforce Supports:** Resources and programs that assist caregivers, including training, financial assistance, and respite care.
- **Centers for Independent Living:** community-based nonprofit organizations providing services to help people with disabilities live independently and participate fully in their communities.
- **Cognitive and Behavioral Health:** The mental health and cognitive wellbeing of older adults, including issues related to dementia, Alzheimer's disease, and other neurological conditions. Improving cognitive health is a key area of focus in Maryland's aging strategy.
- **Community-Based Organizations:** Nonprofit groups that offer local programs and services to older adults, helping them stay connected to their communities and providing referrals to other necessary services.
- **Comptroller of Maryland:** A state official responsible for managing Maryland's finances, ensuring appropriate allocation of tax dollars, and protecting residents through fiscal oversight.
- **Continuum of Care:** A continuous range of services and care a person receives over time.
- **Corrective Action Plans:** Plans developed when issues or challenges arise in service delivery or financial management, outlining steps to resolve problems and improve performance.
- **Cross-Sector Collaboration:** The process of different sectors (e.g., government, private sector, community organizations, philanthropy) working together to achieve common goals. This collaboration is essential to implementing the LRM plan and addressing the diverse needs of Maryland's aging population.
- **Dementia:** A group of neurological disorders that affect memory, thinking, and the ability to perform daily activities
- **Digital Divide:** The gap between those who have access to modern technology and the internet and those who do not. For older adults, this gap often means difficulty accessing essential services, health care, and social connection.
- **Digital Innovation and Access:** Advancements in technology and increasing access to digital resources, including the internet and mobile devices, to help older adults stay connected, informed, and engaged.

- **Direct and Indirect Costs of Dementia Care:** The financial impact of caring for people with dementia, which includes direct costs like medical care and indirect costs such as lost wages due to caregiving.
- **Equity in Aging:** The principle that all people, regardless of race, gender, or geography, should have fair access to the resources and opportunities that promote a good quality of life as they age.
- **Fentanyl, Cocaine, and Opioids:** Types of substances contributing to a national and local drug crisis, with high rates of overdose deaths among the older adult population, especially in Maryland.
- **Funding Flows:** The distribution and allocation of financial resources from various state agencies to support programs and services, especially those targeting older adults.
- **Greatest Economic and Social Need:** The most pressing issue within a community that impacts economic factors like income and employment, and social factors like access to health care, education, and community support.
- **Health Care Providers:** Medical professionals and institutions that provide care across the lifespan, including health promotion, prevention, and treatment, with an emphasis on supporting healthier outcomes as we age.
- **Health Span:** The number of years a person lives in good health, free from chronic illness and disability.
- **Holistic Approach:** Addressing an issue by considering all relevant factors and systems comprehensively.
- **Home- and Community-Based Services:** Services provided within the community aimed at supporting people and reducing the need for institutional care.
- **Housing Expansion and Affordability Act (HB 538):** Legislation introduced by Governor Moore and signed into law on April 25, 2024 to address Maryland's affordable housing shortage. This Act removes barriers to housing construction, promotes density where appropriate, and encourages the use of manufactured housing, especially for older adults.
- **Housing Program Assistance:** Financial or logistical support designed to help older adults find and maintain housing that meets their needs and preferences.
- **Income-Based Programs:** Government or community programs designed to assist people who earn below a certain income threshold, helping them access essential services such as housing, food, and health care.
- **Independent Living:** The ability of older adults to live in their own homes and communities with minimal assistance, maintaining autonomy and self-sufficiency.
- **People with Disabilities:** A person who has a physical or mental impairment that substantially limits one or more major life activities.
- **Interagency Councils:** Collaborative groups formed between different agencies, organizations, and businesses to coordinate services and improve the quality of life for older adults at the local level.
- **Jurisdiction:** There are 24 jurisdictions in the State of Maryland (23 counties plus Baltimore City).
- **Longevity Lens:** A framework used to assess policies, strategies, and services that focuses on the long-term wellbeing of people across their entire lifespan, emphasizing healthy aging, financial security, and supportive systems. It is inclusive of various factors like health care, housing, transportation, and social inclusion from birth throughout the later years of life to achieve long, healthy, and fulfilling lives.
- **Life Expectancy Gap:** The difference in average life expectancy between different groups of people, influenced by factors such as race, income, and geographic location.
- **Lifespan Approach:** A perspective that focuses on the entire life cycle, from early childhood through old age, ensuring that health, education, and social supports are in place to promote wellbeing at every stage of life.
- **Medicare and Medicaid:** Government health insurance programs that help people pay for medical costs.
- **Model Complete Streets:** A Maryland Department of Transportation policy designed to create safer and more accessible streets for all residents, regardless of age or ability.
- **Multisector Plan for Aging:** A comprehensive, state-led plan that involves public and private sectors working together across different industries to create policies and services that support aging populations, aiming to provide sustainable, community-based care and services.
- **Navigation Systems:** Services or tools that help people understand and access available resources and benefits.

- **New Map of Life:** A research-based framework developed by the Stanford Center on Longevity that aims to maximize the benefits of longer lives by aligning lifespans with health spans, emphasizing the interconnectedness of various sectors like health care, education, employment, and caregiving in promoting wellbeing as people age.
- **No Wrong Door:** Multiple agencies coordinate to ensure that regardless of which agency people contact for help, they can access information and one-on-one counseling about the options available across all the agencies and in their communities.
- **Older Americans Act (OAA):** A federal law that ensures access to critical services like nutrition, transportation, caregiving, and health care to keep older adults healthy and independent and protect their rights. The OAA provides funding to support aging programs.
- **OAA Final Rule:** A set of regulations that guide the implementation of the Older Americans Act, ensuring that services provided to older adults meet federal standards.
- **Out-of-State Migration:** Movement of older residents from Maryland to other states, often in search of more affordable living and supportive communities.
- **Person-Centered Counseling:** A type of support that focuses on the individual needs, preferences, and goals of older adults and caregivers, helping them make informed decisions about long-term care and services.
- **Philanthropies:** Organizations that provide funding and advocacy for programs and services that improve the quality of life for older adults, often supporting community-based initiatives.
- **Preventive Measures:** Actions taken to prevent or reduce the likelihood of certain outcomes, such as health issues or dependency on social services.
- **Priority Populations:** Groups that face the most significant challenges due to social, economic, or health disparities. These populations include people with low-income, historically underserved racial and ethnic minorities, rural residents, the LGBTQIA+ community, people with disabilities, and those with limited English proficiency.
- **Public-Private Partnerships:** Collaborations between government agencies and private entities aimed at improving services, resources, and infrastructure for older adults. These partnerships are critical in expanding the reach and impact of aging services.
- **Social Determinants of Health:** Conditions in which people are born, grow, live, work, and age that affect their overall health and wellbeing.
- **Social Isolation:** A lack of meaningful social connections and interactions, which can have negative health outcomes for older adults, such as increased risks of heart disease, dementia, stroke, and mental health challenges.
- **Social Security:** A federal program that provides retirement and disability benefits, which are often a key source of financial security for older adults.
- **Supportive Communities:** Areas that provide services and environments conducive to the wellbeing of older adults to age in place. This initiative partners with local governments and community organizations to build networks of care and support.
- **Technical Assistance:** Support provided by experts to help improve the effectiveness of programs, solve problems, and ensure compliance with regulations.
- **Village Model:** A community-based program designed to help older adults remain in their homes and live independently by providing a network of services, resources, and social connections, often with a focus on mutual aid and volunteer support.
- **Walkable Communities:** The creation of neighborhoods and urban spaces designed to be accessible, safe, and convenient for older adults, people with disabilities, and others to navigate on foot, improving their ability to stay active and engaged in the community.
- **Whole-of-Government Approach:** A strategy where all government agencies work together, rather than in isolation, to address complex issues like aging, ensuring coordination and efficiency in policy development and service delivery.

Appendix D:
Stakeholder Engagement Process and Analysis

Area Agency on Aging (AAA) Four-Year Plan Analysis

Overview

MDOA conducted a systematic analysis of the state's 19 AAA Four-Year Plans to identify overarching themes and potential recommendations for LRM. The plans were grouped by region and subjected to a rigorous comparative analysis utilizing AI-powered analysis tools. A standardized prompt was employed to extract the top five thematic areas and potential state-level recommendations from each document. To enhance the reliability and validity of the findings, this process was independently replicated three times for each region and the AI-generated outputs were manually reviewed by MDOA staff to ensure alignment with the original plan content. The consolidated findings derived from this multifaceted approach form the foundation of this analysis.

The analysis identified the following overarching themes among all five regions:

1. **Enhanced Service Delivery and Accessibility:** Ensure that services are widely accessible, affordable, and comprehensive, addressing both immediate needs and long-term wellness.
2. **Community-Based Care and Independence:** Provide care and services within communities to minimize the need for institutionalization and support aging in place.
3. **Equity and Inclusive Aging:** Ensuring that all older adults, regardless of race, income, or geographic location, have access to necessary services.
4. **Caregiver Support and Wellbeing:** Recognizing the crucial role of caregivers in helping older adults age in place, ensure the provision of necessary supports and resources to manage the challenges of caregiving.
5. **Strategic Partnerships and Collaboration:** Foster strong, multi-sector partnerships between various stakeholders to enhance service coordination, improve efficiency, and avoid gaps in care.

Capital Region Priorities

Frederick, Montgomery, and Prince George's Counties

1. **Emergency Preparedness and Resilience:** Ensure that the aging population is prepared for emergencies and that the region can swiftly recover from disasters by addressing the relevance of crisis awareness training at senior centers. Strengthen infrastructure to support vulnerable older adults during natural disasters or crises (heat waves, flooding, power outages, etc.) and ensure that emergency plans are accessible to older adults, including those with mobility issues or special health needs. Recommended actions include:
    - Develop localized emergency communication systems, emphasizing outreach to older adults in partnership with the local health department, the county's Department of Emergency Services (Emergency Management), and the Health Planning Coalition.
    - Provide training for older adults on emergency response and personal resilience strategies.
    - Equip senior centers and community hubs with necessary resources to serve as emergency shelters.
2. **Collaboration and Partnerships:** Foster strong, multi-sector partnerships by building stronger relationships between government agencies, health care providers, nonprofits, caregivers and community organizations to enhance service coordination and avoid gaps in care. Recommended actions include:
    - Establish formal agreements between agencies at county and state levels to share data and resources.
    - Promote public-private partnerships to leverage expertise and funding.
    - Create cross-county working groups to address shared regional challenges, particularly related to health and wellness.
3. **Comprehensive and Accessible Services:** Provide accessible, affordable, and comprehensive transportation, health care, and social services designed to enhance the quality of life for older adults and ensure that services are comprehensive, addressing both immediate needs and long-term wellness. Recommended actions include:

- Expand transportation options, especially in more rural areas.
- Increase awareness of available services through outreach programs in diverse languages.
- Create a one-stop resource center that assists older adults and their families with navigating care services, housing, and social opportunities.

4. **Age-Friendly and Inclusive Communities:** Promote the development of age-friendly neighborhoods that support active aging, implement policies, and develop infrastructure that allows older adults to remain engaged in their communities, live independently, and enjoy high quality of life. Recommended actions include:
   - Support initiatives that focus on universal design in housing and public spaces.
   - Expand public green spaces, safe walkways, and accessible transit services.
   - Encourage age-diverse housing developments that provide affordable, accessible housing for older adults.
   - Foster inclusion for older adults in social, civic, and cultural life through community programming.
5. **Mental Health and Dementia Care:** Ensure older adults have access to mental health services, particularly for issues related to aging such as dementia, loneliness, and depression. Expand access to mental health resources, increase public awareness of dementia, and provide caregivers with support and training. Recommended actions include:
   - Expand the number of trained mental health professionals who specialize in geriatric care.
   - Provide free or low-cost dementia screenings and educational programs.
   - Establish dementia-friendly communities and train public workers to assist people with cognitive decline.
   - Develop respite care programs and support services for caregivers.

Central Maryland Priorities

Baltimore City and Anne Arundel, Baltimore, Carroll, Harford, and Howard Counties

1. **Increasing Behavioral Health Needs:** Address the growing behavioral health challenges among older adults, including issues related to mental health, substance abuse, and social isolation. Meet the growing demand for mental health and substance abuse services by expanding access, reducing barriers to care, and addressing stigma. Recommended actions include:
   - Increase the number of behavioral health professionals trained in geriatric care.
   - Establish mental health clinics within senior centers or provide mobile mental health services.
   - Promote awareness campaigns that focus on reducing stigma around seeking help for depression, anxiety, and substance abuse.
   - Develop peer support programs to reduce loneliness and isolation among older adults.
2. **Transportation Challenges:** Improve transportation options for older adults, particularly those who no longer drive or live in areas with limited public transportation. Address the transportation challenges that limit access to services and reduce independence by providing reliable, affordable, and accessible options that support independence and to access essential services. Recommended actions include:
   - Increase funding for specialized transportation services like paratransit, ride-sharing programs, and volunteer driver initiatives.
   - Expand public transportation routes and schedules, especially in more suburban and rural areas like Carroll and Harford Counties.
   - Ensure that all transit services are age-friendly and accessible, with easy-to-read signage, low-floor buses, and training for drivers to assist older adults.
   - Partner with community organizations and private companies to develop innovative transportation solutions like senior shuttles or subsidized ridesharing.
3. **Housing and Homelessness:** Address the rising issue of housing instability and homelessness among older adults by providing safe, affordable housing options. Combat housing insecurity and homelessness by expanding affordable housing options and providing targeted support for older adults. Recommended actions include:

- Increase affordable senior housing units, especially in high-demand areas through incentives for developers.
- Expand rental assistance and property tax relief programs for low-income older adults to help people stay in their homes.
- Create housing programs specifically designed for older adults who are homeless or at risk of homelessness, including permanent supportive housing and emergency shelters with wraparound services.
- Ensure that housing services are integrated with health and social services to support independent living.

4. **Food Insecurity**: Ensure that older adults have consistent access to nutritious, affordable food, reducing the risk of hunger and malnutrition. Expand food assistance programs and make them more accessible for older adults facing economic or mobility challenges. Recommended actions include:
   - Increase funding for food programs like Meals on Wheels, congregate meals, and food banks that serve older adults.
   - Establish more mobile food delivery programs, especially in rural areas where grocery stores may be less accessible.
   - Partner with local farms, grocery stores, and nonprofits to provide fresh produce and healthy meal options.
   - Expand Supplemental Nutrition Assistance Program (SNAP) outreach to ensure older adults are aware of and enrolled in food assistance programs for which they qualify.
5. **Support for Caregivers and Independent Living:** Strengthen the support available to family caregivers and enhance programs that promote independent living. Provide caregivers with respite care, training, and financial assistance. Recommended actions include:
   - Increase funding for respite care programs, providing temporary relief for family caregivers to prevent burnout.
   - Offer training programs for caregivers on managing complex medical needs, dementia care, and navigating community resources.
   - Expand in-home care services and home modification programs that enable older adults to age safely and comfortably in their homes.
   - Promote the development of community-based services like adult day care, transportation assistance, and personal care to support independent living.
   - Increase funding for geriatric mental health programs across the state, particularly in underserved areas.
   - Create a statewide initiative to train primary care physicians and health care workers to identify and address behavioral health issues in older adults.

Eastern Shore Priorities

Caroline, Cecil, Kent, Dorchester, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties

1. **Community-Based Care:** Ensure that older adults receive community care and services to minimize the need for institutionalization and increase their ability to age in place. Expand local, community-based programs that offer health, social, and support services. Recommended actions include:
   - Increase funding for in-home care services, including personal care aides, home health visits, and meal delivery, especially in rural areas.
   - Develop more adult day care programs and respite services for caregivers in the region.
   - Partner with local clinics and hospitals to create a seamless referral system, linking older adults to community-based care options upon discharge from medical facilities.
   - Expand access to assistive technologies and home modifications that enable older adults to live safely in their homes.
2. **Equitable Access and Inclusion:** Ensure that all older adults, regardless of race, income, or geographic location, have access to the services and resources they need. Address disparities in service access between rural and urban areas, and ensure that underserved populations, including minorities and low-income older adults, receive equitable care. Recommended actions include:

- Expand outreach efforts to ensure older adults in remote and rural areas are aware of and can access available programs.
- Provide translation and language services for older adults with limited English proficiency to improve access to health care and social services.
- Increase transportation options, particularly in rural areas, to ensure older adults can get to medical appointments, grocery stores, and community centers.
- Work with community leaders to identify barriers in accessing services and develop solutions that prioritize inclusion, such as mobile health clinics or telemedicine options.

3. **Holistic Health and Wellness**: Promote a holistic approach to health that encompasses physical, mental, emotional, and social wellbeing. Provide services that address the full spectrum of health needs, including chronic disease management, mental health care, and social connection. Recommended actions include:
   - Expand wellness programs focused on physical activity, nutrition, and chronic disease prevention, offering more classes at senior centers across counties.
   - Increase access to mental health services—particularly addressing issues like depression, anxiety, and dementia—by partnering with local behavioral health providers.
   - Create more opportunities for social engagement through volunteer programs, community events, and intergenerational activities that reduce social isolation.
   - Promote the use of telehealth to allow older adults in rural areas to receive care without having to travel long distances.
4. **Collaboration and Partnership**: Strengthen collaboration between government agencies, health care providers, and community organizations to provide coordinated services, maximize resources, reduce service redundancies, and improve overall outcomes for older adults. Recommended actions include:
   - Develop regional partnerships with local hospitals, nonprofit organizations, and faith-based groups to offer a wider range of services for older adults, from health care to social support.
   - Encourage data-sharing agreements between agencies to better track the needs and outcomes of older adults receiving services.
   - Establish a regional aging task force that brings together stakeholders across counties to address shared challenges, such as transportation, housing, and health care access.
   - Engage private sector partners in developing age-friendly housing, transportation, and recreational services.
5. **Public Engagement and Advocacy**: Increase public awareness about the needs of older adults and foster a culture of advocacy that supports aging in place and wellbeing. Mobilize the community and stakeholders to advocate for policies and funding that benefit the aging population. Recommended actions include:
   - Launch public awareness campaigns to educate the community about issues facing older adults, such as housing insecurity, food access, and the importance of preventive health care.
   - Empower older adults and their families to engage in local advocacy efforts by providing training on how to communicate with policymakers and participate in public hearings.
   - Advocate for increased state and federal funding for programs that serve older adults on the Eastern Shore, particularly in under-resourced areas.
   - Work with local media outlets to highlight success stories and challenges faced by older adults in the region, and help build broader public support for older adult services.

Southern Maryland Priorities

Calvert, Charles, and St. Mary's Counties

1. **Service Delivery in Rural and Low-Income Areas:** Ensure equitable access to services in rural and low-income areas where resources are limited and access to care can be challenging. Address service gaps in more isolated areas, providing essential health care, social services, and assistance programs to low-income and rural older adults. Recommended actions include:

- Increase mobile health care services, such as mobile clinics, that travel to rural communities to provide primary care, health screenings, and vaccinations for older adults.
- Expand the use of telehealth services to connect rural older adults with health care providers and specialists, reducing the need for long-distance travel.
- Establish satellite senior centers or multi-service hubs in remote areas, providing a one-stop location for social services, health information, and social engagement activities.
- Develop targeted outreach programs to ensure that older adults in underserved communities are aware of and able to access available services like food assistance, housing support, and transportation.

2. **Collaboration and Coordination:** Foster stronger partnerships between local government agencies, nonprofits, health care providers, and community organizations to deliver coordinated services, avoid redundancies, and create a more seamless network of care for older adults through communication and resource-sharing among service providers. Recommended actions include:
   - Develop formal agreements between county agencies, health care systems, and community organizations to share data, streamline referrals, and coordinate care.
   - Create regional task forces to regularly review services and identify areas where gaps in care or duplication of efforts exist, allowing for more efficient service delivery.
   - Implement case management programs that follow older adults across different service providers, ensuring continuity of care and access to a full range of support services.
   - Establish regular forums or working groups that bring together key stakeholders to discuss emerging needs, service improvements, and collaborative initiatives.
3. **Educational Initiatives:** Educate older adults, caregivers, and the broader community about the resources available to older adults and provide training on key aging issues like health care, financial planning, and elder rights. Empower older adults and their families with knowledge and skills to navigate services, manage health conditions, and protect against financial exploitation or abuse. Recommended actions include:
   - Offer workshops and educational seminars on topics like Medicare, Medicaid, financial literacy, long-term care options, and navigating local services for older adults.
   - Partner with local universities, libraries, and community colleges to provide classes that help older adults stay engaged, learn new skills, and maintain mental health.
   - Develop caregiver training programs that teach family caregivers how to manage chronic conditions, assist with activities of daily living, and access community resources.
   - Raise awareness about elder rights and elder abuse prevention through community outreach, workshops, and public service announcements, ensuring that older adults and their families know how to protect themselves and where to get help.
4. **Affordable Housing and Transportation Services:** Address the critical need for affordable housing and reliable transportation services that allow older adults to live independently and remain connected to their communities. Expand affordable housing options and provide accessible transportation services, especially in areas where public transportation is limited or nonexistent. Recommended actions include:
   - Increase the development of affordable, age-friendly housing options, including subsidized rental housing, senior apartments, and assisted living facilities, particularly in underserved areas.
   - Work with local governments and developers to create zoning policies that encourage the construction of mixed-use developments and affordable housing that meets the needs of older adults.
   - Expand older adult-specific transportation programs, including paratransit, volunteer driver networks, and subsidized rideshare services, to ensure older adults can access medical appointments, grocery stores, and social activities.
   - Improve public transit routes and schedules to better serve rural and low-income older adults, ensuring that transportation services are frequent, reliable, and accessible to people with mobility challenges.
5. **Elder Abuse and Rights:** Protect the rights of older adults and prevent abuse, neglect, and exploitation through stronger protections, increased awareness, and more robust enforcement of existing laws. Enhance the systems in place to identify, report, and respond to abuse, while promoting the rights and dignity of older adults. Recommended actions include:

- Increase funding for Adult Protective Services to improve investigations and provide more support for victims of abuse, neglect, and financial exploitation.
- Implement abuse prevention programs in senior centers and community organizations, offering education on recognizing the signs of abuse and how to report it.
- Establish legal clinics or services that offer free or low-cost legal assistance to older adults, helping them protect their rights and deal with issues like housing disputes, financial exploitation, and estate planning.
- Create a regional elder abuse task force to improve coordination between law enforcement, health care providers, and social services, ensuring that cases of abuse are quickly identified and effectively addressed.

Western Maryland Priorities

Allegany, Garrett, and Washington Counties

1. **Health and Wellness:** Promote the overall health and wellbeing of older adults by ensuring access to health care, preventive services, and healthy living programs. Expand health care services, particularly in rural areas, while encouraging preventive care and chronic disease management. Recommended actions include:
   - Increase partnerships with health care providers to offer regular screenings, chronic disease management (e.g., diabetes, heart disease), and mental health services in senior centers and community hubs.
   - Establish physical activity programs (e.g., walking clubs, fitness classes) and health education focused on nutrition, falls prevention, and mental health.
   - Develop more accessible mental health and dementia care services by collaborating with local behavioral health providers to offer on-site or telehealth consultations.
   - Implement programs that offer affordable or free dental and vision care for low-income older adults, with mobile clinics or partnerships with local dentists and optometrists.
2. **Equity and Accessibility:** Ensure all older adults, including those in rural or underserved communities, have equitable access to necessary services and resources. Break down barriers to accessing health care, transportation, and social services for older adults living in remote or low-income areas. Recommended actions include:
   - Expand affordable and accessible transportation services, including on-demand ride services, volunteer driver programs, and enhanced public transportation routes, particularly in rural areas.
   - Create targeted outreach campaigns to ensure that older adults in rural, low-income, and minority communities are aware of and able to access available services.
   - Provide language translation services and culturally competent care for older adults in diverse communities, ensuring that language or cultural barriers do not prevent access to essential services.
   - Advocate for infrastructure improvements (e.g., sidewalks, ramps, automatic doors) that make public spaces and service centers more accessible for older adults and people with disabilities.
3. **Support for Caregivers:** Provide comprehensive support and resources for unpaid caregivers, ensuring they have the tools and resources to manage the challenges of caregiving. Expand respite care, training, and financial support for caregivers to prevent burnout and improve the quality of care provided at home. Recommended actions include:
   - Develop training workshops and online resources for unpaid caregivers in managing chronic diseases, dementia care, personal care, and navigating local services.
   - Increase access to respite care programs by offering affordable in-home care, adult day programs, and short-term stays at assisted living facilities.
   - Create local caregiver support groups, both in-person and virtual, to allow caregivers to connect with others, share experiences, and receive emotional support.
   - Advocate for programs that provide financial support for unpaid caregivers, including tax credits, stipends, or subsidies for caregiving-related expenses.
4. **Community Engagement and Volunteerism:** Promote active aging by encouraging older adults to stay engaged in their communities through volunteerism, social activities, and lifelong learning. Create more opportunities for older adults to contribute to their communities and participate in meaningful social activities. Recommended actions include:

- Develop volunteer opportunities that tap into older adults' skills and experiences, allowing them to contribute to community projects, mentor younger generations, and help other older adults in need.
- Encourage intergenerational programs that bring older adults and younger people together through activities like reading programs, school partnerships, and community service projects.
- Organize social events, outings, and group activities for older adults, fostering a sense of belonging and reducing isolation, particularly for those living alone.
- Partner with local universities, libraries, and community centers to offer educational workshops, technology classes, and art programs for older adults to stay mentally active and engaged.

5. **Aging in Place:** Support older adults who wish to remain in their homes and communities for as long as possible by providing necessary services, support, and home modifications. Expand in-home care, home modifications, and community-based services to enable older adults to live independently and safely in their homes. Recommended actions include:
   - Expand programs that provide home health aides, personal care assistance, meal delivery, and household support services for older adults who want to age in place.
   - Offer financial assistance and technical support for home modifications, such as installing ramps, grab bars, stairlifts, and improving accessibility for older adults with mobility limitations.
   - Support the creation of community-based "Village" networks that allow older adults to help each other and access volunteer services (e.g., rides, home repairs) that make support aging in place.
   - Establish community hubs that provide older adults with comprehensive services, including health care, social programs, and home maintenance resources, in an accessible location.

Priority Population Analysis

Overview

MDOA engaged stakeholders through a variety of activities starting in the spring of 2023 to understand the challenges and opportunities experienced by older adults and aging services professionals in Maryland. In spring 2024, MDOA began tracking stakeholder engagement attendance to identify themes and ensure diversity in geographic and topical engagement. In July 2024, stakeholders were invited to apply for participation in LRM Work Groups to provide recommended objectives and strategies for inclusion in the strategic plan. Upon the Work Group application closure, MDOA analyzed applicant participation and engagement efforts to identify gaps in reach among Maryland's diverse population. A plan was developed to address gaps through targeted focus groups and interviews with populations representing the greatest social and economic need. Six target groups were identified for engagement between August and November 2024. The timing ensured that engagement could effectively inform the review of recommendations received by LRM Work Groups on November 15, 2024, and the following analysis ensured that plan elements were informed by the diverse experiences in Maryland and had the potential to impact those facing significant barriers to healthy long lives.

Methods

In July 2024, MDOA reviewed community outreach tracking to identify gaps where priority populations representing the greatest social and economic need, as defined in the Older Americans Act, had not yet been adequately engaged. This included geographic communities and targeted population groups. MDOA identified six targeted population groups and two geographic areas that had not been engaged to date. MDOA contacted trusted community organizations actively engaged with those communities to request assistance organizing and implementing engagement opportunities. Community organizations provided in-kind consultation and planning, selecting the optimal format of the meeting based on their knowledge of the target community. Community organizations provided available resources, invited attendees, and managed logistics, including the organization of a venue, transportation for participants, and translators for the meetings. MDOA created the agenda and planned talking points, and documented the discussion for analysis.

The following priority populations were targeted:

- **Older adults living with HIV:** A virtual focus group was held on August 2, 2024, with five participants selected by the Maryland Coalition on HIV and Aging.

- **Older adults with limited English proficiency:** Two in-person focus groups were held on October 23, 2024, with older adults selected by the Asian American Center of Frederick (AACF) at their community center. The groups included four Spanish-speaking older adults and six Chinese-speaking older adults. Translators were organized by AACF.
- **Older adults in under-resourced rural communities:** A town hall meeting with 40 older Marylanders invited by Upper Shore Aging, Inc. was held on November 4, 2024, at Amy Lynn Ferris Senior Center in Chestertown, MD. A second focus group was held on November 7, 2024, with ten community members and four professionals selected by the Cecil County Department of Community Services at their office in Elkton, MD.
- **Older adults who are blind or have low vision:** One-on-one phone interviews were held with five older adults who are blind or have low vision, referred by the National Federation of the Blind Maryland Chapter, from October 7 - October 21st, 2024.
- **LGBTQIA+ older adults:** MDOA reached out to both national and local organizations, but was unsuccessful at organizing an event within the planned period of August-November.

Each targeted engagement opportunity was documented by a scribe. The content of the scribe's notes were analyzed to identify key challenges and opportunities that were discussed and should be considered in developing a plan of action. All meeting notes were uploaded to NotebookLM for analysis by individual groups and across groups using the following prompts: What are the common challenges identified by the group?; and What is most important to be healthy as you age, according to the group? The NotebookLM analysis was reviewed and cross-referenced with the human analysis to ensure accuracy, and revisions were made accordingly.

A notable limitation in the process was a lack of internal expertise in qualitative data analysis. The NotebookLM analysis was utilized to reduce the impact of potential bias and streamline the process within staff capacity. An additional limitation was reliance on scribe notes, rather than transcription. Notetakers were utilized due to potential concern about the impact recording might have on open and honest communication.

Analysis identified the following overarching themes among the priority populations:

- **Financial Security:** Participants reported that the cost of living, including housing, health care, and essential goods, is increasing faster than their fixed incomes can manage. They express anxiety about affording basic needs and maintaining their independence, as well as the high cost of caregiving for family members.
- **Lack of Transportation:** Limited access to affordable and reliable transportation emerged as a significant barrier across all groups. Older adults without personal vehicles face difficulty accessing health care, social events, grocery stores, and other essential services due to infrequent public transportation schedules and long distances. This lack of transportation contributes to social isolation, limiting opportunities for engagement.
- **Social Isolation and Limited Community Engagement:** Participants expressed concerns about social isolation stemming from a lack of shared community spaces, activities, and opportunities for meaningful connection. Barriers such as transportation limitations, language barriers, hearing difficulties, and digital access exacerbated this issue.
- **Digital Access and Technology Proficiency:** A significant portion of older adults struggle with digital access and lack the technological skills required to navigate online resources, health care portals, and communication platforms. This issue is a particular challenge among people with certain disabilities including those who are deaf, hard of hearing, are blind, or have a visual impairment. This lack of awareness limited their access to information, services, and social connection, leading to feelings of exclusion and frustration.
- **Navigating Complex Systems and Accessing Information:** Participants expressed frustration with the complexity of finding and accessing information about available services and programs. They encountered challenges with online portals, lengthy applications, and a lack of clear communication about available resources. The need for simplified processes, centralized information hubs, and improved outreach was highlighted.
- **Age-Related Bias and Lack of Respect:** Participants expressed a desire to be valued and respected as contributing members of society. They felt that age-related bias and stereotypes diminished their experiences and contributions, leading to feelings of being overlooked and disregarded.

- **Health Concerns and Access to Care:** While specific health concerns varied, participants consistently expressed challenges accessing adequate and affordable health care. Long wait times for appointments, limited availability of specialists, and the high cost of care were major concerns.
- **Housing Affordability and Suitability:** Finding safe, affordable, and suitable housing emerged as a significant challenge. Participants expressed concerns about rising rent costs, limited availability of senior housing options, and the high cost of home maintenance and repairs. They desired housing options that cater to their needs and allow them to age in place comfortably.
- **Lack of Support for Caregivers:** Participants providing care for older adults expressed feeling overwhelmed and unsupported. They faced financial strain, emotional stress, and limited access to respite care options. They expressed the need for resources, training, and support systems for caregivers.

These shared challenges highlight the need for a comprehensive and coordinated approach to address the diverse needs of older adults in Maryland. Participants emphasized the importance of creating an age-friendly environment that promotes financial security, accessible transportation, and social connection.

Targeted Population Priorities

The following key themes were identified by each group, which contributed to the overall summary analysis.

OLDER ADULTS LIVING WITH HIV

- **Lack of Affordable and Accessible Housing:** The group emphasized that safe and stable housing is fundamental for overall wellbeing in later life and noted that many struggle to find affordable and secure housing. It was noted that this issue is particularly acute for people living with HIV who may face additional barriers due to stigma and discrimination.
- **Food Insecurity and Limited Access to Healthy Food:** The attendees expressed concern about the prevalence of food deserts in Baltimore, where access to fresh produce and nutritious food is limited, especially for those with mobility issues. Existing food assistance programs were criticized for containing unhealthy, processed foods rather than fresh produce.
- **Financial Instability and Inadequate Income:** The group stressed the challenge of maintaining financial security in later life, particularly for those relying on fixed incomes like Social Security. The rising cost of living, coupled with stagnant incomes, makes it difficult for many older adults to afford basic necessities. The discussion also highlighted the issue of Social Security policies that can result in people owing money at retirement, particularly those who have taken long-term medical leave.
- **Inadequate Transportation Options:** Limited access to reliable and flexible transportation emerged as a significant barrier, with attendees highlighting the inflexibility and inability of existing public transportation systems to meet the needs of older adults with mobility issues. This lack of adequate transportation restricts access to health care, social activities, and essential services, contributing to isolation and lower quality of life.
- **Limited Access to Health care and Preventative Screenings:** The attendees raised concerns about accessing timely and appropriate health care, particularly for those living with HIV and other chronic conditions. Participants pointed to long wait times for specialists, limited insurance coverage, and a lack of comprehensive screenings for age-related health concerns.
- **Social Isolation and Lack of Support:** The discussion revealed that many older adults, especially those living with HIV, experienced social isolation and a lack of adequate support, exacerbated by factors such as transportation limitations, stigma associated with certain health conditions, and a lack of awareness about available support services.
- **Disrespect and Age-Related Bias:** The attendees expressed frustration with feeling overlooked and disrespected by service providers and society at large, highlighting the need for greater sensitivity and awareness of the unique needs and experiences of older adults.

OLDER ADULTS WITH LIMITED ENGLISH PROFICIENCY

- **Language Barriers:** Participants identified limited English proficiency as a major barrier to accessing services, navigating daily life, and integrating into the community. The lack of interpreters in smaller health care settings was a particular concern for the Chinese-speaking group, impacting the quality of care received and leading to fear and uncertainty about seeking medical help. The Spanish-speaking group noted that the reliance of online systems for accessing benefits and services is a challenge for those who lack internet access or digital literacy skills.
- **Access to Health Care:** Participants expressed concerns about accessing timely and affordable health care. They highlighted long wait times to see doctors, especially specialists, with delays sometimes stretching for months. They also noted that their insurance often did not cover desired doctors or clinics, forcing them to switch providers and incur higher costs. The Spanish-speaking group specifically mentioned challenges with finding affordable dental and medical services, even when benefits are available. Additionally, the Spanish-speaking group discussed concerns about the quality and safety of care in rehabilitation facilities, recounting experiences of neglect and inadequate care, including people being left unaided with basic tasks, hygiene issues, and a general lack of concern for the wellbeing of residents.
- **Transportation:** The lack of adequate and accessible transportation was a recurring theme. Participants in both sessions expressed frustration with the limited public transportation options available, particularly the infrequency and inconvenience of routes. The Chinese-speaking group specifically pointed to the lack of a direct bus route to health care services and the Spanish-speaking group desired transportation options not only within the county but also for trips outside the county.
- **Social Isolation:** Both groups emphasized the importance of social connection and the challenges of combating isolation as they age. Limited English proficiency, lack of transportation, and a shortage of accessible gathering places were identified as contributing factors to isolation. The Spanish-speaking group specifically called for more senior centers located closer to their homes.
- **Need for Culturally and Linguistically Appropriate Services:** The discussions in both groups underscored the need for services tailored to the specific cultural and linguistic needs of diverse older adult populations. The Chinese-speaking group highlighted the value of English as a Second Language classes, suggesting that these programs facilitate integration and social connection. The Spanish-speaking group shared an example of a successful program in Montgomery County that brings people together for informal language learning, suggesting a model for fostering cross-cultural understanding and communication.

OLDER ADULTS IN RURAL COMMUNITIES

- **Transportation:** A pervasive challenge highlighted in both counties was the lack of reliable, affordable, and accessible transportation. This issue limits access to health care, social activities, and basic necessities like grocery shopping. Specific concerns included limited public transportation options, cost barriers such as tolls and personal vehicles, and the isolation people feel from being geographically isolated.
- **Health Care Access:** Obtaining timely and affordable health care services was a significant concern for older adults in both counties. The lack of local specialists requires residents to travel long distances for care, often to Easton or Baltimore, creating significant burdens for those with limited mobility or transportation options. Participants reported lengthy delays in securing doctors appointments—particularly specialists—leading to frustration and potential delays in necessary care. The increasing reliance on online platforms for medical appointments, information, and record keeping presents a barrier for older adults who lack computer access, internet skills, or comfort with technology.
- **Cost of Living and Financial Security:** The rising cost of living coupled with fixed incomes creates financial strain for many older adults in both counties. Participants cited rising rents, limited availability of affordable housing options, and long waitlists for senior housing as major challenges, as well the financial burden of essential home repairs and maintenance—particularly for older homes.
- **Social Isolation and Lack of Community Connection:** Participants emphasized the importance of social engagement for maintaining mental and emotional wellbeing, but identified several factors contributing to social isolation. Some areas—particularly in Cecil County—lack sufficient community centers and organized activities tailored to the interests and needs of older adults. A lack of transportation restricts older adults' ability to attend social events, visit friends and family, and engage in community activities. Difficulty with hearing was noted as a factor leading to social withdrawal and isolation.

- **Communication and Access to Information:** Staying informed about available services and navigating complex systems was noted as a challenge. Participants expressed a lack of knowledge about existing programs and services, suggesting a need for better outreach and communication strategies. Participants shared that fragmentation of services across various agencies and organizations can make it challenging for older adults to identify and access the support they need. Reliance on digital communications excludes those without internet access or digital literacy skills, highlighting the need for diverse communication channels.

OLDER ADULTS WHO ARE BLIND OR LOW VISION

- **Digital Access and Technology Proficiency:** Many participants shared that they struggle with digital access and a lack of technological skills needed to navigate online resources and services, creating barriers to information and communication and leading to feelings of discrimination and exclusion.
- **Physical Deterioration and Adjusting to Aging:** Participants experienced physical challenges associated with aging, such as declining health and mobility, and adapting to these changes and maintaining a fulfilling lifestyle has been difficult.
- **Financial Insecurity and Access to Affordable Housing:** Participants expressed concerns about the rising cost of living, inadequate Social Security benefits, and the high cost of care. Finding affordable and suitable housing is a major challenge, especially for those with limited incomes.
- **Lack of Respect and Appreciation for Older Adults:** Participants shared a perceived lack of respect and appreciation for the contributions and experiences of older adults.
- **Inadequate Training and Support for Professionals Working with Older Adults:** There is a need for improved training and support for professionals working with older adults, particularly in providing clear information, demonstrating patience, and offering follow-up assistance.
- **Limited Access to Mental Health and Wellness Support**: Participants reported that older adults may face challenges accessing mental health services and support programs tailored to their needs.
- **Communication Barriers for the Deaf Community:** Participants shared that the deaf community often face communication difficulties in health care settings and other environments. This lack of accessibility can lead to isolation and difficulty receiving necessary services.

Work Group Process and Analysis

Overview

Work Group members were recruited to ensure LRM was informed by those with daily personal and professional experience on the benefits and challenges of aging. Work Groups met during fall of 2024 to review available state plans, data, and resources, and recommend objectives and strategies to be included in the plan. The recommendations were reviewed by MDOA staff for alignment with state capacity, strategic planning, and stakeholder participation, and inclusive of innovative programs and policies that support older adults and longevity.

Work Group Composition

In July of 2024, MDOA invited applications from key community members and stakeholders interested in participating in Work Groups to help inform the LRM plan, and more than 200 applications were received. A three-phase process was employed to select participants:

1. Applicant interest was leveraged through an automated logic process that sorted applicants into categories.
2. Applicant alignment with Work Group objectives was evaluated based on experience, expertise, and recommendations for achieving goals.
3. MDOA conducted a panel review of remaining candidates to ensure geographic, demographic, and sector diversity within Work Groups.

More than 100 participants were selected from all Maryland jurisdictions, and placed within the Work Group that best aligned with their interest and expertise. In accordance with the requirements of the LRM Executive Order, Work Groups included representatives from AAAs, the older adult community, aging networks, organized labor, advocacy organizations, caregivers, the private sector, and aging experts from health care, technology, academia, innovation, and philanthropy disciplines.

Roles

The four Work Groups convened between September 5th and November 15th, 2024. The role of each Work Group was to provide actionable, evidence-informed recommendations for their respective Epic Goal. There were three overlapping roles within each Work Group:

- **Work Group Members:** Work Group members developed recommendations and provided supporting information related to the group's assigned goal and priority areas.
- **Chairs:** One Chair was assigned to each Work Group and served as the lead. They worked with MDOA staff to create an agenda for each meeting, facilitate methods to accomplish goals and priorities, identify action steps that must be completed between meetings to ensure success, and coordinate with Work Group members to complete actions. The Chair also participated in the Stakeholder Advisory Group.
- **Stakeholder Advisory Group (SAG) Members:** The SAG convened four times throughout the Work Group period to ensure progress in developing recommendations. The SAG worked to reduce redundancy, identify and address gaps, and ensure recommendations aligned with Executive Order requirements. SAG members also participated in Work Groups.

In compliance with the Open Meetings Act and to ensure that members of the public could participate, Work Group meetings were livestreamed, recorded, and archived. Streams received over 700 views.

Work Group Recommendations

The following objectives were submitted by Work Groups, along with supporting strategies and information that provided context, data, and available resources:

Build a Longevity Ecosystem

- By 2026, the state will have a comprehensive set of short-, medium-, and long-term strategies that build a robust network of hyperlocal community organizations that support older adults as they age in their community.
- By 2030, strengthen the capacity of local governments, organizations, and leaders to support longevity for all Marylanders by expanding and developing a coordinated system across government agencies and community-based organizations.
- Facilitate relationship building and interaction between people across the lifespan.
- By 2034, the age-friendly communities, models, and practices, will be adopted statewide.

Promote Economic Opportunity for All

- Strengthen Maryland's commitment to unpaid caregivers by developing a person-centered approach to caregiving support that spans statewide and regional resources. This unique structure bolsters the resilience and dedication of all Maryland caregivers, ensuring they have the resources needed to sustain their critical role across the lifespan.
- Enhance wages and overall compensation of the direct care workforce to boost recruitment and retention rates using a matched, calculated living wage, benefiting the health care worker, industry, and economy.
- Increase the number of employers operating in Maryland that promote sustainable career opportunities across generations using age-inclusive policies and practices.
- Improve employment outcomes for workers who are 50+ by increasing access to multigenerational workforce support services and programs.

Prepare Marylanders to Afford Longevity

- By 2035, increase by 15% the number of older adults served by public/private partnerships and affordable housing programs, which include but are not limited to programs that create or preserve rental housing units, modify existing housing units, provide housing stability, and address systemic barriers impacting housing equity and the transfer of generational wealth.
- Decrease the hospitalization rate by 20 points from 81 per 100,000 to 60 per 100,000 people over ten years.

- Increase the average income for people over 50 by 10% over the next ten years and raise retirement saving program participation by 25%.
- Enhance access to long-term services and supports by 2035 through a multifaceted approach.

Optimize Health, Wellness, and Mobility

- By 2035, older adults and care partners will have access to comprehensive, trauma-informed, culturally appropriate, effective, and high quality services and supports. These services and supports will address a full range of holistic (physical, behavioral, emotional, and cognitive) needs via a single point of entry to an interdisciplinary, multi-agency system capable of coordinating and meeting diverse preferences for care and addressing social determinants of health with the goal of enhancing brain and physical health.
- By 2035, older adults will be empowered to access services, supports, and programs following Maryland's Person-Centered Planning guidelines in order to optimize healthy aging, independence, inclusivity, individual goals, preferences, and preferred living environment.
- By 2035, MDOA will implement effective strategies to benefit all of us as we age, including improved social infrastructure and developing state guidelines for social connection that align with the National Strategy for Social Connections to improve physical, cognitive, and emotional health as we grow older, working across nonprofit, government, nongovernmental agencies, and people at the state and local level.
- By 2035, increase investment in transportation services that promote safety, accessibility, age-friendly design, and walkability through funding, technical assistance to local communities, and the coordination of state resources and programs.

Analysis and Modification

LRM Work Groups produced 121 strategies across 16 objectives. MDOA reviewed the recommendations and used the following perspectives to inform adaptations.

Overlaps and Alignment

MDOA identified areas where the recommendations across Work Groups overlapped or aligned and modified other objectives and strategies. The following overlapping themes were identified and adaptions made to consolidate content:

- Collaboration and Partnership
- Funding and Resource Allocation
- Education and Awareness
- Technology and Innovation
- Equity and Inclusion

Informed by Available Data

Recommendations were reviewed in light of available data. If the recommendations did not cite specific and relevant data, they were flagged for review. Ultimately, MDOA determined that there was not sufficient data analysis available to retain specific and measurable language within the recommendations. The objectives and strategies were reframed to lay out the vision of the plan, with the opportunity to identify meaningful data sources and develop relevant measures and indicators during the next phases of implementation and planning.

Alignment with State Agency Plans

The recommendations were reviewed for alignment with state agency strategic plans, reports, and programs. MDOA staff cross-referenced each recommendation with relevant state agency strategic plans and data sources and adapted recommendations for alignment to ensure the plan was realistic and actionable based on the work and capacity of state agencies. This involved removing items that were identified as outside the scope or capacity of an agency and aligning the language within the agency's framework.

Alignment with Additional Stakeholder Engagement

The recommendations were reviewed for alignment with the findings from previous stakeholder engagement and analysis, and relevant contributions were incorporated from key state and local partners and community members.

Incorporating Best Practices and Emerging Knowledge

MDOA incorporated best practices, promising models, and emerging opportunities that we encounter daily with national, state, and local experts in aging services and longevity planning.

Conclusion

LRM Work Groups served as an integral part of the planning process, ensuring that LRM is grounded in the expertise, experience, and resources of Maryland stakeholders. Several actionable recommendations will ensure future Work Groups represent diverse backgrounds and expertise within the state and are well-positioned for success. As part of the implementation process, the Stakeholder Advisory Group processes and composition will be reviewed and relaunched so LRM continues to be guided by the contributions of inclusive communities.

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