



Updated January 23, 2019

Older Americans Act: Nutrition Services Program

Introduction

The Nutrition Services Program, authorized under Title III of the Older Americans Act (OAA), provides grants to states and U.S. territories to support nutrition services programs for seniors. As stipulated in the law, the purposes of the program are to (1) reduce hunger and food insecurity, (2) promote the socialization of older individuals, and (3) promote the health and well-being of older individuals by assisting them to access nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutrition or sedentary behavior. According to the U.S. Department of Agriculture (USDA), 7.9% of U.S. households with an elderly member were food insecure in 2017, which means they lacked the ability to purchase or otherwise acquire enough to eat. Households in which elderly lived alone reported a higher rate of food insecurity, at 8.6%. As the largest OAA program, the Title III Nutrition Services Program received \$907 million in FY2019, accounting for 44% of the act's total funding (\$2.1 billion). The Older Americans Act Reauthorization Act of 2016 (P.L. 114-144) extended authorized appropriations through FY2019.

Administration

The Administration on Aging (AOA) in the Administration for Community Living (ACL) within the Department of Health and Human Services (HHS) administers the Nutrition Services Program, which includes

- the Congregate Nutrition Services Program,
- the Home-Delivered Nutrition Services Program, and
- Nutrition Services Incentive Program.

States that implement these programs must target nutrition services to older persons with the greatest social and economic need, with particular attention to people with low-incomes, including low-income minorities, people with limited English proficiency, people residing in rural areas, and those at risk for institutionalization. Means tests for program participation are prohibited, but older persons are encouraged to contribute to the costs of nutrition services. Older individuals may not be denied services for failure to contribute.

Congregate Nutrition Services

Congregate nutrition services provide meals and related nutrition services to older individuals in a variety of group settings, such as senior centers, community centers, schools, and adult day care centers. The program also provides seniors with opportunities for social engagement and volunteering. Individuals aged 60 or older and their spouses (regardless of age) may participate in the congregate nutrition program. The following groups may also receive meals: persons under age 60 with disabilities who reside in housing facilities occupied primarily by the elderly, where congregate meals are served; persons with disabilities who reside with, and accompany, older persons

to meals in congregate settings; and volunteers who provide services during the meal hours. In FY2016, a total of 79.2 million congregate meals were served to nearly 1.6 million meal participants.

Home-Delivered Nutrition Services

Home-delivered nutrition services (commonly referred to as “meals on wheels”) provide meals and related nutrition services to older individuals, with priority given to homebound older individuals. According to AOA, “home-delivered meals are often the first in-home service that an older adult receives, and the program is a primary access point for other home and community-based services.” Home-delivered meals can be an important service for many family caregivers in assisting them with their caregiving responsibilities as well as helping maintain their own health and personal well-being. Individuals aged 60 or older and their spouses (regardless of age) may participate in the home-delivered nutrition program. Services may be available to individuals under age 60 with disabilities if they reside at home with the older individual. In FY2016, a total of 145.2 million home-delivered meals were provided to over 867,000 meal participants.

Nutrition Services Incentive Program (NSIP)

NSIP provides funds to states, U.S. territories, and Indian tribal organizations to purchase food or to cover the costs of food commodities provided by the USDA for the congregate and home-delivered nutrition programs. NSIP was originally established by the OAA in 1974 as the Nutrition Program for the Elderly and administered by USDA. In 2003, Congress transferred the administration of NSIP from USDA to AOA. However, states and other entities may continue to receive all or part of their NSIP grants in the form of USDA commodities. Obligations for commodity procurement for NSIP are funded under an agreement between USDA and HHS.

Funding

The AOA awards separate grants to states and U.S. territories for the congregate nutrition services program and home-delivered nutrition services program. State Units on Aging (SUAs) administer the program at the state level, and in turn, award those funds to over 600 Area Agencies on Aging (AAAs), which oversee the program in their respective planning and service areas. The AOA also awards a separate grant to states, U.S. territories, and tribal organizations for NSIP.

Grants for congregate and home-delivered nutrition services are awarded to states and U.S. territories based on a statutory formula that takes into account each entity's relative share of the population aged 60 and over. States are required to provide a matching share of 15% in order to receive these funds. NSIP grants are awarded to states and

other entities based on each entity's share of total meals served by the nutrition services program (both congregate and home-delivered meals) in all states, U.S. territories, and tribes during the prior year. There is no matching requirement for NSIP grant awards. In FY2019, of the \$907 million appropriated for the Nutrition Services Program, \$495 million is for congregate nutrition (55%), \$251 million for home-delivered nutrition (28%), and \$160 million for NSIP (18%).

Service Delivery

Nutrition services providers are required to offer at least one meal per day, five or more days per week (except in rural areas, where provision can be less frequent). The meals must comply with the Dietary Guidelines for Americans published by the Secretary of HHS and the Secretary of Agriculture. Providers must serve meals that meet certain dietary requirements based on the number of meals served by the project each day. Providers that serve one meal per day must provide to each participant a minimum of one-third of the daily recommended dietary reference intakes (DRIs) established by the Food and Nutrition Board of the National Academy of Sciences. Providers that serve two meals per day must provide a minimum of two-thirds of the DRIs, and those that serve three meals per day must provide 100% of the DRIs. Providers must comply with state or local laws regarding safe and sanitary handling of food, equipment, and supplies used to store, prepare, and deliver meals, and providers must carry out meal programs using the expertise of dietitians and meal participants.

Nutrition service providers may offer nutrition-related services, such as nutrition education and screening, nutrition assessment, and counseling, as appropriate. Providers are encouraged to make arrangements with schools and other facilities serving meals to children to promote intergenerational meals programs. Where feasible, states must ensure that nutrition programs encourage the use of locally grown foods in meals programs and identify potential partnerships and contracts with local producers and providers of locally grown foods.

Program Participation

A national survey of OAA participants shows that in 2017, 48% of congregate nutrition survey respondents were aged 75 and older; 47% lived alone; 11% had annual income of \$10,000 or less; and 51% reported that the congregate meals program provided one-half or more of their daily food intake. Furthermore, many congregate nutrition participants reported these meals have fostered greater socialization, with 83% saying that they saw friends more often due to meals. The same survey found that 62% of home-delivered respondents were aged 75 and older; 58% lived alone; 23% had annual income of \$10,000 or less; and 57% said that the home-delivered meals program provided at least one-half of their daily food intake. According to the survey, home-delivered meals participants tend to be particularly frail and at risk for institutionalization, in part due to the requirement that participants be homebound. Almost 4 out of 10 recipients (39%) reported needing assistance with one or more activities of daily living

(ADLs, such as bathing, dressing, eating, and using the toilet); 14% of these recipients needed assistance with three or more ADLs. In addition, 84% reported needing assistance with one or more instrumental activities of daily living (IADLs, such as shopping, housework, and getting around inside the home).

Program Evaluation

ACL conducted a three-part evaluation of the Nutrition Services Program: a process study, cost study, and outcome evaluation. Results from these studies were compared to the last national evaluation of the nutrition program completed in 1995, where applicable. The process study collected data from SUAs, AAAs, and local service providers (LSPs) to assess program administration and service delivery. It found that more LSPs offer home-delivered meals compared to 1995, while somewhat fewer LSPs offer congregate meals (95% to 93%). However, more congregate meals programs offer breakfast and dinner (in addition to lunch, which all sites offer) and weekend meals. Programs also offer more options for "modified" meals, which are lower in fat, sodium, or calories. More LSPs report waiting lists for home-delivered meals, but waiting lists have fewer people, on average, than in 1995.

The meal cost study estimated the average costs of meals provided and examined cost variation. The report found that, on average, home-delivered meals cost more to provide than congregate meals (\$11.06 vs. \$10.69), including costs of both purchased and donated resources. This finding was consistent with the 1995 evaluation. However, costs vary by program size, geographic region, and urban, suburban, and rural or frontier areas. Researchers found that average meal costs outpaced inflation, which they attributed to food costs increasing at a faster rate than inflation between 1995 and 2015.

The outcome evaluation assessed program effectiveness (e.g., nutrient adequacy, health outcomes). Findings show that most participants had household incomes below 100% of the federal poverty level. Compared to congregate meal participants, a larger proportion of home-delivered meal participants reported being in fair or poor health, being underweight, having difficulty eating due to dental issues, and taking multiple medications. Overall, the study found a positive effect on diet quality and prevalence of adequate nutrition intake and that the majority of participants had positive impressions of these programs. With respect to health outcomes, 75% of participants had at least one chronic condition. Home-delivered meal participants were more likely to experience a health event (e.g., primary care visit, hospital admission, emergency room visit, home health episode) compared to congregate meal participants. Compared to nonparticipant comparison groups, congregate meal participants were less likely to experience certain health events and home-delivered meal participants were more likely to experience such events, likely underscoring the vulnerability of these participants.

Kirsten J. Colello, Specialist in Health and Aging Policy

IF10633

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.