THE OLDER AMERICANS ACT AND SUPPORT FOR OLDER ADULTS LIVING WITH HIV: CHALLENGE AND OPPORTUNITY

The Center 4 Healthy Living with HIV White Paper Series for the Gilead HIV Age Positively Initiative

American Society on Aging

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EXECUTIVE SUMMARY

This paper reviews the challenges created by changes in federal funding and policies around aging, support for people living with HIV (PLWH), and the social stigma that continues to surround HIV. The paper highlights opportunities for advocacy that exist currently at both state and federal levels. State plans on aging and the local Area Agencies on Aging (AAAs) supported under the Older Americans Act (OAA) have become permanent features of the landscape at the state and local levels, and they provide advocates with multiple opportunities to shape policies that address the concerns of aging PLWH.

Opportunities and Strategies for Advocacy. The paper includes Appendices that are detachable, stand-alone pieces that provide advocates with summaries of resources, opportunities, and strategies for advocacy. State-by-state reviews of State Plans on Aging (Appendices A and B) and Multi-Sector Plans for Aging (Appendices C and D) explore opportunities for advocacy in HIV and aging, as well as a set of strategies available to advocates and organizers. A close look at the field surfaces multiple opportunities for advocacy around HIV and PLWH who are aging. This includes not only thinking about the RWHAP and other resources specific to HIV but also planning and resources for aging in general in all states and localities. The ultimate goal of advocacy for PLWH in the sectors affected by aging policy in general is to integrate PLWH and their concerns into the provisions of the OAA (or its successor), reduce stigma, and normalize growing older with HIV in conversations about aging in America. The struggles of the last 40 years in AIDS and HIV activism have extended life expectancies and reduced the impact of HIV on daily life. As PLWH now look to stable health as they grow older, a new era in HIV policy is emerging around the inclusion of HIV and aging with HIV within the community of older adults.

Threats at the Federal Level. The year 2026 will be an inflection point for older adults who are living with HIV. The Older Americans Act (OAA) came up for re-authorization in 2024, but it lapsed at year's end without new legislation to extend or re-authorize it. Despite the introduction of the OAA for re-authorization in the Senate in 2025, the OAA is under threat from multiple sources. Budget cuts and staff eliminations under the Department of Government Efficiency (DOGE) began the process of winding down the OAA's infrastructure and the programs it supported. The One Big Beautiful Bill Act (OBBBA) will eliminate health care funding throughout the country, defund many social services, and reduce the capacity of the federal government to provide support for the health of Americans of all ages.

Opportunities around State and Multi-Sector Plans on Aging. While federal funding is under threat, we turn to State and Multi-Sector Plans on Aging to explore opportunities for advocacy and change that exist at local and state levels around the country. Appendices A and B review 50 state plans on aging and the plan for the District of Columbia to identify points at which they mention HIV or PLWH, and Appendix A collates the language around HIV in the plans. The state plans were also explored for their references to specific policies for housing, care coordination, mental and behavioral health, and chronic medical conditions. These areas for advocacy, even if HIV or aging with HIV is not specifically mentioned in the plan, are opportunities for advocacy around aging with HIV in so far as PLWH and HIV-negative persons share these issues as they age. Tables A1 and A2, which review the plans, provide live links to the state plans for easy access. Appendix C provides similar information for Multi-sector Plans on Aging (MPAs) that exist in 15 states currently. Appendices B and D provide profiles of main goals or features of selected state and multi-sector plans to provide readers with the ability to compare details of sample plans and consider how their concerns might be accommodated in their own state. By comparing, translating, and replicating programs from states and jurisdictions with inclusive approaches to aging with HIV, advocates can extend and level, or at least mitigate, the differences in HIV and aging policy around the country,

Strategies and Tools to Navigate Legislative Uncertainty. Appendix E provides a table of organizations that have recently released papers, toolkits or other resources that can help to guide advocates in addressing the challenges identified in this paper. Finally, Appendix F is a stand-alone review of mechanisms and strategies to navigate advocacy in an environment of legislative uncertainty and shrinking resources. With these tips and strategies, advocates can use this paper to explore plans of action and build strategies to enhance services and alternatives for older PLWH around the country.

INTRODUCTION: THE SOCIAL AND POLICY CLIMATE AROUND AGING WITH HIV IN 2026

The year 2026 will be an inflection point for older adults who are living with HIV. This is the result of the convergence of three things:

- Matters of policy or legislation surrounding the Older Americans Act (OAA), budget cuts across several areas of social and health policy, including the Ryan White program, and uncertainty around future legislation;
- The changing epidemiology of HIV/AIDS and resultant aging of the population of persons living with HIV (PLWH); and
- The overwhelmingly persistent stigma around HIV.

Legislative and Funding Issues

The legislative apparatus that provides funding and administrative support for older adults, both those living with HIV and those who are HIV-negative, has been diminished and threatened by budget cutting and legislative stalemate. This wide-ranging attack includes the OAA, the Ryan White HIV/AIDS Program (RWHAP), the Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau (HAB), and other health policy and programming threatened by the reorganization of the former Department of Health and Human Services (DHHS) into the new Administration for a Healthy America (AHA).

The Older Americans Act (OAA). The OAA was part of the Great Society legislation that addressed poverty and well-being across the life cycle in the mid-1960s. In 2024, as the OAA neared its 60th anniversary as the landmark commitment of the Federal government to older adults, it came up for re-authorization in Congress. At that time, however, the Republican-led Congress was unable to move forward with re-authorization, without which the OAA lapsed. As of December 2025, re-authorization has been advanced in the Senate by Bill Cassidy (R-LA) and Bernie Sanders (I-VT), but any Senate re-authorization will still require passage by the House of Representatives and could result in further stalling of re-authorization or the elimination of the OAA if the obstacles to re-authorization cannot be overcome.

The uncertainty around the OAA threatens funding streams supporting local programming for older adults in communities small and large across the country. For 2025 and 2026, the programs supported by the OAA are being preserved at current levels of funding by "continuing resolution" (CR), which is a mechanism that temporarily extends funding for federal programs based on the previously passed budget. CRs are used by Congress and the White House to exit budget impasses and extend the time for budget deliberations without causing extensive harm to existing programs. Under the CR, programs may continue, but nothing is guaranteed. Without a re-authorized OAA, the federal government's commitment to older adults will pass wholly to the states.

DOGE and the One Big Beautiful Bill. At the same time as the OAA has languished in re-authorization limbo, other programs impacting older adults and our system of health care are being undermined by chaotic attempts at budget cutting that are abrupt and based on manufactured, pretextual arguments divorced from the empirical reality of these programs' costs and benefits to the public. This includes the elimination of programs considered unduly contaminated by "woke" values, the reorganization of the DHHS, and the medical and scientific misinformation driving the debate in Congress and the White House in 2025. Budget cuts and staff eliminations under the Department of Government Efficiency (DOGE) began the process of winding down the infrastructure and programs supported by the OAA. The One Big Beautiful Bill Act (OBBBA), passed in 2025 as the administration's landmark tax-cutting and funding legislation, further reduces health care funding throughout the country, defunds many social services, and reduces the capacity of the federal government to provide support to persons of all ages. "Reduction-in-force" actions by the federal government have resulted in the layoff of approximately 25% of the DHHS workforce.[1] The layoffs are not spread evenly through the DHHS, and the Administration for Community Living (ACL), which administers much of the programming provided under the OAA, saw its workforce reduced by 40%.[2]

HIV funding across departments and agencies. Finally, the RWHAP and other HIV-related funding have not been spared. The current FY2026 funding proposed in the House of Representatives will slash approximately $2 billion in federal HIV funding. This includes ending many specially-targeted programs in Parts C, D and F of the RWHAP and Minority AIDS Initiative funding.[3] The cuts in Parts C and D include funding for early intervention services, capacity building, and programs for women, children, and youth. Part F cuts include diverse mechanisms supporting the programs in Ryan White Parts A, B, C and D:

- AIDS Education Training Centers (AETCs), which provide capacity-building and technical assistance to RWHAP-funded HIV clinics
- Special Projects of National Significance (SPNS), which are pilot projects that the RWHAP uses to develop new interventions, models of care, and/or approaches to clinical care in specific communities at high risk for HIV
- Minority AIDS Initiative (MAI), which is a special fund that enhances services across the Ryan White portfolio targeted specifically for HIV/AIDS treatment and care with racial and ethnic minority adults, children, and youth

Remaining funds in the RWHAP would be for Parts A and B, which are bloc grants to metropolitan and local jurisdictions (Part A) and states (Part B) that are heavily impacted by the epidemic.

Other HIV-related cuts include 230 HIV-specific NIH (National Institutes of Health) grants and funds for the Ending the HIV Epidemic (EHE) initiative, which has provided hundreds of millions of dollars in funding associated with a 12% decrease in the incidence of new HIV infections between 2018 and 2022. The EHE initiative will be decimated, leading to a reversal of gains under the initiative.[4]

The aging of the epidemic

Prior to 2025, the RWHAP represented a 30-plus year commitment by the Federal government to limiting and eventually eliminating HIV/AIDS. Federal and local programming for health education and prevention around HIV risk, along with advances in the medical treatment of HIV, have lowered the rate of new infections while extending the life expectancy of PLWH to nearly that of the overall population. Antiretroviral treatments turn out to be extremely effective at both halting damage to the immune system and preventing the spread of the virus through new infections. This dual shift—fewer people acquiring HIV each year and the extension of life expectancy for PLWH—has pushed up the average age of PLWH to the point at which 53% of PLWH in 2023 were over 50 years of age.[5]

The Continuing Impact of HIV Stigma

Stigma surrounding HIV, AIDS, and PLWH continues to be a major factor disrupting the availability and effectiveness of treatment. Stigma spoils and diminishes the clinical experience of PLWH and others at risk for acquiring HIV, fueling medical mistrust and depression.[6] Stigma against PLWH was a major reason for the lack of action by the government in the 1980s, when President Reagan refused to acknowledge the AIDS epidemic. The passage of the Ryan White CARE Act in 1990 brought considerable resources to the struggle against HIV/AIDS, but by this time the virus had a decade-plus "head start" in the population. Those already affected by the epidemic became impoverished and isolated as death and disease came to define the national experience of the epidemic in the 1980s and early 1990s. Nobody spoke of "aging with HIV" because nobody could imagine living more than a few years with the virus.[7]

Internalized HIV stigma has been a major factor preventing persons at risk for HIV from learning about the virus and how it spreads.[8] Internalized stigma breeds fear and resignation. It contributes to an avoidance of testing, which increases the transmission of the virus to others and is associated with lower levels of medication adherence for many who are in treatment.[9] HIV stigma is a world-wide phenomenon, not limited to the United States. Stigma affects all PLWH regardless of race, ethnicity, sexual orientation, and gender identity. In African American communities, which have the highest levels of HIV incidence in the country, stigma fuels high levels of medical mistrust and the avoidance of medical care among those with HIV, regardless of gender.[10,11] While stigma has been on the decline over the last 20 years, it remains a major impediment to reaching the critical mass of individuals who are not in treatment and who are not adherent to HIV medications.[12]

In the context of aging with HIV, stigma may be the most impactful factor standing in the way of creating, preserving or enhancing programs for older PLWH and/or including PLWH in programming for older adults. It is stigma that makes it imperative that we seek strategies to enhance care and support for older PLWH, both as PLWH with the specific challenges that come with HIV and also as older adults who face many of the same challenges and issues their HIV-negative counterparts. It is stigma that mandates the dual strategy of carving out support for the issues related to HIV as part of state response to the OAA and the agendas of local Area Agencies on Aging (AAAs, or "triple-As") at the same time as we advocate for the continuation and restoration of specific funding and programs for HIV care and PLWH of all ages.

Challenge and Opportunity in 2026 and Beyond

The elections of 2026 and 2028 have great potential to impact the future of funding and services for older community members. For the OAA, outcomes range from renewed support for re-authorizing or expanding the OAA, to its reduction or elimination entirely. In turn, local programming to address the needs of older persons must be secured at the state level and, with fewer federal resources available, local programs are likely to suffer even in places with local legislatures that favor programs supporting aging and older community members. For older PLWH, the stakes are even higher, since reduced funding for OAA-sponsored programs is being implemented at the same time as funding is being reduced for the RWHAP. At this intersection of aging and HIV, PLWH have an opportunity to achieve recognition among the communities of older adults by advocating for the inclusion of HIV in plans that address chronic conditions and care coordination in general. This outcome is not guaranteed, but it is possible and not out-of-place in the against-all-odds story of HIV legislation and programming in the first place—evolving from the resistance of the ACT-UP movement into the Ryan White CARE Act and historically bipartisan support for PLWH.

This paper examines that opportunity. There will be legislation to support older adults, whether in a new bill or in the re-authorization of past legislation. Programming will continue, be resumed, or start anew in communities around the country. Older PLWH and advocates will need to join new coalitions and cross-sectoral communities in order to unite the concerns of those living with HIV with other concerns and issues common to aging Americans. Overall, the goal is to have programming that benefits PLWH outlined within support for older adults generally (as in care coordination for chronic conditions), as well as on its own terms.

The central challenge at the intersection of HIV care for older PLWH and the OAA is to define which elements of care for older PLWH can be accommodated within care for the aging population generally and which will require special focus, whether it is through enhancing RWHAP or other legislation. Our essay and the appendices that review policy state-by-state will surface the state-level differences in planning and approaches to HIV and aging, with some state providing models for others. Recognizing the key differences per state will help readers enhance their knowledge and understanding of the challenges and opportunities and provide specific targets for action in communities around the country.

METHODOLOGY

This paper was researched with available public data, reports, gray literature, research and scholarly literature as of January 2026. It was supported with funding by Gilead's HIV Age Positively Initiative and the Ribbon Center for Excellence in Aging and HIV, with writing and research from the staff at TRX Development Solutions. The opinions and assertions are those of its authors alone, and any errors or mis-statements are the responsibility of TRX staff and not attributable to Ribbon or Gilead.

The literature review went back to 2008, to establish a picture of HIV and aging just as scholars and advocates began to consider aging in light of evidence of longer life expectancies for PLWH in regular treatment. Epidemiological study of the changes in incidence and prevalence over time helps to establish the magnitude of change for aging with HIV. Data searches included decades worth of funding under OAA and the EHE nitiative to analyze their impact over time. We examined all 50 current state plans for aging and the plan for the District of Columbia for language inclusive of PLWH and the concerns of aging with HIV (Appendix A). The same analysis was performed for the 15 multi-sector plans (MPAs) that have been developed from 2020 through 2024 (Appendix C). The analysis also included how other programming under the OAA might provide important benefits for older PLWH. Almost half (22) of the state plans created under the OAA from 2020 through 2024 include references to HIV, PLWH, and HIV services among programs and alternatives for older persons. Two of the 15 multi-sector plans bring HIV into the planning (New York and Maryland). Massachusetts does not bring HIV into its multi-sector planning, but it includes LGBTQIA+ services and health and disease promotion.

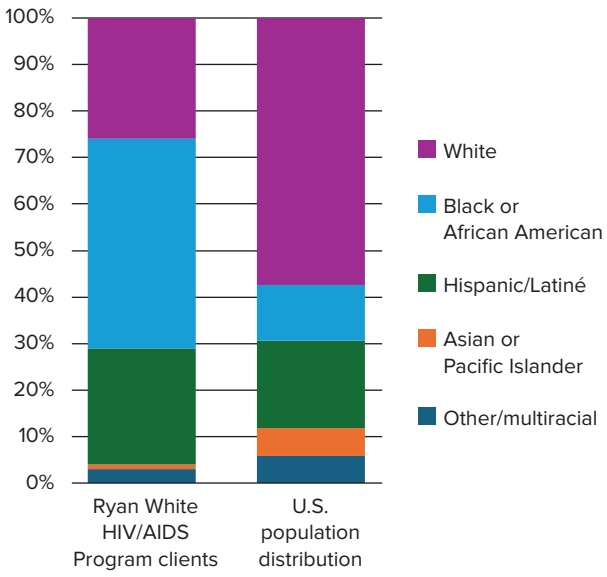
HIV AND AGING: POLICY AND MEDICAL ADVANCES

For the first 20 years of the HIV epidemic, "aging" was not a large part of the conversation around living with HIV, whether in worlds of policy or everyday life. As noted earlier, the story of HIV policy development was not a straight path. It involved years of assertive, public activism and cycles of societal interest and indifference that gradually gave way to widespread agreement on pursuing a coordinated strategy to end the epidemic—a strategy based on science and driven by population health strategy.

The Ryan White CARE Act of 1990

In the immediate years after an unknown syndrome of symptoms appeared in the early 1980s among gay men, Haitian communities, injection drug users, and persons living with hemophilia, the focus was on identifying the source of such deadly immune system collapse.[13] By 1985, researchers identified the Human Immunodeficiency Virus (HIV) as the source of Acquired Immune Deficiency Syndrome (AIDS). With the virus causing AIDS now known, the search for methods to cure, or at least contain, the virus began in earnest.

Figure 1. Ryan White HIV/AIDS Program (RWHAP) Clients & U.S. Population, by Race and Ethnicity



Source: US Population Data; KFF, State Health Facts; and HRSA, Ryan White HIV/AIDS Program Annual Client-level Data Report, 2022.

In the general public, however, the association of HIV/AIDS with socially marginalized populations, along with its apparently incurable and lethal status for most people who acquired HIV, resulted in silence around HIV and AIDS throughout the 1980s. The national mobilization of the ACT-UP movement, along with a growing number of HIV-related deaths among well-known public figures, challenged lawmakers to action and resulted in great pressure on the federal government to do something about HIV. As a result, in 1990 the Ryan White Comprehensive AIDS Resources Emergency Act (Ryan White CARE Act) was signed into law by President Bush, establishing the RWHAP to provide prevention materials, medical care, and other supportive services for PLWH. Over the next 35 years, the RWHAP grew to support over half a million low-income PLWH, 75% of whom are Black (45%), Latiné (25%), or members of other non-white communities (4%), compared to the distribution in the general population, which is 58% white, 12% Black, 19% Latiné, 6% Asian or Pacific Islander, and 6% multiracial or another identity (Figure 1).

Beyond clinical services, the RWHAP grew to include a program to evaluate pilot initiatives for HIV services ("Special Projects of National Significance," SPNS), support for dental health, AIDS education and training programs, and, in 2003, the "President's Emergency Plan for AIDS Relief" (PEPFAR). While the RWHAP had been established initially to support persons impacted by the epidemic in the United States, PEPFAR was targeted abroad to provide treatment support in countries that did not have adequate resources to reduce or treat HIV on their own. In the ensuing years, PEPFAR became the largest commitment by any country to HIV/AIDS care, with 21 million people in over 50 countries benefitting from life-saving antiretroviral treatment supported by PEPFAR, while another 84 million have been provided with testing services.[14] In addition, researchers have documented "spinoff" effects of PEPFAR "including significant reductions in all-cause mortality, increases in childhood immunizations and in GDP growth, and retention of children in school.[15]

Advances in Medication and Gains in Life Expectancy

From 1995 on, researchers began to document increasing evidence supporting the effectiveness of antiretroviral treatment, while the medications themselves became easier to tolerate with fewer and less severe side effects.[16] In 2006, the AIDS Community Research Initiative of America (ACRIA) published the first results from a study based on interviews with 914 PLWH over 50 years of age in New York City, which became one of the first glimpses of HIV among older persons.[17] In 2008, *The Lancet*, Britain's leading scientific medical journal, published a paper by a consortium of researchers examining life-span outcomes across 14 countries that showed life expectancy extending into the early 70s for PLWH who adhered to antiretroviral treatment, with the earlier start of treatment yielding the longest life expectancy.[18] In 2010, GMHC released one of the first publicly available, comprehensive reviews of the aging with HIV, bringing together science, policy, and advocacy around aging with HIV.[19] Between 2018 and 2022 incidence of new cases of HIV declined by 12% as life expectancy increased. With the dual forces of declining incidence and increasing life expectancy, the average age of PLWH began to increase, and by 2023, over 53% of PLWH were over 50.[20]

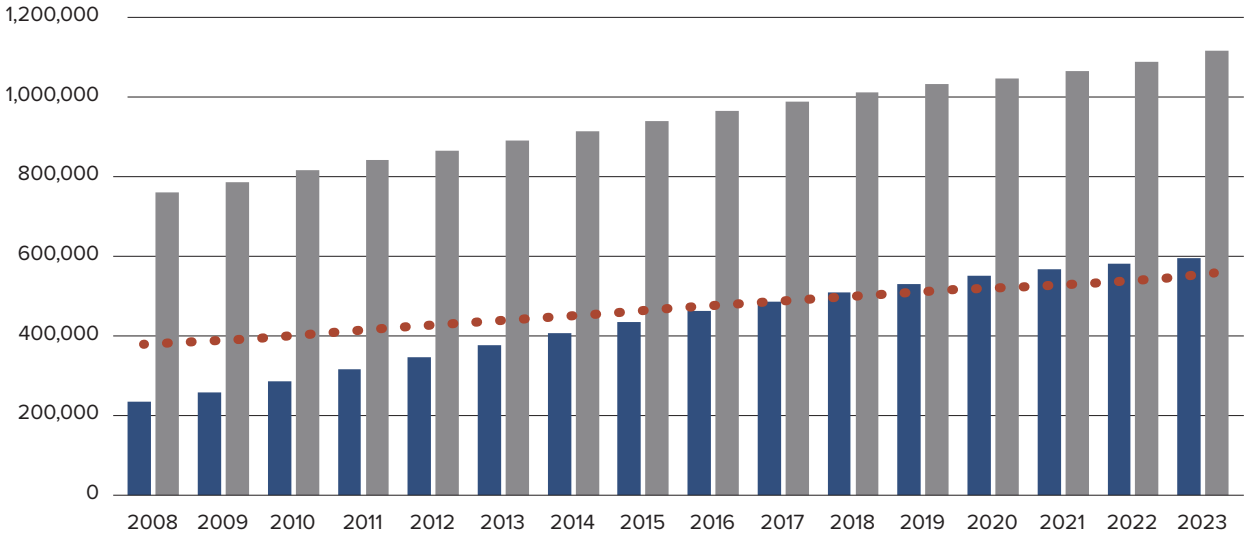
THE "GRAYING" OF THE EPIDEMIC THROUGH TREATMENT AS PREVENTION

PLWH are a rapidly "graying" population. From approximately 30% in 2008, the percentage of PLWH grew to over 53% in 2023 (Figure 2).[21] Treatment itself has become prevention, contributing to further reductions in incidence as life expectancy increased overall prevalence. In the 2010s, research showed that PLWH who adhered to antiretroviral treatment could achieve viral loads so low that they were "undetectable" in HIV tests. Formally, the standard for an "undetectable" viral load is less than 200 copies of the virus in a milliliter of blood, but treatment adherence can drive viral load to 50 copies per milliliter or even lower. Once a person's viral load is undetectable, they can no longer transmit the virus to others, even during unprotected sex. Health promotion and HIV prevention campaigns are now built on the slogan, "U=U," meaning "undetectable equals untransmittable." Thus, HIV treatment not only extends the lives of PLWH, but it also helps to prevent transmission and reduce the rate of new cases (incidence), forming part of the biomedical prevention toolkit along with Pre- and Post-Exposure Prophylaxis (PrEP and PEP).

Shared Conditions and Circumstances

While older PLWH face many of the same concerns as persons who are HIV-negative as they age, PLWH also contend with unique challenges and hardships that require higher levels of coordination and care management. HIV may be highly contained and controlled by medication, but changes in medications and treatment practices, as well as lapses in medication adherence can have severe consequences if they go unchecked. At the same time, older PLWH who are undetectable and have relatively healthy immune systems due to their ARV adherence also face the same issues affecting the general population. Shared conditions, regardless of HIV status, may include changes in physical activity and/or cognitive functioning, managing multiple chronic conditions, and expected life cycle transitions such as menopause. For PLWH, these common concerns can be enhanced by HIV comorbidity, often commencing at an earlier age and progressing more rapidly than among HIV-negative individuals. At the same time, PLWH also

Figure 2. HIV Prevalence Nationally (2010-2023), CDC



Source: CDC, HIV Surveillance Report, 2008-2024.

face potential long-term impacts of HIV, possible side effects of ART treatment, and interactions among multiple medical treatments. Older PLWH who use various medications to address multiple conditions at the same time — sometimes called "polypharmacy" — can show increased risk of adverse drug events/interactions, potential falls, and cognitive impairment.[22]

In what follows, we discuss some of the more common conditions affecting older adults — menopause, cardiovascular disease, cancer, and mental health. Menopause is a life cycle condition that begins as the menstrual cycle ends for individuals with a uterus and ovaries, usually occurring among persons in their 50s, though it can begin earlier for some. Among older adults, heart disease and cancer are the top two causes of mortality.[23] Mental health diagnoses have been increasing dramatically among older persons, with an increase of 57% among persons 65 and older and 36% among those 51 to 64 during the period from 2019 to 2023.[24] A brief exploration of these conditions is instructive for understanding the specific needs and shared overlaps in care practice for PLWH and others.

Menopause. Menopause is a significant life cycle event for half of the population that signals the end of fertility and ovulation, It is often accompanied by symptoms such as sleep disturbances, mood changes, accelerated bone density loss, and vasomotor instability — the widening and narrowing of blood vessels — which leads to hot flashes and night sweats, For women living with HIV, medical comorbidities often intersect with age-related life course changes such as menopause, which can influence cardiovascular risk, bone health, and mental well-being. This may further complicate clinical assessment and care management for women aging with HIV. Evidence indicates that women living with HIV commonly experience bothersome vasomotor symptoms and may enter menopause at earlier ages, both of which can negatively affect quality of life and broader systemic health.[25] Experiences of menopause among women living with HIV are further shaped by stigma, including HIV-related stigma, gender-based stigma, ageism, and, for many, intersecting racial and socioeconomic discrimination. Stigma has been shown to negatively affect engagement in care, patient–provider communication, and trust in health systems, contributing to under-recognition and under-treatment of menopausal symptoms.[26, 27]

Women living with HIV who exhibit symptoms such as vasomotor instability or early onset of menopause may not be offered the same therapy as their HIV-negative counterparts. This gap in care occurs within a broader context in which HIV suppression and access to comprehensive health services vary substantially by region and race, reflecting differences in access to care, social and economic conditions, and the distribution of public health resources.[28] In addition, women living with HIV face multiple risks to bone health and may benefit from the bone-strengthening effects of Menopausal Hormone Therapy (MHT) when prescribed in an appropriate, clinical context. Taken together, these factors underscore the need for coordinated, gender-responsive, and age-informed care models that address both the biological and structural dimensions of menopause for women aging with HIV.

Physical Comorbidities. Cardiovascular disease is one of the many chronic conditions that aging PLWH have to contend with, often at higher rates than the general population. A study by the Kaiser Family Foundation with over 4,000 patients showed that adults living with HIV had higher rates of heart attacks and hospitalization for coronary heart diseases compared to the general population.[29] Cardiovascular risk may be further shaped by menopause-related hormonal changes, which are associated with increased cardiometabolic risk and may compound existing vulnerabilities among women living with HIV. With a lack of formal HIV-specific guidelines for managing cardiovascular diseases, risk assessments might not always be able to capture the risk for persons with HIV. Systems in place that provide older adults with the resources they need for proper medical screenings are essential for a healthy population. This need becomes more pronounced in older PLWH, and ensuring they receive adequate treatment is essential as they continue to age.

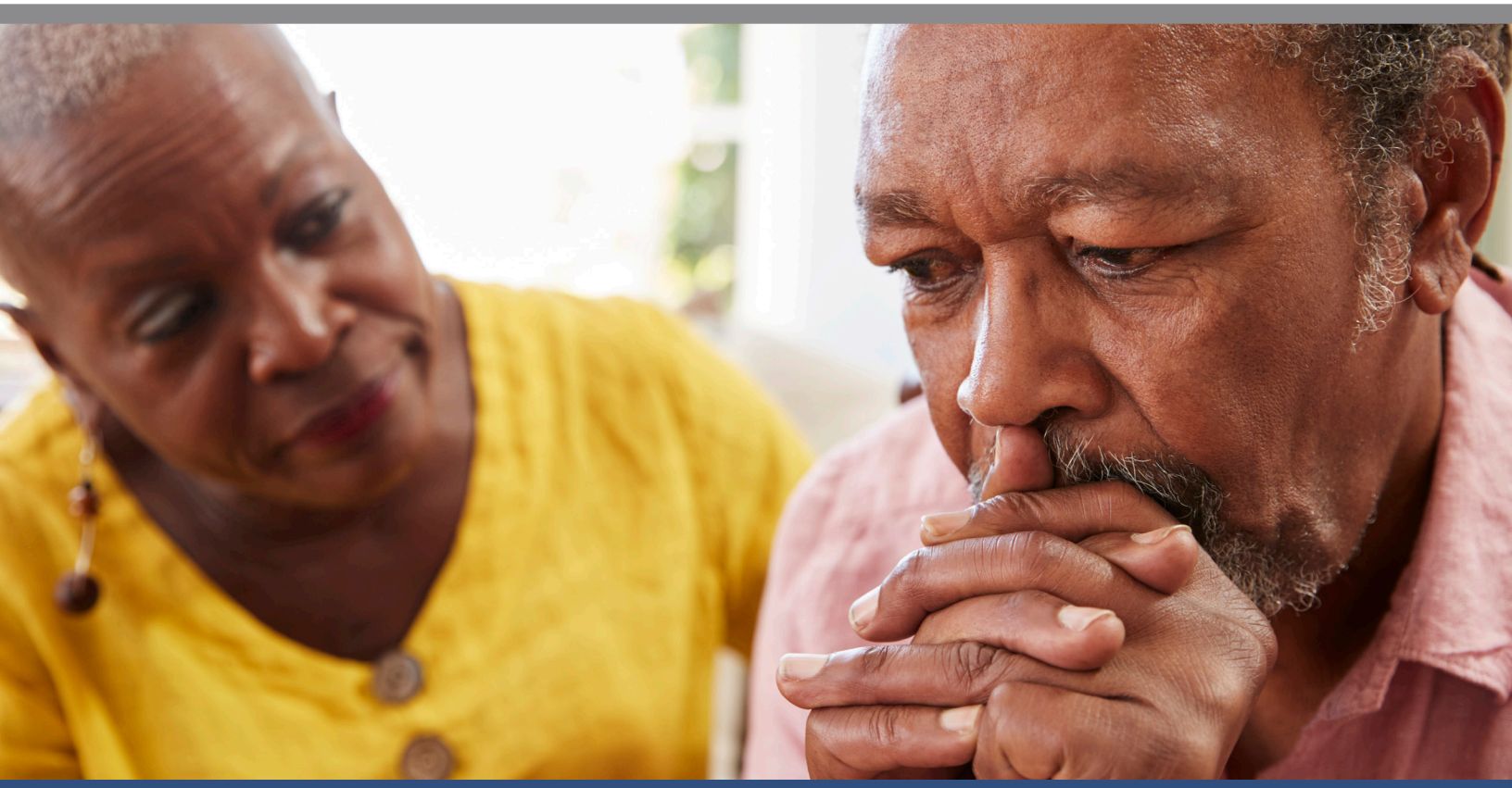
As the median age of PLWH increases, the incidence of non-AIDS defining cancers has increased over the last two decades as well. A global study has shown that cancer is the leading cause of death in PLWH in highly developed countries, involving both HIV/AIDS-related cancers such as Kaposi sarcoma, as well as non-AIDS-related cancers (NARCs) that are among the top sources of mortality among the general population.[30] While the rise of antiretroviral treatment has led to a decline in incidence for

Kaposi sarcoma and other cancers that occur among immune-suppressed individuals, older patients are still subject to an elevated risk of developing other forms of cancer that can be made more complex when dealing with HIV. For women aging with HIV, menopause-related changes such as declines in estrogen and bone density may further complicate cancer risk profiles, screening, and treatment decisions. Coordination between all members of a patient's care team is essential in properly monitoring health status and what will be necessary as they continue to age. Polypharmacy, noted above with the discussion of HIV treatment, is more common among older persons generally. Living with HIV enhances the risks of polypharmacy when other physical conditions are present and can lead to more adverse drug events as patients age. For PLWH, care coordination and close monitoring of vital organ health are necessities.

Mental Health Comorbidities. The risk of neurocognitive impairment increases with age for both PLWH and others who are HIV-negative. Depression and anxiety are increasingly diagnosed among older persons. As with cancers and heart disease, we need to understand both the commonalities and the specific differences in mental health needs among PLWH and other older persons.

When cognitive impairment cannot be readily attributed to a non-HIV comorbidity, it may be referred to as "HIV-associated neurocognitive disorder" or "HAND." HAND includes three domains that indicate the presence of different symptoms: Asymptomatic neurocognitive impairment (ANI), Mild neurocognitive disorder (MND), and HIV-associated dementia (HAD). One study with over 1,500 PLWH across the United States showed 52% of the sample with some form of neuropsychological impairment, with higher rates showing in groups with more comorbidities.[31] Failure to contend properly with the impact of neurocognitive impairment can be potentially life-altering. This could lead to reduced adherence to treatment, potentially negative interactions with other comorbidities, and increase the risk of losing patients in care.

Behavioral health statistics paint a similar picture when looking at disparities between the rates of mental health conditions among PLWH and the general population. Depression, for example, is seen at higher rates among aging PLWH, with some large-scale national studies showing the disparity as large as three times higher than that of the general population in the same age range.[32] Depressive disorders are one of the largest contributors to non-fatal health loss in the



world, contributing to millions of "years lived with a disability (YLD) worldwide. Research shows that depression is also associated with higher HIV viral loads, lower CD4 cell count, elevated risk of mortality, and hastening of the progression from HIV to AIDS.[33] HIV-related stigma, survivors' guilt and loneliness are some common factors related to depression in this population that can lead to a decrease in overall quality of life. Medical adherence is key for both mental health and HIV treatments. For PLWH of any age, a lack of adherence to ART medications can lead to a weakened therapeutic effect, reduce viral suppression, and sustain the capacity to transmit HIV to others. Any threat to the dissemination of biomedical and other prevention practices could reverse gains in reducing HIV incidence that have been achieved in the last 15 years.

The combination of an increasingly older population of PLWH and comorbidities that are naturally more frequent as people age has created a great challenge to policy makers, with the risk that the disparities affecting older PLWH could be ignored and reinforce the conditions of marginality and stigma that PLWH have dealt with since the beginning of the epidemic. State-level and multi-sector planning is essential to ensuring this group is able to access the necessary resources to live long and healthy lives. The significant increase in this population over the past decade threatens to strain current systems in place if proper resources are not devoted to maintaining and expanding what is currently offered. Legislation is the main tool by which resources are allocated in the systems of care for PLWH, and there have been several landmark laws signed that have been instrumental in providing PLWH with the services they require as they continue to age.

Incidence Among Older Community Members

While the need for elder care among PLWH is a definite consequence of effective medications and growing life expectancy, new incidence among older adults is also a source of HIV needs among older persons. Older adults who are unable to become pregnant may be less likely to use condoms or other HIV prevention measures, and physiological changes associated with menopause, including thinning and dryness of the vaginal epithelium and changes in local immune response, may further increase susceptibility to HIV acquisition.[34] In 2023, 29.2% of new cases of HIV nationally were among individuals at 50 years of age or older.[35] In New York City, a study of surveillance data in 2023 showed that almost a third (31.7%) of individuals diagnosed with HIV over 50 were concurrently diagnosed in late-stage HIV with AIDS.[36] At the core of these findings are cultural assumptions and stigma around sexuality and aging.

A stereotype across our society is that older adults have little to no sexual activity in their lives. Providers and their older patients tend not to address sexual health, the specific risks that older persons have, or sex-positive ways to enhance prevention. Research across multiple studies shows that this is a complex situation involving internalized stigma and shame around sexuality on the part of both providers and patients.[37] Federal testing guidelines provide little support for those seeking to discuss HIV with their older patients; current CDC guidelines for HIV and STI screening only apply to individuals ages 15 to 65. This situation reflects a belief that older adults have little to no chance of acquiring HIV or other sexually transmitted infections (STIs).[38] As a result, older persons have limited access to HIV and STI biomedical prevention strategies, which leaves them more at risk for contracting HIV.[39] While there is evidence for declining sexual activity with age, its onset and tapering are gradual; one study in 2007, at the onset of the era of extended life expectancy for PLWH, showed that sexual activity was reported by 73% of respondents 57 to 64 years of age, 53% among those 65 to 74, and 26% among those 75 to 85.[40] The epidemiological impact of these assumptions and stigma is that older adults who acquire HIV are less like to know their status, more like to pass the virus to others, less likely to seek care until they are very ill, and more likely to have a concurrent AIDS diagnosis when they are first screened for HIV.[41]

THE OLDER AMERICANS ACT (OAA)

The OAA was passed into law in 1965 as part of the suite of legislation and programming that comprised Lyndon B. John's "Great Society," an umbrella term for the whole package of laws and acts that created some of the most common features of American society today: Medicare and Medicaid, expanded federal support for education, federal support for local "community action" programs and agencies, the Voting Rights Act of 1965, and others. Even with the Social Security Act of 1935 in place for almost 30 years, approximately one-third (35%) of older individuals in the early 1960s were living in poverty.[42] While the life expectancy of Americans born in 1965 was 66.8 for males and 73.8 for females, those aged 65 years in 1965 could expect to live another decade or more (12.9 for males and 16.3 years for females)[43], constituting a large population in need of care and support for many years. With the OAA, Congress provided older persons with social support and an administrative and service provision infrastructure to ensure the availability of programming. The text of the OAA in 1965 spelled out its mission and purpose, which was to "secure equal opportunity to the full and free enjoyment" of (Public Law, 89-73):

1. An adequate income in retirement in accordance with the American standard of living.
2. The best possible physical and mental health which science can make available and without regard to economic status.
3. Suitable housing, independently selected, designed and located with reference to special needs and available at costs which older citizens can afford.
4. Full restorative services for those who require institutional care.
5. Opportunity for employment with no discriminatory personnel practices because of age.
6. Retirement in health, honor, and dignity — after years of contribution to the economy.
7. Pursuit of meaningful activity within the widest range of civic, cultural, and recreational opportunities.
8. Efficient community services which provide social assistance in a coordinated manner and which are readily available when needed.
9. Immediate benefit from proven research knowledge which can sustain and improve health and happiness.
10. Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives.

These goals have been expanded in successive re-authorizations over time but remain essentially the same as in the original legislation. With the OAA, "Area Agencies on Aging," called "Triple-As" in the context of aging policy, became commonplace throughout the nation. "Senior citizens" could begin to rely upon governmental, private, and non-profit agencies for services to support healthy meals and nutrition, senior centers with social programming, access to public transportation for older and disabled persons, and other forms of support.

State and Multisector Planning Under the OAA

The OAA requires that states wishing to receive support under the act must have a statewide plan for policies and programs affecting older residents. Concurrent with the 2020 OAA re-authorization, some states began "multi-sector planning" as a way to build out and connect statewide planning for aging across state agencies, ensuring that older residents' concerns receive proportionate support from all organs of government, with incentives and private sector inducements to enable older residents to enjoy "age-friendly" cities, towns, and policies across the nation.

Should the OAA be re-authorized, state- and multi-sector planning processes will begin again around the country. If the OAA is not re-authorized, we may see similar opportunities for state-level planning anyway, since plans created for the 2020–2024 OAA will eventually expire or need renewal. For multi-sector plans for aging (MPAs), the situation is more open-ended, because many MPAs are still in development around the country (see Appendix C). The process for creating state and multi-sector plans for aging offers advocates numerous points of leverage. All plans must utilize some form of needs assessment that will include public processes of testimony, community research, and debate. SAGE, a national advocacy organization

on LGBTQ+ aging, has recently released an advocacy guide for addressing HIV in multi-sector planning processes that details potential levers and opportunities.[44] While written with multi-sector planning in mind, the recommendations and guidance can be applied to the development process for state plans as well, since both involve many of the same data collection and aggregation processes. The most important best practice noted by SAGE at the very beginning of the paper is to "Highlight the benefits of HIV inclusion across all sectors," fully integrating the concerns of PLWH into aging policy and programming.

State plans on aging. Appendix A provides a review of all 50 state plans under the 2020–2024 OAA, as well as the plan for the District of Columbia. Of these 51 entities, 22 states have plans that include some mention of HIV or PLWH. The inclusion of HIV varies from general statements of inclusion without further specification to integration of specific programming to address the aging of PLWH within the context of the whole plan on aging. An example of the former is the general inclusion statement in the Arizona state plan. Goal Three of the plan states, "Older adults in Arizona can maintain individual well-being and safety to remain active, healthy and independent," and under this goal the state unit on aging is to connect resources that, among other things, "Continue to partner in support of individuals with HIV/AIDS ..." For the latter example of more expansive inclusion, the New York State plan mentions HIV and PLWH in several contexts: HIV, HIV, hepatitis C virus (HCV), and sexually transmitted infections (STIs) prevention; information or education on dating, physical intimacy, and STI; integration of HIV into other programs; and implementation of an anti-HIV Stigma program.

To provide some examples of how state plans and implementation of the OAA create opportunities for advocacy, Appendix B provides profiles of four states that express some of the diversity to be found in different locations around the country: Texas, Georgia, Oklahoma, and Illinois. Each state plan includes language or policies that provide leverage points for advocates. States that have included HIV in their plans provide examples that can be used in states that do not recognize HIV in their plan on aging. Policies provided for housing, care coordination, or transportation in states that do not include HIV in their plans may have room to accommodate the concerns of PLWH; they may even provide other examples of policy that can be implemented in states that include HIV and PLWH in their plans. The multiplicity of plans in differing contexts around the country provides advocates everywhere with numerous examples of ideas for policies, language and statistics that can be useful in securing gains for older PLWH.

Multi-sector plans on aging (MPAs). Multi-sector planning for aging began in California in 2020, with the 2020–2021 California Master Plan for Aging. Although the 2020 OAA did not require multi-sector plans, the California model showed that integrating state planning for aging throughout state policy and implementation bodies could be an efficient way to scale programming for aging and extend the reach of OAA funding and support. MPAs are aligned with the OAA's language promoting coordination across state agencies. The progress of MPAs is promising and shows how states are, one by one, exploring ways to leverage OAA support and scale its benefits to support our aging population.

MPAs are distinct from the State Plans on Aging that each state is required to have. The MPAs seek

to incorporate multiple state-level plans that affect aging populations, including the State Plan on Aging, Medicaid Plans, state health improvement plans, “age-friendly’ plans, and others. The incorporation of planning across sectors is intended to elevate individual plans and enhance the entire continuum of services that support older community members. The Center for Healthcare Strategies documented the progress of MPAs in 2025 and found that 15 states have some form of MPA authorization from state leadership and another 23 states without authorization are taking action toward developing an MPA. Appendix C provides a table of current MPAs, showing that of 15, two (New York and Maryland) have specific language incorporating the concerns of PLWH in the plans, and one (Massachusetts) explicitly acknowledges the need for support of LGBQ+ people in its MPA.

MPAs will continue to gather momentum across the country regardless of the outcome of the OAA re-authorization. Many state plans have been adopted legislatively, creating local laws and programs that, while dependent on OAA funds, have become part of the expected suite of services provided to residents. Similarly, MPAs across the states serve state needs and help local governments manage programs for an aging population. Independent of OAA re-authorization, many of these programs in state and multi-sector plans will continue growing more common and comprehensive over time, offering advocates more opportunities to push for programs and support in very specific ways and places. Appendix D provides a review of goals in three state MPAs in California, Maryland, and New York. Along with the SAGE resource cited earlier, the information in Appendices A–D should help to provide ample information for multiple points of advocacy or leverage in the coming years.

FEDERAL CUTS IN HIV AND PROGRAMS FOR OLDER ADULTS

The OAA's 2020 re-authorization ended at the conclusion of 2024. Funding for programs under the OAA has been sustained by continuing resolution since then. Senators Bill Cassidy (R-LA) and Bernie Sanders (I-VT) introduced OAA re-authorization in the Senate in the summer of 2025, but the bill has stalled as of December 2025. Along with all programming supported under the former Department of Health and Human Services, both aging and HIV programming are under heavy scrutiny and face large cuts to budgets and specific programs under the current Congress, which is up for re-election in 2026.

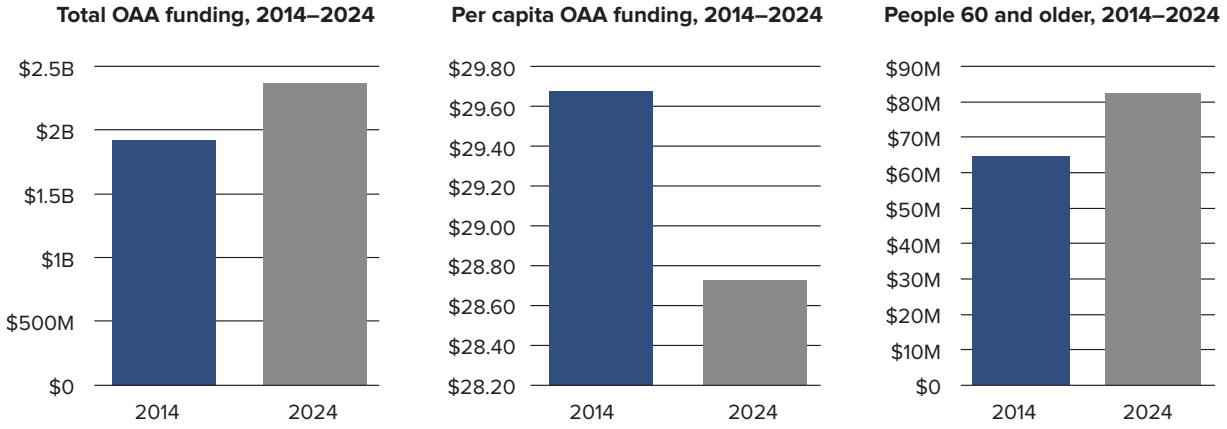
Multiple Funding Sources

Federal funding plays a critical role in supporting programs related to the EHE initiative and other initiatives that serve older adults, particularly PLWH. However, funding has remained essentially stalled or declining over recent years. Figure 3 shows that Federal funding for the OAA has not kept pace with inflation or with the growth of the older adult population. Figure 4 shows funding for PLWH through the RWHAP and EHE initiative, indicating that RWHAP funding has remained steady at $2.3B annually, with the expansion of funds devoted to PLWH coming through the addition of EHE initiative funds from 2020 on. Throughout the period reflected in Figure 4, the number of persons receiving care through the RWHAP has been over 500,000 and is increasing annually. RWHAP funding has lost some of its value through inflation, as measured in the declining value of the program in 1991 dollars (Figure 5). The small increases in funding for PLWH are almost entirely through the EHE programs, and these may not fully address the rising costs of housing and healthcare. At the same time, federal funding does not fully address the growing complexity of care needed for aging PLWH, who often face higher rates of comorbidities such as cardiovascular disease, diabetes, or neurocognitive decline, requiring consistent access to specialized and coordinated care. Medicaid continues to serve as the primary source of insurance coverage for PLWH, covering nearly 40% of individuals with diagnosed HIV in the United States.[45] Any reduction in federal Medicaid funding or eligibility would therefore have significant downstream effects on access to antiretroviral therapy, primary care, and supportive services.

The One Big Beautiful Bill Act (OBBBA), 2025

The OBBBA, signed into law on July 4, 2025, is poised to alter the landscape of federal support for PLWH by drastically reducing access to Medicaid, eliminating federally funded support for health insurance obtained under the Affordable Care

Figure 3. Funding for OAA Programs Cannot Keep Pace with the Number of Older Americans



Note: OAA is Older American Act. Dollar amounts in nominal terms.
Source: KFF analysis of Congressional Research Service, "Older Americans Act: Overview and Funding," May 6, 2024; Census Bureau Population Estimates 2014–2024 for adults 60 and older.

Act (ACA), and reductions in "food stamp" support through the Supplemental Nutrition Assistance Program (SNAP). The non-partisan Congressional Budget Office (CBO) estimates that the OBBBA will lead to a $2.4 trillion increase in the deficit[46], while the Center on Budget and Policy Priorities (CBPP) estimates that act will increase the number of uninsured Americans by 9.9 to 14.9 million by 2034.[47] While funding for Housing Opportunities for Persons with AIDS (HOPWA) has continued through FY2026, the President's Budget proposal for 2027 calls for the complete elimination of HOPWA funding, along with reductions in other HIV funding that has been sustained since the OBBBA was passed.[48]

The OBBBA also dismantles other core components of the federal HIV response. The Act eliminates funding for domestic HIV prevention at the Centers for Disease Control and Prevention (CDC), elements of the Minority AIDS Initiative (MAI), and Part F of the Ryan White HIV/AIDS Program, which supports

Figure 4. Ryan White Program Funding Increases were Driven by EHE Funding, FY2014-FY2024

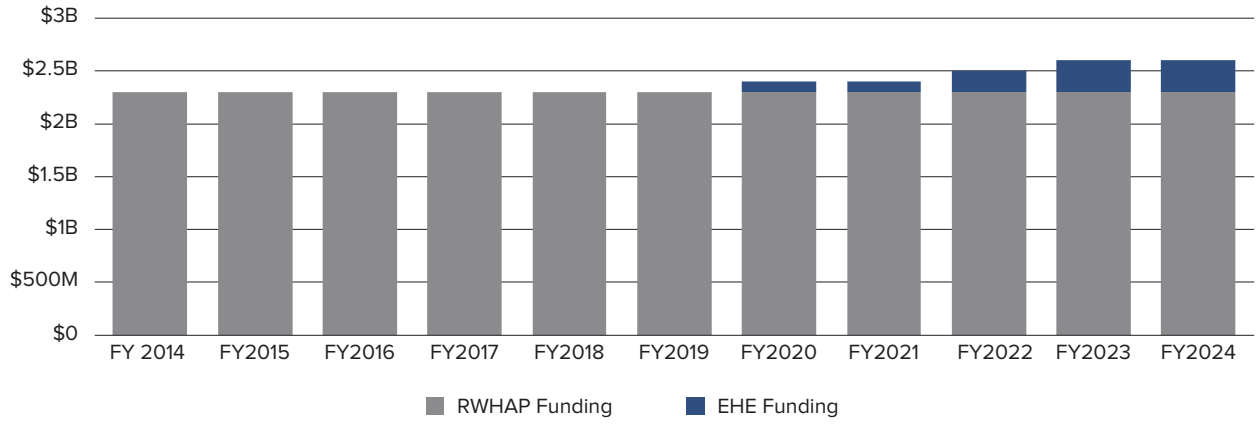
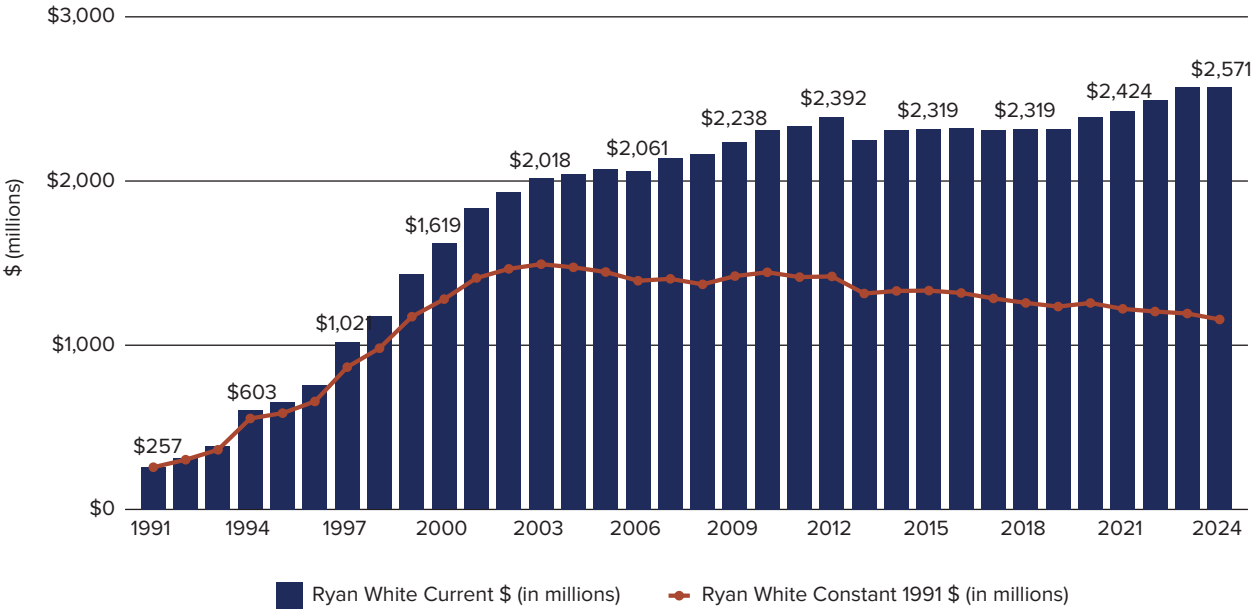


Figure 5. Federal Ryan White Funding, FY1991–FY2024



Note: Funding adjusted using CPI–U tables from the U.S. Bureau of Labor and Statistics.
Source: KFF analysis of data from OMB, Congressional Budget Justifications, and appropriations bills.

education, training, and capacity building for providers. The Medicaid work requirement demands that some recipients complete 80 hours per month of work, community service, or job search activities or be enrolled at least half-time in school to maintain eligibility (H.R.1—One Big Beautiful Bill Act, 2025). PLWH may qualify for a disability exemption if they receive SSI/SSDI benefits or have been receiving HIV/AIDS services for over 20 years, but the OBBBA modifies eligibility thresholds and cost-of-living adjustments for SSI/SSDI recipients. These reductions could push more individuals below the poverty line and force millions of Americans, including PLWH, into difficult choices between paying for medications, rent, or food.

The Administration for Community Living

At the same time, the Administration for Community Living (ACL) will be restructured and renamed as the Administration for Community and Family Care (ACFC) under the administration's Fiscal Year 2026 Department of Health and Human Services (HHS) budget proposal. This reorganization merges the functions of ACL with the Office of the Assistant Secretary for Health (OASH), Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), Agency for Toxic Substances and Disease Registry (ATSDR), and National Institute for Occupational Safety and Health (NIOSH). Together, these structural shifts and funding reductions raise significant concerns about the future capacity of federal programs to meet the needs of older adults and PLWH. While the proposal is framed as an efficiency measure, it risks diluting specialized support for aging populations and PLWH by embedding these services within a broader, less targeted administrative structure. These policy shifts raise serious concerns about the federal government's ongoing capacity to sustain progress toward ending the HIV epidemic and ensuring equitable access to care and housing for older adults living with HIV. As service organizations lose funding and experienced staff, older PLWH may face greater social isolation and mental health challenges. These changes not only undermine the nation's commitment to the EHE initiative but also jeopardize the dignity, health, and stability of a generation of survivors who have spent decades building and sustaining the HIV care infrastructure now at risk.

CONCLUSION: ADVOCACY IN AN ENVIRONMENT OF UNCERTAINTY

The potential dissolution of the OAA, along with threats to sources of HIV-specific programming in the RWHAP and other agencies, requires a significant pivot from service delivery within a functioning, federally supported network to one that builds new, more localized networks and focuses on advocating for state-level replacement structures.

Resources and Toolkits

The urgency of the situation is indicated by a growing number of advocacy toolkits and papers, such as this one, that are becoming available online and in other media. Appendix E reviews these resources and provides website address and specific URLs for resources, which are available from the following organizations:

- The **American Society on Aging** (https://asaging.org/) brings together the largest, most diverse community of professionals working in aging in America. The ASA is source to cultivate leadership, advance knowledge and strengthen the skills of members and others who work with and on behalf of older adults. The ASA is a partner with Ribbon and TRX Development Solutions in the Center for Excellence in Aging with HIV.
- The **Center for Health, Law, and Policy Innovation** (https://legalservicescenter.org/chlpi/) at Harvard was founded in 1987 as the AIDS Law Clinic. It was the nation's first law school–based legal services program to serve low-income people living with HIV and AIDS. It specializes in providing legal assistance and direct legal services to PLWH. Its recent paper on ending the HIV epidemic in 2026 reviews the broad array of challenges in funding and regulation to provide insight into overcoming these obstacles and continuing the fight to end the epidemic.
- The **Center for HIV Law and Policy** (CHLP, https://www.hivlawandpolicy.org/) is a resource for advocates to stay informed on changes in HIV policy that could affect their communities. CHLP centers its work in communities most affected by HIV, particularly communities of color. Their work includes legal advocacy, high-impact research initiatives, and the potential to network with other communities for support. CHLP's Aging Initiative began 2022 to respond to the unique challenges faced by those living and aging with HIV.
- **Ribbon – A Center of Excellence** (https://ribbon3.org/) was founded and is led by Black women living with HIV and has evolved from an HIV-centered organization to encompass a broader mission of ending racial and social disparities that rob vulnerable communities of health and wealth. Ribbon is the lead partner in the Center 4 Healthy Living with HIV.
- **SAGE** (https://www.sageusa.org/), as noted earlier, is a cross-sectoral advocacy and service organization whose mission is to improve and enhance the lives older LGBTQ+ adults. SAGE produces toolkits for community members and leadership, while maintaining an advocacy presence in New York and Washington DC.
- **Save HIV Funding** (https://savehivfunding.org/) was launched in 2023 by PrEP4All, AVAC, and the HIV Medicine Association, and the Federal AIDS Policy Partnership. It currently has over 110 partner organizations around the country and aims to support collective action to address, mitigate, and reverse attempts to reduce funding and other supports for HIV programming.
- **USAging** (https://www.usaging.org/) is a national association representing and supporting the network of Area Agencies on Aging and advocating for the Title VI Native American Aging Programs. Their membership includes local leaders that develop, coordinate and deliver a wide range of home and community-based services, including information and referral/assistance, case management, home-delivered and congregate meals, in-home services, caregiver supports, transportation, evidence-based health and wellness programs, long-term care ombudsman programs and more. USAging's advocacy alerts help their members prepare for advocacy opportunities such as the re-authorization of the OAA.

This list is not exhaustive. Many organizations are stepping up to provide policy and advocacy resources. In spite of the level of challenge, there is evidence that advocacy works. PEPFAR has been

able to prevent elimination. However, its funding has been reduced and paused and is under continuing threats, while its operation has been impacted by cuts to US foreign aid in general.[49] In behavioral health, a recent attempt to eliminate $2 billion in discretionary funding for mental health and substance use programming was met with immediate resistance and advocacy by groups across the nation—resulting in a reversal of the cuts within two days.[50]

Navigating the Environment of Uncertainty

Advocacy along these lines will require navigating an uncertain environment in the federal and state legislatures, particularly as regards the financial resources available for aging services. In this environment, organizations that advocate for and provide services need to systematically review the impact of this uncertain environment on their organizations and develop strategies to restructure their use of resources. Appendix F provides a step-by-step process for organizations to move from impact assessment to the advocacy targets that is a stand-alone pull-out from this paper. The resource reviews the steps along the way to a set of fundamentally important policy targets that include the following three strategies:

1. Medicaid Integration: Advocate with state officials for the expansion of Medicaid Home and Community-Based Services waivers to cover non-medical social supports that were previously provided by the OAA such as respite care, transportation and non-medical at-home assistance.

2. State-Level Safety Net: Enter into action-oriented coalitions with similarly oriented organizations such as AARP to lobby state legislatures for funds to replace services once provided under Title III of the OAA.

3. Ryan White HIV/AIDS Treatment Extension Act of 2009: In the event that OAA funding ceases, funding from the Ryan White CARE Act will become even more critical. Advocates can play a leading role in ensuring that Ryan White programs successfully integrate geriatric and long-term care services into their models, recognizing that HIV survivorship is now synonymous with aging.

This paper reviewed challenges facing aging with HIV in light of the uncertainty around the future of the OAA. Our stress has been on identifying opportunities for advocacy that exist currently, at both state and federal levels. State plans on aging and the local AAAs that they support have become permanent features of the landscape at the state and local levels and provide advocates with multiple opportunities to shape policies on aging that are important to the concerns of aging PLWH. The Appendices to the paper provide state-by-state reviews and opportunities as well as a set of strategies available to advocates and organizers.

The most important thing that we can do at present is study the field and identify as many opportunities as possible to advocate for PLWH who are aging. This includes not only thinking about the RWHAP and other resources specific to HIV, but also demands that we explore planning and resources for aging in general in all states and localities. The ultimate outcome of the advocacy process in aging sectors will be to help integrate aging with HIV into aging policy more generally, reduce stigma, and normalize growing older with HIV. The struggles of the last 40 years in AIDS and HIV activism have extended life expectancies and reduced the impact of HIV on daily life to make advocacy for aging with HIV not only possible but have shown the way for the community in the face of current circumstances.

APPENDIX A. STATE PLANS ON AGING

TABLE A1. STATE PLANS FOR AGING THAT HAVE PROVISIONS FOR PLWH OR LIVING WITH HIV (1 OF 3 PAGES)

Tables A1 and A2 refer to the state plans for aging (including the District of Columbia). All state plans on aging can be found online. Most states publish them on their state website. ADvancing States is the national association representing state agencies that working areas of aging. Its purpose is to "ADvance programs, policies, and services for individuals who are aging, who have a disability and their caregivers so that they can live independently in their homes and communities for as long as they choose." As of this writing, the state plans on aging (including the District of Columbia) can be found on ADvancing States' website via an interactive map of state resources found at https://www.advancingstates.org/about/state-agencies/state-resources. Clicking on individual states provides links to the state plan and other available resources.

Note: Other key terms mentioned in the plan: "housing" (H); "care coordination" (CC); "behavioral health or mental health" (BHM); "chronic conditions/illnesses/disease" (CHR).

State	Year Published	Are "HIV" or "AIDS" mentioned in state plan on aging?	Other key terms mentioned in the plan	State plan language for HIV
Arizona	2023	Yes	H CC BHM CHR	Continue to partner in support of individuals with HIV/AIDS.
Arkansas	2023	Yes	H CC BHM CHR	Objective 2: (Focus Area-Advancing Fairness in the aging population) Conduct outreach efforts with special emphasis placed on reaching older individuals with the greatest economic or social needs, with particular attention to underserved and minority individuals with low incomes, individuals residing in rural areas and older adults living with HIV/AIDS.
Hawaii	2023	Yes	H BHM CHR	Target referral and recruitment of participants with co-morbidities including HIV.
Illinois (See detailed profile in Appendix B.)	2022	Yes	H CC BHM CHR	Strategy 2.1c: Engage in ongoing discussions through the Aging network and ensuring openings on IDoA advisory councils committees — using lessons from ongoing active engagement described in the Strategy 2.1b — and modify in response programming, funding, resources, and partnerships to better reach and meet their needs of older adults who are underserved, including those living with HIV, who are disabled, or facing other sources of marginalization, discrimination, or exclusion.
Iowa	2022	Yes	H BHM CHR	The Office of the State Long-Term Care Ombudsman (OSLTCO) serves as an advocate and resource for residents and tenants who receive services and supports while residing in Iowa's long-term care facilities and assisted living programs, as well as for Medicaid managed care members enrolled in one of Medicaid's seven home and community-based service (HCBS) waiver programs. The seven HCBS waivers in Iowa are the AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver, and Physical Disability Waiver.

State	Year Published	Are "HIV" or "AIDS" mentioned in state plan on aging?	Other key terms mentioned in the plan	State plan language for HIV
Louisiana	2023	Yes	H CC BHM CHR	Louisiana's Governor's Office of Elderly Affairs (GOEA) contracts with the Area Agencies on Aging (AAA) for provision of service delivery. Providers are required to give priority for services using the targeting factors of rural, greatest economic need (low income), greatest social need/social isolation, of ethnic minority, severely disabled, members of the LGBTQIA+ community, persons living with HIV/AIDS, members of religious minorities and at risk for institutional placement.
Michigan	2024	Yes	H BHM CHR	Throughout the assessment and planning process, special attention was paid to ensuring the plan equitably addresses the needs of all of Michigan's older adults, especially those with the greatest economic and social need. This includes older adults of various races and ethnicities; veterans; the lesbian, gay, bisexual, transgender, queer (LGBTQ+) community; adults with disabilities; older adults living with HIV/AIDS; Native Americans; refugees; and those with limited English proficiency.
Minnesota	2024	Yes	H CC BHM CHR	With the 2020 Dementia interviews and the Minnesota 2022 LGBTQ Aging Needs Assessment Report as a backdrop, the state of Minnesota is working with the aging network to expand services to LGBTQ+ and AIDS/HIV+ older adults (p. 10).
Missouri	2024	Yes	H BHM CHR	The Bureau of HIV, STD and hepatitis within DHSS operates the RWHAP — Part B. The program includes the AIDS Drug Assistance Program, HIV Medical Case Management, as well as a range of core medical and supportive services aimed at reducing barriers to engagement in HIV medical care for low-income Missourians living with HIV (p. 11).
Nebraska	2023	Yes	H BHM CHR	Promote Health Promotion and Disease Prevention programming that serves older adults living with HIV/AIDS, as well as caregivers of older adults (p. 29).
New Hampshire	2023	Yes	H BHM CHR	The Bureau of Adult and Aging Services (BAAS) has started a connection with the NH Ryan White CARE Program. The Ryan White CARE Program provides a network of medical care, as well as providing support for identified needs for people living with HIV.
New Jersey	2021	Yes	H CHR	AIDS Distribution program (p. 6).
New York	2019	Yes	H BHM CHR	Multiple mentions of HIV: prevention, information on dating, physical intimacy, sexually transmitted infections (STI), awareness, and prevention efforts (including HIV and hepatitis C); integration of HIV into other programs; and implementation of an anti-HIV stigma program.

State	Year Published	Are "HIV" or "AIDS" mentioned in state plan on aging?	Other key terms mentioned in the plan	State plan language for HIV
North Dakota	2022	Yes	H BHM CHR	Strategy 1: Train all Aging Services staff in specialized areas such as trauma informed care, suicide prevention, LBGTQ+, HIV, North Dakota Health Disparities and Social Determinants of Health, and cultural diversity.
Ohio	2022	Yes	H CC BHM CHR	Needs Assessment: "Additionally, there are many other groups of older Ohioans who require custom strategies and resources, including veterans, people living with HIV/AIDS, Amish communities, people who are justice-involved, and people who are unhoused."
Oklahoma (See detailed profile in Appendix B.)	2023	Yes	H CC BHM CHR	Objective 3: Increase awareness of available resources and services for older adults living with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS).
Oregon	2023	Yes	H BHM CHR	Objective 1.4: Increase public knowledge, and knowledge among professionals serving older adults, of services and supports available for all older adults, with emphasis on reaching populations in greatest economic and social need (with particular attention to older adults living with HIV/AIDS, Holocaust survivors and those at risk for institutional placement).
Texas (See detailed profile in Appendix B.)	2022	Yes	H CC BHM CHR	Objective 3: Increase awareness of available resources and services for older adults living with HIV/AIDS.
Vermont	2022	Yes	H CC BHM CHR	"Identify and build relationships with groups and organizations representing Vermont's populations, including LGBTQ+, older adults living with HIV, Abenaki, and New Americans, to participate and inform strategic planning."
Virginia	2023	Yes	H CC BHM CHR	Deliver Communication, Referral, and Information and Assistance (CRIA) in a manner that is culturally and linguistically appropriate and trauma-informed regardless of race, ethnicity, gender, disability, religion, sexual orientation, HIV/AIDS status, or socioeconomic status (p. 29).
Washington	2023	Yes	H CC BHM CHR	In partnership with the Washington Department of Health, the Early Intervention Program provides eligible older adults living with HIV/AIDS with services costs related to prescription medications, medical and mental health care, and dental care (p. 14).
Wisconsin	2023	Yes	(none)	During the State Plan period, Bureau of Aging and Disability Resources (BADR) will expand its collaborative relationship with the Wisconsin Division of Public Health's HIV/AIDS program within the Bureau of Communicable Disease (BCD) (p. 16).

TABLE A2. STATE PLANS FOR AGING THAT DO NOT HAVE PROVISIONS FOR PLWH OR LIVING WITH HIV (1 OF 3 PAGES)

Note: Other key terms mentioned in the plan: “housing” (H); “care coordination” (CC); “behavioral health or mental health” (BHM); “chronic conditions/illnesses/disease” (CHR).

State	Year Published	Are “HIV” or “AIDS” mentioned in state plan on aging?	Other key terms mentioned in the plan
Alabama	2021	No	H CC BHM CHR
Alaska	2024	No	H CC BHM CHR
California	2021	No	H CC BHM CHR
Colorado	2025	No	H BHM CHR
Connecticut	2020	No	H CC BHM CHR
Delaware	2020	No	H CC BHM CHR
Florida	2021	No	H BHM CHR
Georgia (See detailed profile in Appendix B.)	2024	No	H CC BHM CHR

State	Year Published	Are "HIV" or "AIDS" mentioned in state plan on aging?	Other key terms mentioned in the plan
Idaho	2020	No	H CC BHM CHR
Kansas	2021	No	H BHM CHR
Kentucky	2022	No	H BHM CHR
Maine	2020	No	H BHM CHR
Maryland	2021	No	H CC BHM CHR
Massachusetts	2021	No	H BHM CHR
Mississippi	2022	No	H BHM CHR
Montana	2023	No	H BHM CHR
Nevada	2021	No	H CC BHM CHR

State	Year Published	Are "HIV" or "AIDS" mentioned in state plan on aging?	Other key terms mentioned in the plan
New Mexico	2021	No	H CC BHM CHR
North Carolina	2019	No	H BHM CHR
Pennsylvania	2020	No	H BHM CHR
Rhode Island	2019	No	H BHM CHR
South Carolina	2021	No	H BHM CHR
South Dakota	2021	No	CHR
Tennessee	2021	No	H CC BHM CHR
Utah	2020	No	H CC BHM CHR
Washington, D.C.	2019	No	H CC BHM CHR
West Virginia	2022	No	CHR
Wyoming	2021	No	H CC BHM CHR

APPENDIX B. PROFILES OF SELECTED STATE PLANS ON AGING

Texas

Texas illustrates both the opportunities and challenges inherent in advancing multisector planning under the OAA for diverse and rapidly growing older adult populations. The state's policy landscape for older adults living with HIV is shaped by three major federal pillars: the Older Americans Act (OAA), the Ryan White HIV/AIDS Program (RWHAP), and HOPWA (Housing Opportunities for Persons With AIDS). Exploring these federal opportunities at the state level in Texas reveals urgent vulnerabilities and strategic opportunities.

Texas is the second largest state in the nation. Its population includes more than 30 million people. Between 2010 and 2019, Texas' older population grew faster than that of the United States as a whole. By 2019, Texas had the third largest older adult population in the nation, with its share of the national older adult population increasing from 6.1% to 6.5%.[51] Today, individuals 60 years and older make up 14% of the statewide population; approximately 6 million people.[52]

To meet the needs of this population, the state administers 28 Area Agencies on Aging (AAA), ranging from single-county metropolitan agencies in Harris and Bexar counties to multi-county agencies serving large rural regions.[53] According to AARP, the OAA in Texas funds more than $52 million a year for meals and nutrition services, $21 million in support and preventive services, and roughly $9 million for caregiver support in Texas.[54] In addition to the OAA, other funding sources that support older Texans include the State Health Insurance Program (SHIP), Medicare Improvements for Patients and Providers Act (MIPPA), and Senior Medicare Patrol, which allow states and local partners to apply to enhance focus on dementia, evidence-based disease prevention, nutrition innovation, and lifespan respite.

In 2021, the Texas HHSC Aging Service Coordination (ASC) office conducted a survey to understand the needs, concerns, and priorities of older adults, informal caregivers of older adults, and organizations providing services to older adults. Among older adults, physical health, access to services and support in the community, and access to social engagement opportunities were the top three priorities.[55] These priorities mirror many of the needs of older Texans living with HIV, who often experience accelerated aging, higher rates of chronic disease, and increased risk of isolation.

For older Texans living with HIV, RWHAP and HOPWA provide vital support. The latest data available from Texas Health and Human Services (2023) finds an estimated 114,000 Texans are living with HIV (375 per 100,000). People living with HIV (PLWH) over 55 account for roughly 31% of all PLWH in Texas.[56] Older adults living with HIV in rural regions of Texas face additional barriers, including limited access to infectious disease specialists, primary care providers who are informed about HIV, transportation, and affirming senior services. Many OAA-funded providers have limited HIV-specific training or experience serving LGBTQ+ older adults or long-term survivors. As the aging HIV population grows, AAA programs will increasingly serve older adults with HIV.

Despite these challenges, Texas offers promising examples of innovation aligned with the OAA's multisector planning goals. The Seasoned Survivors Senior Center in Fort Worth demonstrates how a dedicated space can address social isolation, provide tailored support groups, and connect older adults with HIV to services.[57] The Texas State Plan on Aging for 2023–2025 echoes this need, calling for stronger integration between AAAs and HIV service providers, especially in planning, data-sharing, and community outreach.[58] Such commitments demonstrate the state's recognition that aging and HIV systems must increasingly operate as interconnected, rather than parallel, service structures.

Given that a significant number of older Texans with HIV rely on federally funded programs, federal budget cuts could disproportionately disrupt care, transportation, meals, housing, and community support. Rural and underserved areas in Texas would likely be especially vulnerable, as older adults living with HIV in such areas may lack robust local Ryan White clinics or HOPWA-funded housing, making the safety net fragile. Beyond this, some AAAs and senior service providers may

not yet be fully equipped or culturally adept to serve HIV-positive older adults, particularly around confidentiality, peer support, and trauma-informed care.

Texas' aging population is expanding rapidly, and older adults living with HIV represent a critical part of this growth. As the need for coordinated medical, social, and housing supports intensifies, strengthening the relationship between OAA, Ryan White, and HOPWA systems will be essential. By improving cross-system collaboration, expanding culturally competent care, and addressing ongoing structural barriers, Texas has an opportunity to build a more resilient and equitable support network for older adults with HIV.

Georgia

Georgia provides another example of how demographic shifts, socioeconomic vulnerability, and fragmented planning around HIV intersect with the OAA's multisector planning mandate. In 2022, 15% of Georgia's population was 65 and over, which was an increase of almost 3% from 2019. Two million older Georgians live in poverty, highlighting the need for tailored plans and departments focused on helping this population.

The Georgia Department of Human Services (DHS) and the Division of Aging Services (DAS) are the designated state units on aging. The DAS partners with a network of local agencies and partners to develop and implement the State Plan on Aging across the state. There are 12 Area Agencies on Aging (AAA) that provide services to help people aged 60 and older, particularly aimed at those individuals who are low-income, minority, residing in rural areas, or with limited English proficiency. The AAAs cover 159 counties in Georgia, ensuring coverage for every aging Georgian. The AAAs are responsible for developing local Area Plans on Aging and administering them, as well as for resource development. They use these resources to work with local community leaders, elected officials, and the private sector to create coordinated services of delivery.

The goals for the State plan are as follows:

> Goal 1: Provide long-term services and supports that enable older Georgians, their families, caregivers, and persons with disabilities to fully engage and participate in their communities for as long as possible.
>
> Goal 2: Ensure older Georgians, persons with disabilities, caregivers, and families have access to information about resources and services that is accurate and reliable.
>
> Goal 3: Strengthen the aging network to enable partners to become viable and sustainable and develop a robust network of aging service partners.
>
> Goal 4: Prevent abuse, neglect, and exploitation while protecting the rights of older Georgians and persons with disabilities.
>
> Goal 5: Utilize continuous quality improvement principles to ensure the State Unit on Aging operates efficiently and effectively.

Outside of the State plan, the DAS also coordinates and facilitates the activities of the other strategic plans implemented across the state. These plans cover Alzheimer's & Related Dementias, Senior Hunger, and Employment. Despite the high prevalence of HIV in the state (The Atlanta-Sandy Springs-Alpharetta metro area has the fourth highest HIV/AIDS prevalence in the country), there is no mention of HIV in the State plan, nor does it have its own strategic plan dedicated to the needs of People Living with HIV. Aging PLWH rely on programs and resources funded by the Ending the HIV Epidemic initiative (EHE), from which Ryan White programs receive their funding. HIV prevention funding increases have been spurred by EHE funding, but the future of that funding is currently up for debate. Integrating HIV considerations into aging policy, improving coordination between the aging network and HIV providers, and ensuring sustained federal investment remain essential steps for advancing equitable aging policy in the state.

Oklahoma

Oklahoma offers a distinct and instructive model for how states can operationalize the OAA's multisector planning mandate to include older adults living with HIV explicitly. Unlike many states whose aging plans make little or no mention of HIV, Oklahoma's State Plan on Aging for FYs 2023–2026 details the state's commitment to addressing the needs of aging PLWH. Oklahoma's plan recognizes older adults living with HIV as a distinct population facing significant economic and social disadvantages within broader society. This level of explicit attention reflects that HIV has evolved into a chronic condition and therefore necessitates a policy commitment to equity within the state's aging network.

Oklahoma's inclusion of a detailed plan of action for aging PLWH reflects a necessary shift in how aging services are provided. The plan implicitly recognizes several critical factors driving this need:

- The Aging Population and HIV: Advances in antiretroviral therapy (ART) have transformed HIV into a manageable chronic condition. As a result, a rapidly growing segment of people living with HIV is now aged 50 and older and requires access to traditional aging services (in-home care, nutrition assistance and transportation assistance) in addition to HIV medical management.
- Dual Challenges: Older adults living with HIV may be at increased risk of comorbidity with certain conditions (e.g., cardiovascular disease, diabetes, and certain cancers) along with higher rates of social isolation and poverty. These issues necessitate specialized, integrated care that traditional aging services may not be equipped to provide without targeted training.
- Equity Mandate: Oklahoma's plan recognizes that dedicating focused attention to aging PLWH is a matter of equity. Oklahoma's plan asserts that older adults living with HIV fall within what it describes as those experiencing the "greatest economic and social need." and as such require proactive measures to ensure meaningful access to services provided under the OAA.

The third objective of the state plan specifically addresses HIV/AIDS: "Increase awareness of available resources and services for older adults living with Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS)."

The plan identifies three strategies that address barriers as they pertain to both providers and clients:

> *Strategy 1: Partnering with the Oklahoma State Department of Health (OSDH) and other community entities.* The purpose of this goal is to leverage public health infrastructure to distribute information about aging services. This strategy posits that AIDS Service Organizations (ASOs) are the most effective delivery points for information on services available.
>
> *Strategy 2: Training for ASOs.* This strategy seeks to enhance the capacity of HIV service providers to function as referral agents for the Aging Network. Staff at ASOs are experts in HIV care but may lack a detailed understanding of the complexities of OAA programs.
>
> *Strategy 3: Training for the Aging Network.* The intention of this strategy is to destigmatize and ensure culturally competent care for aging PLWH within the mainstream aging network.

The strategies are paired with explicit performance measures such as counts of awareness events, educational materials distributed, and ASO trainings. Additionally, short and intermediate-term outcomes include increased awareness of access to services and resources for older Oklahomans living with HIV/AIDS and improvement in the number of older Oklahomans living with HIV/AIDS accessing available OAA Title III Services.

The main vehicle for Oklahoma's work in solidarity with aging PLWH, as laid out in its State Plan on Aging, is the state's AIDS/HIV Coordination and Information Services (ACIS) program. This case management and referral program is integrated directly into the state's Aging Network structure and provides the following framework for specialized care:

- Integrated Case Management: ACIS acts as the primary contact point for older adults living with HIV/AIDS. It is tasked with providing case management and comprehensive care coordination given that aging PLWH often have complex medical and social needs that necessitate linkages between various services (HIV clinics, OAA services, primary care physicians, etc.).
- No Financial Barriers: A key element of the ACIS is the explicit statement that its services are provided without regard to income or resource restrictions. This ensures that the most vulnerable individuals are not excluded due to their financial status. This provision is especially critical at a time when millions of Americans are burdened by rapidly rising living costs.
- Information Hub: The ACIS is central to meeting the State's objective of increasing awareness and familiarity with its services by serving as the primary source for information and resources both within the aging network and the broader HIV/AIDS service ecosystem.

Oklahoma's State Plan was partially based on input received from participants in various focus groups. The fourth of these focus groups was carried out with staff who provide services to PLWH. This input highlighted three major service areas for

improvement within the scope of the services provided within the Aging Network:

- Mental Health/Substance Abuse Service Enhancement: The focus group identified this as a frequently overlooked need for aging PLWH, some of whom may have faced decades of compounded trauma, stigma, and depression. While the OAA primarily offers supportive services, the Aging Network can play a critical role in facilitating referrals to specialized mental health resources.
- Transportation Assistance: This was identified as a high-priority need. Lack of reliable transportation is a major barrier (especially in rural parts of the state) to medical adherence (crucial for ART), clinic appointments, and accessing other OAA services like congregate meals. The state's aging transportation programs could be a direct solution to this critical gap.
- Adoption of Telehealth/Virtual Care: The plan specifically mentions the benefit of virtual appointments, including telehealth, for immunocompromised populations, which often struggle with transportation. While the State Plan itself does not fund telehealth technology, the stated commitment implies the State's intention to ensure aging service providers are integrating or facilitating access to virtual care models wherever possible.

Illinois

Advocates and policy makers in Illinois began working on the integration of programming for PLWH into its state plan on aging in 2020, as HIV surveillance data began to indicate that over half of RWHAP recipients in the state were 50 years of age or older. Home to the third largest metropolitan area in the country, Chicago, Illinois has a higher number of PLWH than surrounding states. The AIDS Foundation of Chicago (AFC) is one of the nation's foundational AIDS Service Organizations established in 1985, early in the epidemic. In 2022, the state established the Illinois Commission on LGBTQ Aging, which includes advocacy around aging with HIV and PLWH over 50. The Illinois Public Health Association (IPHA) has implemented an assertive effort to advocate for and contribute to public education around HIV and Aging. Both the AFC and IPHA are grantee participants in the national HIV Age Positively Initiative of Gilead Sciences.

Work on aging policies and programs to address the needs and concerns of older PLWH has been taken up by several local AAAs ("Triple A's," in OAA parlance). The AgeLinc AAA, covering several central Illinois counties and the state capitol of Springfield, has partnered with the IPHA to develop the "OUTSafe: LGBTQ+ Older Adult Violence Prevention Program" curriculum. The program addresses the rising levels of anti-LGBTQ+ violence and hate crimes, helping community members access resources and support. Specifically, the program is an "in-person introductory training for local health department staff and other public health professionals will provide education and understanding for service providers on the victimization of older LGBTQ+ adults and will assist providers in best caring for older LGBTQ+ adults who come forward about their victimization."[59]

Goal Two of the Illinois state plan is to "Expand and ensure equitable access to programs that address the social determinants of health with a focus on identifying and understanding the needs of underserved and diverse populations." Under this goal, Strategy 2.1 mandates that the Illinois Department of Aging Advisory Councils engage in discussion throughout the state network to "modify in response programming, funding, resources, and partnerships to better reach and meet their needs of such groups as:

- older adults who are disproportionately underserved by or under-represented in aging network services, especially groups and individuals facing one or more systems of oppression or discrimination
- older adults living with HIV, with a focus on reaching those who have also faced injustice and discrimination and may not trust public systems
- older adult immigrants, especially undocumented immigrants
- older adults who have experienced trauma and mental illness, including historical trauma
- older adults experiencing or who have experienced homelessness
- older adults who have one or more disabilities

APPENDIX C. MULTI-SECTOR PLANS ON AGING

TABLE C1. MULTI-SECTOR PLANS FOR AGING (MPAs)

States	MPA In Place	Mentions services for PLWH?	Mentions Older Americans Act?	Mentions support for LGBTQIA+ groups	Health/Aging Disease Promotion
California	Yes	No	Yes		Yes
Colorado	Yes	No	Yes		Yes
Illinois	No	NA	NA		NA
Indiana	No	NA	NA		NA
Maryland	Yes	Yes	Yes		Yes
Massachusetts	Yes	No	Yes	Yes	Yes
Minnesota	Yes	No	No		NA
Missouri	Yes	No	Yes		Yes
New York	Yes	Yes	No		Yes
North Carolina	Yes	No	Yes		Yes
Oklahoma	Yes	No	Yes		Yes
Pennsylvania	Yes	No	No		Yes
Tennessee	Yes	No	Yes		Yes
Texas	Yes	No	Yes		Yes
Utah	Yes	No	No		Yes
Vermont	Yes	No	Yes		Yes

APPENDIX D. PROFILES OF SELECTED MULTI-SECTOR PLANS ON AGING

California's Fourth Annual MPA, January 2025

California's MPA is organized around five main goals for driving progress.

1. Housing for all ages & stages
    a. Expanding tax credits to develop more affordable senior housing
    b. Expanded assisted living
    c. Expanded access to housing related services/supports
        - In February 2024, the U.S. HHS and the U.S. Department of Housing and Urban Development (HUD) selected California to participate in the Housing and Services Partnership Accelerator program. The program supported states in developing or expanding innovative housing-related supports and services for Medicaid-eligible older adults and people with disabilities who are experiencing or at risk of homelessness. DHCS served as the lead state entity, in partnership with CDA, California Department of Rehabilitation (DOR), BCSH, and HCD.
        - Expand emergency shelter/emergency housing assistance and provide supportive services for victims/survivors of crime with specialized needs, including older adults, people with disabilities, LGBTQIA+, non-English speaking or culturally or religiously marginalized populations through the Specialized Emergency Housing (Key Elements [KE]) Program.
    d. No mention of HOPWA for PLWH

2. Health Reimagined
    a. Free Medicare part A
        - On January 1, 2025, California became a Medicare Part A buy-in state. This means that eligible Medi-Cal members will receive Medicare Part A services for free if they are enrolled in Medicare Part B and they qualify for the Qualified Medicare Beneficiary program (QMB). For these members, Medicare, instead of Medi-Cal, will provide primary coverage for hospitalizations and other inpatient benefits. Under this new buy-in agreement with CMS:
            - California will eliminate the conditional enrollment requirements for Medicare Part A at the Social Security Administration.
            - California can enroll eligible QMB members in Medicare Part A year-round without any late enrollment penalties.
            - All eligible full-scope Medi-Cal members receiving SSI/SSP will be automatically enrolled in Medicare Part A if they are enrolled in Medicare Part B and qualify for the QMB program. Non-SSI/SSP individuals can apply and enroll in the QMB program once enrolled in Medicare Part B at their county office. Once QMB-enrolled, DHCS will automatically enroll them in the Medicare Part A buy-in and pay their Part A premium.
    b. No mention of PLWH specifically

3. Inclusion and Equity, Not Isolation
    a. Establish an Aging & Disability Lived Experience Advisory Board (AD-LEAB) that represents the lived experience of older adults, people with disabilities, and caregivers from underrepresented and underserved populations and communities to inform and guide the Master Plan for Aging (MPA).
    b. Ensure people of color, both older adults and people with disabilities, are represented as a population of focus in the Racial Equity Framework, through the work of the California Racial Equity Commission.

c. Conduct outreach to and focus groups with LGBTQIA+ older adults to deepen California's understanding of the population and improve access to affirming services, building upon California's first statewide study on LGBTQIA+ older adults.
d. No mention of PLWH specifically

4. Caregiving that works
    a. Advance the implementation of the National Strategy to Support Family Caregivers by launching California's Caregiver Equity Roadmap, which seeks to expand access to culturally responsive caregiver services for underserved and underrepresented populations and communities.
    b. Launch Cal CARES (California Caregiver Awareness, Resources, Education & Support), with a focus on underserved and underrepresented populations and communities to improve awareness of and outreach to caregivers, navigation of caregiver resources, and access to caregiver education and training opportunities.
    c. No mention of PLWH specifically

5. Affordable Aging
    a. Promote and support access to healthy foods for older adults and people with disabilities through state and federal programs, including the Senior Farmers' Market Nutrition Program, Farm to Community Food Hubs Program, and Farm to Food Bank Program.
    b. Conduct and publish a comprehensive population analysis that reports on current and projected need for Long Term Services and Supports (LTSS) in California.
    c. No mention of PLWH specifically

Maryland MPA Details

Maryland's MPA is organized around four main "Epic Goals."

1. Build a longevity ecosystem
    a. Strengthen partnerships with service providers, community organizations, nonprofits, academia, and the private sector to leverage public-private partnerships and support community-driven action.
    b. Enhance multi-disciplinary prevention and response policies for elder abuse, neglect, and exploitation across state agencies.
    c. Increase the distribution of resources across state programs to historically underserved and under-resourced communities.
        - 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.
    d. Maximize the benefits of older volunteers across sectors.

2. Promote Economic Opportunities
    a. Strengthen Maryland's ongoing commitment to family caregivers.
        - 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.
    b. Improve the quality of direct care careers.
    c. Increase the number of Maryland employers that promote sustainable career opportunities using age-inclusive policies and practices.

3. Prepare Marylanders to Afford Longevity
    a. Improve access to affordable, accessible housing options that support aging in place.
        - 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.
    b. Assist Marylanders with long-term financial planning.
    c. Streamline access to public benefits and services.
        - Incorporate programs targeting Marylanders across the lifespan, including older adults, adults with disabilities, and caregivers into the universal eligibility benefits application.
        - Increase awareness of Social Security survivor benefits for non-married same-sex couples.

4. Optimize Health, Wellness, and Mobility
    a. Improve equitable access to holistic health care that addresses physical, behavioral, emotional, and cognitive health.
        - 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 well-being.
    b. Increase access to healthy food and physical activity.
        - 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.
    c. Increase investment in services and transportation infrastructure that promote safety, accessibility, and mobility.
        - 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.
    d. Enhance a culture of social connection.

New York MPA

Throughout the MPA process, more than 100 proposals were developed, thanks in particular to thousands of hours of work by external stakeholders and members of the public. These proposals are organized across 9 pillars identified through the subcommittee and workgroup process. Proposals under each pillar are reviewed in detail on the New York State "Master Plan for Aging" webpage, https://planforaging.ny.gov/pillars. Highlights related to HIV are pulled out in bullets for Pillars 3 (prevention) and 8 (stigma):

1. Informal Caregiver and Workforce Support and Modernization of Community Based Aging Network Service

2. Modernization and Financial Sustainability of Health Care, Residential Facilities and Community-Based Aging Network Service Providers

3. Prevention, Wellness Promotion and Access
    a. Provide information and education to older adults to maintain optimal sexual health and intimacy wellness. This includes information on dating, physical intimacy, and sexually transmitted infections (STIs) awareness and prevention efforts (including HIV and Hepatitis C). This includes the importance of ongoing testing, the use of condoms, and information on medications, such as PrEP and Doxy-PEP.
    b. Establish training and materials to better serve older adults related to their sexual health and intimacy needs to prevent sexually transmitted infections (STIs), sexual violence, and to foster healthy communication and relationships.

- Continue and expand awareness and access to sexual health and prevention efforts (i.e., PrEP, Doxy-PEP, hepatitis, intimate partner violence, etc.) to all treatment providers and ancillary staff who can proactively initiate conversations with older adults.
- Advocate for STI and HIV education and testing for older adults, even those over 65.

4. Housing Access and Community Development

5. Affordability of Basic Necessities

6. Access to Services in and Engagement with Historically Underserved Communities

7. Social Engagement of Older Adults

8. Combating Elder Abuse, Ageism, Ableism and Stigma
   - Develop anti-stigma and education campaigns specifically focusing on aging with HIV, the LGBTQ+ aging population and addressing sexual health with aging New Yorkers.
   - Develop education, training, and awareness about HIV and the needs of people with HIV and the LGBTQ+ population, in collaboration with the AIDS Institute, for staff in long-term care facilities, caregivers, and aging related health and community providers.

9. Technology Access and Development

APPENDIX E. ADVOCACY RESOURCES

Organization/ Author	Source Title	Publication Date	Source Type	Main Point/Relevance	Key Terms Used by Source
American Society on Aging	Making the Aging Network HIV-Inclusive: A Practical Guide for Aging Services	12/2025	Toolkit	The guide from the American Society on Aging provides aging service providers with a practical roadmap to better support older adults living with HIV by creating welcoming, stigma-free, and affirming environments. It emphasizes building HIV knowledge among staff, embedding inclusive practices into intake and care coordination, addressing social determinants of health, and partnering with HIV service organizations to ensure dignity and equitable care. The guide frames HIV inclusion as a necessary evolution of aging services to meet the needs of a growing population aging with HIV.	"HIV [as] an aging issue" "HIV-inclusive aging services" "Older adults living with HIV"
Center for Health Law & Policy Innovation	Healthcare in Motion: Ending the HIV Epidemic in 2026	1/14/2026	Advocacy Paper	The paper outlines how recent federal budget proposals, Medicaid work requirements, and state policy changes are threatening access to HIV prevention, care, and support services, even as medical tools like antiretroviral therapy and PrEP make ending the epidemic possible. It stresses that advocates must fight to protect, fund, and expand effective HIV programs and ensure government policies support access to treatment and prevention for all communities.	"advocacy for federal funding to protect programs" "uncertainty in appropriations and level funding concerns" "advocacy across government levels"
The Center for HIV Law and Policy	Aging & HIV: An introduction to legal issues facing people living and aging with HIV, CHLP (2024)	8/2024	Legal Primer	The paper outlines how the growing number of older adults living with HIV face significant legal and systemic challenges, such as discrimination, criminalization, and barriers to autonomy, that hinder their ability to age with dignity. The author explains existing legal protections and support systems under federal law and offers guidance for people living with HIV and advocates to overcome these obstacles and prioritize policy change.	"legal barriers" "HIV aging population and expanding needs" "guidance for self-advocacy and community empowerment"
O'Neil Institute Center for HIV and Infectious Disease Policy	Better Integration Between HIV and Aging Systems is Critical	8/2024	Policy Brief	The Georgetown O'Neill Institute report emphasizes that the majority of people with HIV in the U.S. are over 50 and face unique clinical and social challenges as they age. It calls for expanding provider capacity, integrating HIV and aging services, and adapting prevention and sexual health interventions to meet the needs of older adults with HIV. The report also highlights disparities in care, including late diagnoses, comorbidities, and insufficient provider expertise, and recommends federal and state policy actions to improve access and quality of care for this population.	"integrating HIV and aging services" "clinical and social needs of older adults with HIV" "interagency collaboration for HIV and aging programs"

Organization/ Author	Source Title	Publication Date	Source Type	Main Point/Relevance	Key Terms Used by Source
Ribbon Organizing Center for the HIV Age Positively Initiative (ROC4Aging+)	Congressional Policy Paper on HIV and Aging	6/14/2023	Policy Paper	The Congressional Policy Paper on HIV and Aging outlines the unique health, social, and economic challenges faced by people aging with HIV, especially older adults, long-term survivors, and lifetime survivors. It calls for federal action to improve their quality of life through targeted funding, research, and supportive services. The paper emphasizes strengthening healthcare and social service systems, expanding evidence-based care models, addressing stigma and disparities, and enhancing workforce capacity to meet the complex needs of an aging HIV population.	"Older adults living with HIV" "lifetime survivors" "long-term survivors"
Save HIV Funding	Save HIV funding campaign sounds alarm on perfect storm emerging for HIV care with state and federal cuts colliding across the country: Rapid response media resource kit	1/14/2026	Media Resource Kit	The Save HIV Funding campaign released a media resource kit to alert the public and journalists about converging federal and state budget cuts that threaten HIV care services, especially potential restrictions to Florida's AIDS Drug Assistance Program and nearly $2 billion in cuts to mental health and HIV prevention grants. The coalition of advocates is tracking disruptions nationwide and urging action to protect critical funding before a potential lapse in FY26 appropriations, emphasizing the real-world harm these cutbacks could cause to people living with or vulnerable to HIV.	"funding threats" "disruptions of health services"
USAging	November 3, 2025 Advocacy Alert	11/03/2025	Advocacy Alert and Letter Template	The advocacy alert was created during the fall 2025 government shutdown. It acknowledges that while the OAA and other aging programs will be safe for FY26, funding delays will persist even after the shutdown ends, affecting the work Area Agencies on Aging do to ensure older adults have access to services such as caregiver assistance, transportation and meals. The alert urges people to contact their lawmakers to come to a bipartisan agreement that will allow them to reopen the government and provides an email template.	"risk of service interruption"
USAging	January 6, 2026 Advocacy Alert	1/06/2026	Advocacy Alert	The advocacy alert states that funding for many aging and health programs only lasts until January 30, 2026, which raises the risk of another shutdown. Lawmakers are now negotiating a final FY 2026 spending bill that could significantly impact the OAA (specifically, Title V, the Senior Community Service Employment Program) and other aging services. Advocates are being asked to speak up now to protect current funding, push for increases, and ensure these programs are not cut in the final agreement.	"appropriations bills" "protect and increase funding for aging programs"

APPENDIX F. STRATEGIES FOR NAVIGATING LEGISLATIVE UNCERTAINTY

Given the central role that the Older Americans Act (OAA) plays in the provision of services meant to benefit individuals aged 60 and older, its dismantling would beget significant financial hardship for adults across the United States as billions of dollars in federal funding for nutrition, transportation, caregiver support, and in-home assistance would be lost. It is not hyperbole to speculate that the collapse of the OAA could cause the collapse of the national aging network composed of State Units on Aging and Area Agencies on Aging.

Any commitment to addressing racial, social, and health disparities for vulnerable communities, particularly aging PLWH, confronts a double challenge in the loss of the OAA, that of a rapidly growing elderly population whose needs and demands on the system are growing commensurately.

The following is an exploration of the possible fallout resulting from the collapse of the OAA and how advocates can position themselves and their communities to weather this scenario.

Impact Assessment

Begin with assessing the problem. The dismantling of the funding structure created by the OAA would inflict a two-pronged shock on advocates and the communities they serve: the loss of a national care network along with the loss of significant funding streams. Lacking funding and an administrative infrastructure, local and state agencies have restricted abilities to meet basic needs.[60]

Network Collapse

The OAA funds a national network of State Units and Area Agencies on Aging along with thousands of community service providers. State governments, local agencies, and community advocates rely on this network for referrals, intra-network coordination, and the coordination of resource delivery.

Aggravated Social Conditions

Aging PLWH often face higher rates of chronic comorbidities. The OAA helps address that by providing eligible older adults with easier access to at-home and congregate meals as well as transportation to and from appointments, doctors' visits and pharmacies.

Financial Restructuring

As dire as this situation would surely be, there are concrete steps that advocates and organizations can take to protect their agencies and their communities in the event of the dismantling of the OAA in 2026. Similar steps have been taken by non-profits across sectors in response to federal funding freezes and cuts in 2025.[61] Strategies for dealing with lower or more restricted funding include:

Insurance Reimbursement

Dedicate more organizational resources to providing services that are reimbursable under Medicare Advantage and Medicaid Managed Care plans. Shifting from relying on dollars provided by federal grants to health insurance reimbursement will allow community organizations to manage the financial volatility brought about the termination of OAA funding opportunities.

Private and Corporate Funding[62]

Launch targeted capital and operational campaigns aimed at major national foundations whose foci and missions align with organization purpose and community needs.

Earned Income and Consulting[63]

Organizations and their leadership can create reliable streams of revenue by marketing their subject matter expertise to other organizations looking to work in solidarity with the older PLWH. The services that will grow and sustain this revenue stream could be centered around the provision of training and technical assistance, particularly to other health and human service providers.

Individual Giving

Cultivate a donor base composed of high-net worth individuals, particularly those who are champions of the kind of work that the organization carries out, as well as people who may have been alienated by the current federal administration.

Avoid Service Duplication

In an environment where many long-standing services made possible by OAA funding may be forced to suspend operations due to the dismantling of the OAA, we should not try to fully replace large-scale OAA funded services (such as by creating a wide-reaching Meals on Wheels program, for example). Instead, we should focus on providing specialized health and case management services to and in conjunction with local, community-based programs and organizations engaged in work that was once the domain of larger federally funded service providers.

Advocacy Pivot

Finally, the dissolution of the OAA would necessitate a significant pivot from service delivery within a functioning federally supported network to one that builds new, more localized networks and focuses on advocating for state-level replacement structures. Elements of this advocacy can include the following strategies:

Medicaid Integration

Organizations can advocate with state officials for the expansion of Medicaid Home and Community-Based Services waivers to cover non-medical social supports that were previously provided by the OAA such as respite care, transportation, and non-medical at-home assistance.

State-Level Safety Net

Enter into action-oriented coalitions with similarly oriented organizations such as AARP to lobby state legislatures for funds to replace services once provided under Title III of the OAA.[64]

Ryan White HIV/AIDS Treatment Extension Act of 2009

In the event that OAA funding ceases, funding from the Ryan White CARE Act will become even more critical. Advocacy can play a leading role in ensuring that Ryan White programs successfully integrate geriatric and long-term care services into their models, recognizing that HIV survivorship is now synonymous with aging.

While the loss of funding from the federal government under the OAA would present significant challenges to organizations working in spaces of aging and HIV, leadership can continue to work in solidarity with the communities by diversifying their organizational funding bases and shifting focus to state-level advocacy and funding initiatives in addition to entering into partnerships with organizations to recreate the supportive networks for constituents once made possible by OAA funding.

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