DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2014

Administration for Community Living

Justification of Estimates for Appropriations Committees

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From the Administration for Community Living

I am pleased to present the first Administration for Community Living (ACL) budget request to the Congress. This includes FY 2014 budget requests for our two main program agencies: the Administration on Aging and the Administration on Intellectual and Developmental Disabilities.

Secretary Sebelius formed ACL as a single agency charged with working with States, localities, Tribal organizations, the nonprofit sector, businesses and families to help more seniors and people with disabilities have the option to live in their homes and to fully participate in their communities. For many of these individuals, access to home and community supports and services can make the difference between living at home and having to move into a nursing home or another institution.

The national aging services network annually serves nearly 11 million seniors and their caregivers. These services are especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission. The developmental disabilities network provides access for people with disabilities and their family members to facilitate living independently in a home of their choosing, receiving appropriate services and supports. The array of programs provided through these networks work toward ACL's overarching goal of connecting Americans with the long-term community services and supports that they need.

This budget recognizes the fiscal challenges of the nation and proposes simply to maintain most funding at current levels to keep these successful community-based programs, which work to protect the rights and interests of people with disabilities and older adults, as strong as possible.

Our vision for ACL is about more than simply maintaining our current programs; we will continue to work to improve long-term services and supports for this country. Too many Americans experience unnecessary facility-based care simply because they are older or have a disability. Our nation's long term services and supports system has a well-documented over-reliance on institutional services. ACL will continue to promote a better understanding of the home and community-based options available to those with functional needs and where they can turn when they need assistance.

ACL provides an opportunity to better align the medical, clinical, and community-based supports that comprise our nation's long-term care delivery system. This will prove to be incredibly beneficial to older Americans and people with disabilities who often have a disproportionate reliance on our healthcare system. Through this improved alignment, we hope to see better health outcomes, quality of daily life, and increased efficiencies for these two often-vulnerable populations.

Kathy Greenlee

Administrator & Assistant Secretary for Aging

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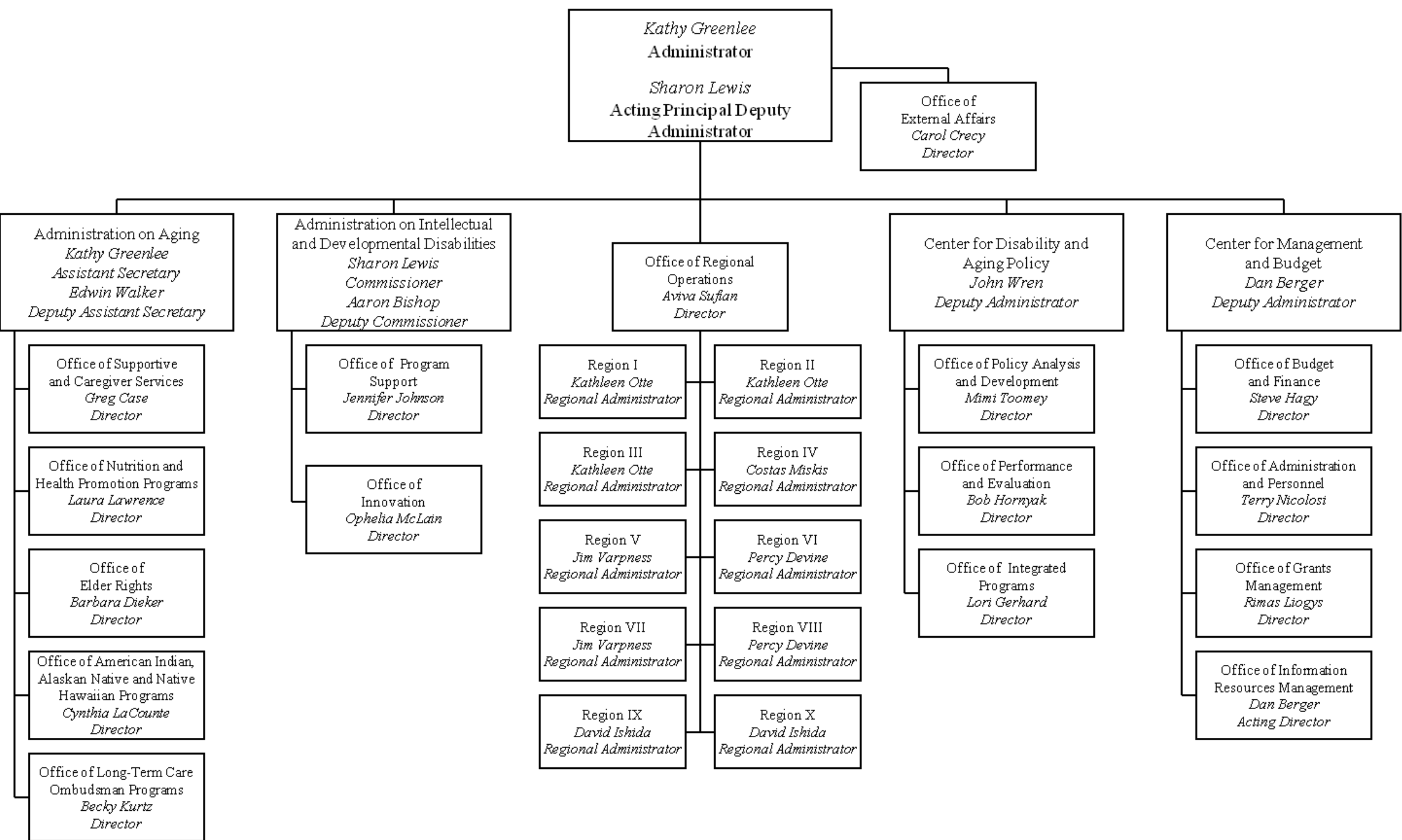
ADMINISTRATION FOR COMMUNITY LIVING ORGANIZATIONAL CHART



As of February 13, 2013

Introduction and Mission

The Administration for Community Living (ACL) is the newest Operating Division within the U.S. Department of Health and Human Services (DHHS), formed by Secretary Sebelius in April 2012 as a single agency charged to work with States, localities, Tribal organizations, nonprofit organizations, businesses and families to help more seniors and people with disabilities have the option to live in their homes and fully participate in their communities. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers.

Those with disabilities or functional limitations of any type, regardless of age, have a common interest. For these populations, access to home and community-based supports and services can make the difference in ensuring that people can fully participate in all aspects of society, including having the option to live at home instead of having little choice but to move into some form of institutional care. ACL works to improve this access through two distinct program lines that address the unique needs of each community: programs serving seniors and caregivers under ACL's Administration on Aging (AoA) and programs for people with intellectual and developmental disabilities and their families under ACL's Administration on Intellectual and Developmental Disabilities (AIDD).

AoA advances the concerns and interests of older people, and works with and through the national aging services network to promote the development of comprehensive and coordinated systems of home and community-based care that are responsive to the needs and preferences of older people and their caregivers. The network is comprised of 56 State and Territorial Units on Aging (SUA), 629 Area Agencies on Aging (AAA), 256 Indian Tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. AoA's core programs, authorized under the Older Americans Act (OAA), help seniors remain at home for as long as possible. These services complement existing medical and health care systems, help prevent hospital readmissions and support some of life's most basic functions, such as bathing or preparing food.

AIDD advances the concerns and interests of people with developmental disabilities and their families, working through a network that includes, in each State and Territory, State Councils on Developmental Disabilities, State Protection and Advocacy systems, and University Centers for Excellence in Developmental Disabilities (UCEDDs). AIDD programs fund capacity-building and systems change efforts to ensure that people with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life.

To enhance and strengthen these distinct program lines going forward, ACL will promote consistency and coordination in community living policy and seek to better align the medical, clinical, and community-based supports that are critical to both constituencies. ACL's Center for Aging and Disability Policy will provide a focal point for these efforts to develop new polices and initiatives that support both older Americans and persons with disabilities in accessing services and supports and fully participating in their communities.

Overview of Budget Request

The FY 2014 discretionary request for the Administration on Community Living (ACL) is $2,094,755,000, a reduction of -$57,704,000 from the FY 2012 enacted level.[1] This budget—ACL's first— generally proposes to maintain funding at current levels for these successful community-based services and supports, which enable seniors and people with disabilities of any type, regardless of age, to remain in their communities and to fully participate in society.

Under the request, three programs – the Department of Labor's Senior Community Employment Program (SCSEP), the Centers for Medicare & Medicaid Services State Health Insurance Assistance Program (SHIPs), and the Center for Disease Control and Prevention's Paralysis Resource Center (PRC) are all proposed for transfer to ACL. Each of these three programs will complement the existing population served and success provided by ACL.

The FY 2014 program level also requests $24,700,000 from the Prevention and Public Health Fund authorized by the Affordable Care Act. Of this, $10,000,000 would support continued funding for Chronic Disease Self-Management Education programs across the nation. The remaining $14,700,000 would support the continuation of activities under the President's Alzheimer's Initiative, including an outreach campaign and the development of more dementia-capable long-term service and support systems designed to meet the needs of caregivers of individuals with Alzheimer's Disease.

In addition, the overall budget includes $20,710,000 in mandatory funding that is appropriated or will be otherwise available in FY 2014. Of this total, $10,000,000 is for Aging and Disability Resource Centers (ADRCs) in the final year of funding authorized under the Affordable Care Act. In addition, $10,710,000 is available for Health Care Fraud and Abuse Control activities.

ACL's programs provide services and assistance to a growing segment of the population. The U.S. population over age 60 is projected to increase by 26 percent between 2012 and 2020, from 61 million to 77 million[2]. Over the same period, the number of seniors age 65 and older with severe disabilities – defined as 3 or more limitations in activities of daily living – who are at greatest risk of nursing home admission, is projected to increase by nearly 30 percent[3]. The US

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[1] Note that totals include both AoA and AIDD funding for the first time. Comparisons to prior years are adjusted for comparability to include both bureaus.

[2] U.S. Census Bureau, "2012 National Population Projections," Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060 released December 2012, accessed 29 March 2013.

[3] Data extrapolated by AoA from Ibid and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2010." < http://www.cdc.gov/nchs/hdi.htm> Accessed 28 August 2012.

Census Bureau also estimates that 37 million people have a disability, representing 12.1 percent of the civilian noninstitutionalized population. Broken down by age group, this includes:

- 4 percent of children 5 to 17,
- 10 percent of people 18 to 64, and
- 37 percent of adults 65 and older. [4]

Studies indicate that individuals with developmental disabilities comprise between 1.2 and 1.65 percent of the U.S. population, or between 3.7 and 5.2 million individuals.[5]

Maintaining funding for community-based services and supports for these two growing populations is vital. ACL's services assist people to remain independent and in their communities, potentially delaying institutionalization. Institutional care can be more expensive to the government, and Medicaid is a major payer of these services.

For example, a recent AARP study found that in 2009, approximately 42.1 million family caregivers provided assistance to adults with limitations in daily activities.[6] These unpaid caregivers provided an AARP-estimated $450 billion in services. The long-term needs of today's growing numbers of elderly place tremendous strain on families, and underscore the critical importance of ACL programs. If families become overwhelmed by the burdens of caregiving, the costs of providing this care could fall on other government resources.

To address these needs, most ACL funding would be maintained in this request for programs serving seniors and caregivers under the Administration on Aging, as well as for programs serving people with developmental disabilities and their families under the Administration on Intellectual and Developmental Disabilities (AIDD). Specific funding requests follow:

<u>Administration on Aging (AoA)</u>

The request includes $1,454,924,000, an increase of +$7,527,000 over the FY 2012 enacted level, for programs to maintain seniors' health and independence, caregiver services, and services to protect vulnerable older Americans. These include:

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[4] U.S. Census Bureau, 2011 American Community Survey 1-Year Estimates. Table DP02: Selected Social Characteristics In The United States. < http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType =table> Accessed 29 March 2013.

[5] Extrapolated from Developmental Disabilities Assistance and Bill of Rights Act of 2000, Section 101(a)(1) and census estimates of U.S. Population, July 1, 2012

[6] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

- *Health and Independence Programs ($1,249,623,000)*, which provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive institutional care. These programs include home and community-based supportive services, nutrition services (both meals in congregate settings and those delivered to seniors in their homes), preventive health services, and related training and technical assistance activities.

- *Caregiver Services ($172,012,000)*, which support caregivers, elders, and people with disabilities by providing critical respite care and other support services for family caregivers, training and recruitment of care workers and volunteers, information and outreach, counseling, and other supplemental services. This also includes supports specifically focused on those caring for people with Alzheimer's Disease.

- *Services to Protect Vulnerable Older Americans ($43,287,000)*, which prevent, detect, and respond to elder abuse, neglect, and exploitation, both at home and in institutional settings. These programs help to prevent and mitigate the negative effects of abuse, neglect, and exploitation on the health and independence of seniors, and also help to detect and prevent fraud in Medicare and Medicaid.[7] This includes $8,000,000 in continued support for the Adult Protective Services program demonstrations, which received startup funding in FY 2012 from the Prevention and Public Health Fund.

Administration on Intellectual and Developmental Disabilities (AIDD)

The request includes $167,983,000, the same as the FY 2012 enacted level, for five programs that address the needs of those with developmental disabilities. These include:

- *State Councils on Developmental Disabilities ($74,774,000)*, which engage in advocacy, capacity building, and systemic change activities that contribute to a coordinated and comprehensive system of community supports and services that promote self-determination, integration, and inclusion for people with developmental disabilities.

- *State Protection and Advocacy systems ($40,865,000)*, which protect the legal and human rights of all people with developmental disabilities by pursuing legal, administrative and other appropriate remedies, including investigating incidents of abuse and neglect.

[7] Lachs M. S., Williams C., O'Brien S., Hurst L., Kossack A., Siegal A., et al. (1997). "ED use by older victims of family violence." Annals of Emergency Medicine. 30:448-454.

- *University Centers for Excellence in Developmental Disabilities ($38,792,000)*, which conduct interdisciplinary training, community services, research, and information dissemination activities that promote opportunities for people with developmental disabilities to be independent, productive and integrated and included in the community.

- *Projects of National Significance ($8,317,000)*, which fund grants, contracts, and cooperative agreements to create opportunities for individuals with developmental disabilities to directly and fully contribute to and participate in all facets of community life.

- *Help America Vote Act (HAVA) grants ($5,235,000)*, which assist Protection and Advocacy systems to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places.

Common Proposals

The budget proposes to transfer the Paralysis Resource Center from the Centers for Disease Control and Prevention to ACL. This program will benefit from ACL's connections to the disability networks and focus on community living, and it will serve as an important component of ACL's growing role as HHS' source of disability expertise and advocacy.

The FY 2014 budget request also continues to support the transfers to ACL of the State Health Insurance Assistance Program (SHIPs) from the Centers for Medicare & Medicaid Services (CMS) and of the Senior Community Service Employment Program (SCSEP) from the Department of Labor. These programs will benefit extensively from ACL's connections to the aging and disability networks, and will be made more efficient and effective under ACL's administration. This budget includes a difficult decision to reduce the Senior Community Service Employment program by -$68,251,000; ACL intends to make improvements to program performance by developing a proposal to better target limited resources to individuals with the greatest need by considering all sources of income for future enrollees.

In FY 2014, ACL is requesting $3,000,000 to restore funding for the National Long-Term Care Clearinghouse. Funding for this program originally authorized under the Deficit Reduction Act of 2005, was provided by the Affordable Care Act through FY 2015. However, mandatory funding was rescinded under the American Taxpayer Relief Act. The Clearinghouse provides important services that help educate consumers about their long-term care options. The FY 2014 budget requests discretionary funding in order to continue operation of the Clearinghouse, contributing to efforts that prepare Americans to pay for long-term services and supports.

Finally, ACL's request includes a single budget line for Program Administration of $30,035,000, an increase of +$477,000 over the FY 2012 enacted level for ACL's predecessor components, to carry out its programs. This request includes $2,167,500 in base funding which is reserved in FY 2013 for costs related to the expiration of ACL's current headquarters lease and its move to a new building. ACL has delayed this move until FY 2014. Therefore, ACL requests that these funds be retained in its base to ensure that funding for the move continues to be available. Should these funds not be needed for that purpose, ACL will redirect these funds to support critical services. Funds would also pay for administrative costs related to the transfer of the Paralysis Resource Center and the cost of the FY 2014 pay raise.

Looking to the future, ACL looks forward to opening a dialogue about how, during this time of limited resources, the Administration and HHS's broader resources can be leveraged to contribute and enhance community living and full participation for all Americans. Finally, too many Americans continue to experience unnecessary entry into facility-based care simply because they are older or have a disability, which reflects the nation's well-documented over-reliance on institutional services. ACL looks forward to working with our partners on ways to increase community integration and care management targeted at helping ACL's high-risk target populations avoid nursing home placement, Medicaid spend down, hospital readmission and emergency room visits, and entry into out-of-home 24 hours placement.

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Overview of Performance

In April 2012 AoA, AIDD, and the Office on Disability were reorganized into a single agency that supports both cross-cutting initiatives and efforts related to helping those with functional limitations live in the community. The Administration for Community Living (ACL) is focused on the unique needs of individual groups, such as persons with developmental disabilities or seniors with dementia, as well as the common issues that face individuals who need community-based supports, to have the option of living in the community rather than in institutional settings. This new agency will work to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers by advancing effective policies, services, and supports. The various components that came together to form ACL will continue their historical commitments to program performance. Below, an overview of performance is provided for AoA and AIDD.

AoA Overview of Performance

AoA program activities have a fundamental common purpose which reflects the legislative intent of the Older Americans Act (OAA) and the AoA Mission: to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities.

The Aging Services Program's fundamental purpose, in combination with the legislative intent that the National Aging Services Network actively participate in supporting community-based services with particular attention to serving economically and socially vulnerable elders, led AoA to focus on three measures: 1) improving efficiency; 2) improving client outcomes; and 3) effectively targeting services to vulnerable elder populations. Each measure is representative of several activities across the Aging Services Program budget and progress toward achievement of each measure is tracked using a number of indicators. The efficiency measure and corresponding indicators are reflective of the Office of Management of Budget (OMB) requirements to measure efficiency for all program activities. The client outcome measure includes indicators focusing on consumer assessment of service quality and outcome indicators focusing on nursing home predictors, successful caregiver program operation and protection of the vulnerable elderly. The targeting measure and indicators focus on ensuring that States and communities serve the most vulnerable elders. Taken together, the three measures and their corresponding performance indicators are designed to reflect AoA's goals and objectives and in turn measure success in accomplishing AoA's mission.

Consistent with this Administration's emphasis on transparency and accountability, AoA has taken several steps to improve the analysis and availability of performance information while also enhancing the rigor of program evaluations. To this end, AoA has:

- Expanded the availability of performance information via an on-line system that enables National Aging Services Network professionals and the public to develop benchmarks and examine trends nationally and at the State level.

- Submitted public use data sets to the http://www.data.gov/ system.

- Further analyzed the results from the AoA's National Survey of Older Americans Act Participants to help inform decision makers. Results show:

    - AoA is effectively reaching those most at risk of institutionalization;

    - Service recipients report Title III services enable them to remain in their own homes; and

    - Comparison of service recipients to the overall US population 60 and older shows that Title III serves older people who are less healthy and have more limitations than other older adults even after adjusting for demographic and socioeconomic differences between the groups.

- Tested through the Performance Outcomes Measurement Project (POMP) several methods for measuring the impact of services. Analysis of administrative data sets from four States, using Cox proportional hazards models, show a consistent lowering of the relative risk of nursing home placement with an increase in number of services utilized; and there was an increase in mean survival time in the community (i.e. months before nursing home entry) with increases in the total number of services used.[8]

- Conducted a comprehensive review of 2009 Title III-E National Family Caregiver Support performance data on a state by state basis. ACL regional staff prepared reports for states and held state level meetings covering topics such as outlier data, reasons for significant data variations, program design and variability as well as program/funding changes.

- Employed rigorous program evaluation methods including longitudinal data collection and matched comparison groups. Specifically:

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[8] Brock, D. B., Rabinovich, B., Severynse, J., Ficke, R. (2011). Risk factors for nursing home placement among Older Americans Act service recipients: Summary analysis of data from five sources. December 2011.

- The Title III-C Elderly Nutrition Services program evaluation employs a complex design that includes three major components and several subcomponents. The major components include a process study that surveys each level of the National Aging Services Network on a large array of topics; a costs study that measures the actual cost of providing a meal by cost category (e.g. labor, food, overhead); and an individual outcome study. The individual outcome study will measure the program's success at meeting the legislative intent of the program (reduce hunger and social isolation while improving health and well-being of consumers). In addition, AoA and Centers for Medicare and Medicaid Services (CMS) have entered into an Inter-Agency Agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost data of program participants compared to a matched group of seniors who do not participate in the program.

- The evaluation of the Title III-E National Family Caregiver Support program will be the first for this OAA program. It is designed as a longitudinal study with a comparison group so that the effects of the five service categories can be measured over time.

- AoA has finalized the design and operational plan for an evaluation of Aging and Disability Resource Centers (ADRC). Data collection is scheduled to begin in the spring of 2013 pending satisfaction of Paperwork Reduction Act requirements. The evaluation includes a process evaluation examining populations served, services provided, and organizational characteristics including funding levels and partnerships. The evaluation also includes a quasi-experimental design that compares consumer experiences and outcomes associated with accessing long-term care services and supports through an ADRC to those of consumers from non-ADRC communities.

- AoA awarded a contract in the fall of 2011 for the conduct of a process evaluation of its Chronic Disease Self Management Program (CDSME). The process evaluation will examine who the grantees serve, how local sites implement the program, what program completion rates are in general and by important subpopulations, and the extent to which grantees have built statewide distribution systems. The process evaluation will rely on existing program data such as consumer and site level data submitted by grantees and grantee progress reports. ACL is working closely with CMS to match the data from CDSME participants with their Medicare records to examine the implication of program participation on health care utilization. Initial reports should be completed spring 2013.

- o AoA awarded a contract in the fall of 2011 to develop a design for a rigorous evaluation of the impact of the Long-Term Care Ombudsman Program (LTCOP). This evaluation will ultimately consider program efficiency, including cost and resource utilization, and program effectiveness at the client/family, facility, municipal/State, and national levels. An evaluation design report for ACL was completed in January 2013. ACL is reviewing the report recommendations and implementation options.

- o AoA awarded a contract in the fall of 2012 to complete an organizational analysis on the Senior Medicare Patrol (SMP) program. This analysis is divided into two parts—an As-Is report and a To-Be report. The analysis looks at all aspects of the SMP program including its structure, management, performance measures, and results. Based on the results of the analysis, the program will determine how to best implement the changes recommended in the To-Be report. The As-Is analysis will be completed in June 2013 with the To-Be report completed in December 2013.

Current Performance Information

An analysis of AoA's performance trends shows that through FY 2011 most outcome indicators have been maintained or steadily improved. While service counts are declining due to flat funding and inflationary factors, AoA outcome indicators demonstrate that services are continuing to be effective in helping older persons remain at home. Some key successes are indicative of the potential of AoA and the National Aging Services Network to meet the challenges posed by the growth of the vulnerable older adult population, the changing care preferences of aging baby boomers, the fiscal difficulties faced by State budgets, and the expanding needs of both the elderly and their caregivers. Below are some examples of these successes:

- OAA programs help older Americans with severe disabilities remain independent and in the community: Older adults that have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home placement. Measures of the National Aging Services Network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2003, the National Aging Services Network served home-delivered meals to 280,454 clients with three or more ADL impairments and by FY 2011 that number grew by 30% to 358,376 clients. Another approach to measuring AoA's success is the nursing home predictor score. The components of this composite score are predictive of nursing home placement based on scientific literature and AoA's POMP which develops and tests performance measures. The components include such items as the percent of clients who are transportation disadvantaged and the percent of congregate meal clients who live alone. As the score increases, the prevalence of nursing home predictors in

the OAA service population increases. In 2003, the nursing home predictor score was 46.57 and preliminary data show it has increased to 62.79 in FY 2011.

- OAA programs are efficient: The National Aging Services Network is providing high quality services to the neediest elders and doing so in a very prudent and cost-effective manner. AoA has significantly increased the number of clients served per million dollars of AoA Title III funding over the last decade. In FY 2011 The National Aging Services Network served 8,881 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, AoA and the National Aging Services Network have met or exceeded efficiency targets.

- OAA programs build system capacity: OAA programs stay true to their original intent to "encourage and assist State agencies and Area Agencies on Aging to concentrate resources in order to develop greater capacity and foster the development and implementation of comprehensive and coordinated systems." (OAA Section 301). This is evident in the leveraging of OAA funds with State/local or other funds (almost $3 in other funds for every dollar of OAA funds expended), as well as in the expansion of projects such as the Aging and Disability Resource Center initiative, which has grown to over 492 sites across 52 States and territories to date.

- OAA programs are high quality: OAA clients report that services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services. In 2011, over 96% of transportation clients and caregivers rated services good to excellent. To help ensure the continuation of these trends in core programs, AoA uses its discretionary funding to test innovative service delivery models for State and local program entities that show promise for generating measurable improvements in program activities. For example, AoA has worked with CMS and the Department of Veterans Affairs to better integrate funding for long-term care service delivery, eliminate duplication and improve access to services through Aging and Disability Resource Centers.

Performance for FY 2014

Federal support for OAA programs is not expected to cover the cost of serving every senior. For Home and Community-based Services, with the same funding levels in FY 2014 as provided in FY 2012, outcomes are projected to show similar performance; however, service counts and other outputs are projected to decline because of rising costs, declining State and local program contributions, and staffing constraints at the State and local level. OAA programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute significant funding. States typically leverage resources of $2 or $3 per every OAA dollar. Regardless of the historic nature of State and local support for these

programs, AoA expects declining leveraged funds, as State, local, and private budgets continue to face economic hardships. This may adversely impact performance through FY 2014.

Performance Detail

Taken as a whole, AoA's performance measures and indicators form an interconnected system of performance measurement akin to the three legs of a stool (efficiency, outcomes and targeting) holding up AoA's mission and goals. Below is a summary of each measure, its indicators and their relationship to AoA's mission and vision.

Measure 1: Improve Efficiency

Program efficiency is a necessary and important measure of the performance of AoA programs for two principal reasons. First, it is important to be a responsible steward of Federal funds. Second, the OAA intended Federal funds to act as catalyst in generating capacity for these program activities at the State and local levels. It is the expectation of the OAA that States and communities increasingly improve their capacity to serve elderly individuals efficiently and effectively with both Federal and State funds.

Improvements in program efficiency support AoA's mission and HHS's strategic plan objective 4.A to ensure program integrity and responsible stewardship. Through optimal utilization of resources, improvements in program efficiency ensure that affordable and accessible community-based long-term care is available to promote the well-being of seniors and their family caregivers.

For FY 2014, there are two efficiency indicators for AoA program activities. Indicator 1.1 addresses performance efficiency at all levels of the National Aging Services Network in the provision of home and community-based services, including caregiver services. Indicator 1.3 demonstrates the efficiency of AoA in providing services to Native Americans.

A summary of program efficiency indicators for FY 2014 follows:

- Indicator 1.1: For Home and Community-based Services, including Nutrition Services, and Caregiver services, increase the number of clients served per million dollars of Title III OAA funding.

- Indicator 1.3: Increase the number of units of service provided to Native Americans per thousand dollars of OAA funding.

Measure 2: Improve Client Outcomes

While improving efficiency, AoA is committed to maintaining quality and improving client outcomes. The FY 2014 performance budget includes nine core performance indicators supporting AoA's commitment to improving client outcomes. AoA has multiple quality assessment indicators in this plan reflecting separate assessments provided by elders for services such as meals, transportation and caregiver assistance. Also, in developing the outcome indicators, AoA included measures to assess AoA's fundamental outcomes: to assist elders who wish to stay at home and in the community, and to measure results important to family caregivers. The measures for the Ombudsman program focus on the core purposes of this program: advocacy on behalf of older adults.

This measure supports AoA's overall mission, it is strongly tied to HHS Goal 3. Advance the Health, Safety and Well-Being of the American People and specifically Objectives 3.B promote economic & social well-being; 3.C improve services for people with disabilities and elderly; and 3.D promote prevention and wellness.

A summary of the client outcome indicators for FY 2014 follows:

- Indicator 2.6: Reduce the percent of caregivers who report difficulty in getting services.
- Indicator 2.9a: 90% of home delivered meal clients rate services good to excellent.
- Indicator 2.9b: 90% of transportation clients rate services good to excellent.
- Indicator 2.9c: 90% of National Family Caregiver Support Program clients rate services good to excellent.
- Indicator 2.10: Increase the likelihood that the most vulnerable people receiving OAA Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. This will be tracked by the use of a "nursing home predictor index" which measures the prevalence of select characteristics of the service population that research has shown to be predictive of nursing home placement. An increasing score shows an increased proportion of the client population is high risk with respect to institutionalization.
- Indicator 2.11: Increase the percentage of transportation clients who live alone.
- Indicator 2.12: Decrease the average number of complaints per long-term care facility.

- Indicator 2.14: Decrease the number of complaints not resolved to the satisfaction of the nursing home resident.

- Indicator ALZ.2: Increase number of individuals served with evidence-based interventions (Alzheimer Program).

Measure 3: Effectively Target Services to Vulnerable Elderly

AoA believes that targeting is of equal importance to efficiency and outcomes because it ensures that AoA and the National Aging Services Network will focus their services on the neediest, especially when resources are scarce. To help seniors remain independent, AoA and the National Aging Services Network must focus their efforts on those who are at the greatest risk of institutionalization.

Effective targeting of OAA services supports AoA's mission and HHS Goal 3. Advance the Health, Safety and Well-Being of the American People and specifically Objectives 3.B promote economic & social well-being; 3.C improve services for people with disabilities and elderly; and 3.D promote prevention and wellness. AoA's four indicators for effective targeting are crucial for ensuring that services are targeted to the most vulnerable client groups. A summary of the client outcome indicators for FY 2014 follows:

- Indicator 3.1: Increase the number of caregivers served.

- Indicator 3.2: Increase the number of older persons with severe disabilities who receive home-delivered meals.

- Indicator 3.3: The percentage of OAA clients served who live in rural areas is at least 10% greater than the percent of all US elders who live in rural areas.

- Indicator 3.4: Increase the number of States that serve more elderly living below the poverty level than the prior year.

AIDD Overview of Performance

The purpose of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) is "to assure that individuals with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life, through culturally

competent programs…" The Administration on Intellectual and Developmental Disabilities (AIDD) works with our partners in every state and territory to achieve the goals embodied in the DD Act. The AIDD Network consists of three programs – State Councils on Developmental Disabilities (SCDD), the Developmental Disabilities Protection and Advocacy program (PADD), and University Centers for Excellence in Developmental Disabilities (UCEDDs). Current data for the SCDD, PADD and UCEDDs are collected via annual program performance reports (PPRs). AIDD also implements the Projects of National Significance (PNS) which are designed to support the AIDD Network through data and research projects as well as fund innovative approaches to improving outcomes for those with developmental disabilities.

AIDD is undertaking multiple activities as part of a comprehensive review of performance measurement and data reporting activities across all DD Act programs, with an increased focus on outcomes. As a key part of this effort, AIDD has assembled a performance measurement workgroup to develop overarching performance measures across AIDD programs. With the reorganization into the Administration for Community Living, AIDD is now working with ACL performance staff as well as AIDD performance measurement workgroup members to integrate this process into the larger organization's performance measurement and management strategy.

In addition, in 2005 AIDD engaged evaluation experts who conducted an independent study of the programs to assess program effectiveness and efficiency. The study utilized performance measurement workgroups to propose performance criteria for measuring program results. As part of the independent study, data was collected on a sample of 60 AIDD grantees (e.g., 20 SCDD, 20 PADDs, and 20 UCEDDs) in FY 2010. The final report for the study was issued in December 2011. AIDD is utilizing the proposed performance criteria to make improvements to the way in which programs are monitored periodically as a component of the AIDD performance measurement system.

Finally, AIDD has established three program-specific performance measurement workgroups to review and evaluate the annual program performance reports used by the grantees to report on results. Through this process, AIDD will have in August 2013 data from the UCEDDs that is based on a more robust performance measurement system. AIDD will continue to work with the SCDD and the P&As in developing revised performance measures for the programs to better measure results and outcomes.

State Councils on Developmental Disabilities

State Councils on Developmental Disabilities (SCDD) work in each state and the territories to promote the development of a comprehensive, statewide, person-centered and family-centered system that provides a coordinated array of culturally-competent services and other forms of assistance for people with developmental disabilities, including individuals with autism, and

their families. SCDD have a significant impact on promoting self sufficiency and community living for persons with developmental disabilities. The State Councils do not provide services directly, but rather review and analyze the quantity and quality of services that are provided at the State and local level.
State Councils engage in a variety of activities that promote systems change and capacity building. Council activities include, but are not limited to, program and policy analysis, demonstration of new approaches, training, outreach, community support, interagency collaboration and coordination, and public education. A key activity for many Councils is leadership training to individuals with developmental disabilities and their family members to enhance civic engagement for creating more effective policy solutions.

At the end of each fiscal year, each State Council submits an annual Program Performance Report (PPR) that provides qualitative and quantitative data to describe its achievements during the past 12 months. The State Councils report in the PPR on the following outcome measure: Increase the percentage of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. The FY 2012 results for State Councils will be available in July of 2013. In FY 2013, the program expects to increase the percentage by at least 0.1 percent over the previous year's result, to demonstrate the impact the SCDD have on promoting self sufficiency and community living for persons with developmental disabilities.

The SCDD efficiency measure – the number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community per $1,000 of federal funding – reflects performance data reported to AIDD on existing annual reports from the states. The AIDD collected data for this efficiency measure from the State Councils starting in FY 2006, finding 7.82 individuals with developmental disabilities reached per $1,000 federal funding (2005 constant dollars) to the Councils. The target for each successive year is a one percent increase over the previous year. FY 2012 results are expected to be available in July of 2013. This result is important given the economic pressures in the states, which works against systems change and capacity building efforts.

AIDD is analyzing changes in performance to better understand the trends and to improve the provision of on-going technical assistance to the Councils. In FY 2011, AIDD engaged a workgroup of Council representatives and an expert in performance evaluation to review and evaluate the current measurement system used by Councils to report progress on an annual basis. As a result, new performance measures were drafted. In FY 2012, AIDD will continue to collaborate with the Councils, including members of the workgroup: to finalize the new draft measures, pilot the measures to ensure quality control in the data collection process using the new measures, and to develop a revised PPR template to ensure better narrative reports from the

Councils on their activities. AIDD anticipates the new PPR template, including the measures will be ready for use in the near future.

Developmental Disabilities Protection and Advocacy Program

The Developmental Disabilities Protection and Advocacy program (PADD) establishes and maintains a Protection and Advocacy (P&A) system in each state and territory to protect the legal and human rights of all persons with developmental disabilities. The P&A system has the authority to pursue legal, administrative, and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect and to access client records. Grantees must be independent of any agency that provides services to people with developmental disabilities. The PADD program is one of eight P&A programs housed in three federal agencies (Department of Health of Human Services, Social Security Administration, and Department of Education), which positions the systems to work across a variety of disability populations. The PADD program provides training, legal and advocacy services and information and referral services to people with developmental disabilities and their families. PADD funds also support training and technical assistance to leadership and staff of the P&A system to improve their performance.

PADD performance is reported through an annual measure of the percentage of individuals who have their complaint of abuse, neglect, discrimination, or other human or civil rights corrected compared to the total assisted. This measure demonstrates the rate of successful benefits accruing from the P&A program to individuals with developmental disabilities. Results for FY2012 are expected to be available in July of 2013. During the remainder of FY 2013, the program expects to further increase the result by one half of one percent over the previous year.

As part of AIDD's comprehensive review of performance measures and data reporting activities, a performance measurement workgroup was established in FY2012 to strategically review the PADD PPR to analyze program specific performance measurements and make recommendations for improvement. This workgroup has drafted revised measures for the PADD and anticipates having final measures by October 2013. The final measures will be pilot tested for quality control prior to full implementation. AIDD anticipates testing the new measures beginning in FY 2014.

Developmental Disabilities – Projects of National Significance

Projects of National Significance (PNS) is a discretionary program providing grants, contracts and cooperative agreements to public or private non-profit entities that support and supplement the work of the SCDD, the PADD, and UCEDDs. PNS complement these other DD programs by supporting the development of national and state policies, including federal interagency

initiatives; through demonstration projects addressing innovative and emerging best practices to expand opportunities for individuals with developmental disabilities to contribute to, and participate in, all facets of community life. Current PNS initiatives include employment initiatives, technical assistance, longitudinal data collection and analysis, evaluation, and monitoring.

AIDD continues to undertake a comprehensive review of performance measurement and data reporting activities across all DD Act programs with an increased focus on outcomes, including, the establishment of performance measurement workgroups, enhancement and streamlining data collection, and engagement with evaluation experts to recommend improvements.

University Centers for Excellence in Developmental Disabilities

UCEDDs are interdisciplinary education, research and public service units of a university system or are public or not-for-profit entities associated with universities that engage in interdisciplinary pre-service training, community services, research, and information dissemination activities. One of the unique contributions UCEDDs make to the intellectual and developmental disabilities community is in the area of training. UCEDDs provide interdisciplinary training to students from a wide array of professional backgrounds including but not limited to: pediatrics, social work, education, nursing, and administration to improve the quality of services and supports for people with developmental disabilities. UCEDDs also provide leadership in advising federal, state, and community policymakers about opportunities for individuals with developmental disabilities to exercise self-determination, be independent, productive, and integrated and included in all facets of community life. The UCEDDs use their federal grants to leverage additional funds to implement their core activities of interdisciplinary training, community service, research, and information dissemination.

A current measure used to demonstrate UCEDD performance in this area is the percentage of individuals with developmental disabilities receiving the benefit of services through activities in which UCEDD trained professionals were involved. The result for FY 2010 was 36.02 percent, which was slightly less than the target of 36.05 percent. A number of efforts are underway to increase the program's reach to individuals with developmental disabilities, including providing technical assistance on a variety of topics such as outreach to unserved and underserved populations, strategies for leveraging funds for carrying out the core functions, and enhancing engagement of self-advocates.

A UCEDD performance measurement workgroup has developed a UCEDD logic model that was used to make strategic updates to the UCEDD PPR template to ensure meaningful outcome measurements. New performance measures were pilot tested in 2012. UCEDDs began collecting data on the new measures in August 2012 and results will be reported in August 2013.

ACL's Internal Performance Management Plan

ACL's programs provide grants to the Aging and Developmental Disability Networks. AIDD administers several programs via grants made to States, including the SCDD (formula grants), PADD (formula grants), and the UCEDDs (discretionary grants), which are directly included in AIDD's current outcomes measures for the developmental disabilities programs. PNS, a discretionary program, also provide grants, contracts and cooperative agreements to support and supplement the work of AIDD and the DD Network. AIDD continues to strive to refine and improve the measures for these individual programs, as well as working to develop overarching, program-wide performance measures to reflect the success of the DD Network under the purposes of the DD Act.

The Administration on Aging provides formula grants to States or tribes and there is a great deal of flexibility in state program implementation. States, in turn, provide flexibility to the Area Agencies on Aging, where the home and community-based programs are actually administered. Since ACL is not directly involved in hands-on service provision, the Agency employs a program performance improvement strategy with multiple components that are expected to yield performance improvements. Examples of activity supporting the overall strategy follow:

- Collaboration with other Federal agencies.
- Collaboration with non-governmental organizations.
- Enhanced partnerships between Aging and AIDD Networks.
- Programmatic technical assistance.
- Improved performance measurement capacity and information collection tools.
- Rigorous program evaluation.
- Program Innovations demonstration grants.
- Senior leadership's involvement in performance management and reporting.

Some activities cited above are conducted directly by ACL's Central and Regional Office staff, and some are conducted through discretionary grants and contracts.

ACL senior management is directly engaged in developing these activities through grants and procurement planning. There is a rigorous process in which each office within ACL develops Program Funding Plan Memoranda which detail the proposed discretionary grant and procurement activities for the office and justify each proposed activity consistent with ACL's mission and performance measures. Senior leadership has also implemented processes to better use performance data for management decision-making, including a quarterly discretionary dashboard, weekly reports for the Administrator/Assistant Secretary, quarterly reviews of operating budgets, and bi-monthly managers meetings.

ACL also monitors senior manager performance by including measurable performance targets in performance plans. These performance targets must support ACL's mission and are consistent with the Agency's performance measures.

This and other performance information are used during the year to update ACL's Executive Leadership so that adjustments can be made as needed to ACL programs; it is also discussed and used as appropriate in ACL internal discussions as decisions are made each year regarding requested funding levels.

By establishing a culture where performance improvement is expected and by working collaboratively with our State and partners toward this end, the Aging Services and Developmental Disability Networks demonstrate solid performance over the past ten years.

All Purpose Table

Administration for Community Living

(dollars in thousands)

Program	FY 2012 Enacted	FY 2013 Annual CR	FY 2014 President's Budget	FY 2014 +/- FY 2012
Health and Independence				
Home & Community-Based Supportive Services	366,916	369,162	366,916	--
Congregate Nutrition Services	439,070	441,757	439,070	--
Home-Delivered Nutrition Services	216,830	218,157	216,830	--
Nutrition Services Incentive Program	160,389	161,371	160,389	--
Preventive Health Services	20,944	21,073	20,944	--
Chronic Disease Self-Management Education [PPHF] 3/	10,000	N/A	10,000	--
Senior Community Service Employment Program	448,251	450,994	380,000	(68,251)
Native American Nutrition & Supportive Services	27,601	27,770	27,601	--
Aging Network Support Activities	7,873	7,921	7,873	--
Subtotal, Health and Independence	1,697,874	1,698,205	1,629,623	(68,251)
Caregiver Services				
Family Caregiver Support Services	153,621	154,561	153,621	--
Native American Caregiver Support Services	6,364	6,403	6,364	--
Alzheimer's Disease Supportive Services Program	4,010	4,035	9,537	5,527
Alzheimer's Disease Initiative -- Services [PPHF] 3/	--	N/A	10,500	10,500
Lifespan Respite Care	2,490	2,506	2,490	--
Subtotal, Caregiver Services	166,485	167,505	182,512	16,027
Protection of Vulnerable Adults				
Adult Protective Services 4/	6,000	TBD	8,000	2,000
Long-Term Care Ombudsman Program	16,761	16,864	16,761	--
Prevention of Elder Abuse & Neglect	5,036	5,067	5,036	--
Senior Medicare Patrol Program	9,402	9,460	9,402	--
Health Care Fraud and Abuse Control 1/ [HCFAC]	10,710	10,710	10,710	--
Elder Rights Support Activities	4,088	4,113	4,088	--
Subtotal, Vulnerable Adults	51,997	46,214	53,997	2,000
Developmental Disabilities Programs				
State Councils on Developmental Disabilities	74,774	75,232	74,774	--
Protection and Advocacy	40,865	41,115	40,865	--
University Centers for Excellence in Developmental Disabilities	38,792	39,029	38,792	--
Projects of National Significance	8,317	8,368	8,317	--
Subtotal, Developmental Disabilities	162,748	163,744	162,748	--

Consumer Information, Access & Outreach				
Aging and Disability Resource Centers (Discretionary)	6,457	6,497	--	(6,457)
Aging and Disability Resource Centers [ACA]	10,000	10,000	10,000	--
Voting Access for People with Disabilities (HAVA)	5,235	5,267	5,235	--
Alzheimer's Disease Initiative--Communications Campaign [PPHF] 3/	4,000	N/A	4,200	200
State Health Insurance Assistance Program	52,115	52,434	52,115	--
National Clearinghouse for Long-Term Care Information 5/	3,000	86	3,000	--
Paralysis Resource Center 6/	6,700	6,741	6,700	--
Subtotal, Consumer Information, Access & Outreach	87,507	81,025	81,250	(6,257)
Program Administration 2/	29,558	29,739	30,035	477
Medicare Improvements for Patients and Providers Act (MIPPA)				
State Health Insurance Assistance Programs [TRA]	--	7,500	--	--
Aging and Disability Resource Centers [TRA]	--	5,000	--	--
Area Agencies on Aging [TRA]	--	7,500	--	--
National Center for Benefits Outreach Enrollment [TRA]	--	5,000	--	--
Subtotal, Program Level	**2,196,169**	**2,211,432**	**2,140,165**	**(56,004)**
Less: Funds From Mandatory Sources				
HCFAC Wedge Funds 1/	10,710	10,710	10,710	--
ACA Direct Appropriations	13,000	10,086	10,000	3,000
Prevention & Public Health Fund (ACA) 3/	20,000	N/A	24,700	(4,700)
Taxpayer Relief Act	--	25,000	--	--
Total, Discretionary Budget Authority	**2,152,459**	**2,165,636**	**2,094,755**	**(57,704)**

1/ $10,710,000 is a placeholder amount for FY 2014. The Secretary and Attorney General will determine the final amount.

2/ Includes comparable transfers in FY 2012 of $1,264,000 for funds from OS for the Office of Disability, $4,982,000 from ACF for the Administration on Developmental Disabilities, and $249,000 from CDC for the Paralysis Resource Center.

3/ The FY 2013 Prevention Fund Resources are reflected in the Office of the Secretary

4/ Funding for this activity was provided from the Prevention and Public Health Fund in FY 2012. The FY 2014 request is for discretionary funding.

5/ Funding for this program was provided by the Affordable Care Act in FY 2012 and FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act in FY 2013 (save for obligations through January 3, 2013). The FY 2014 request is for discretionary funding.

6/ Funding for this program was provided to the Centers for Disease Control and Prevention in FY 2012 and FY 2013. It is proposed for transfer to ACL in FY 2014.

Appropriations Language

Administration for Community Living

Aging and Disability Services Programs
(including transfer of funds)

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965 (``OAA''), [section 398 and title] *titles III and XXIX* of the PHS Act, section 119 of the Medicare Improvements for Patients and Providers Act of 2008, *section 6021(d) of the Deficit Reduction Act of 2005,* [and] title XX-B of the Social Security Act, *the Developmental Disabilities Assistance and Bill of Rights Act, parts 2 and 5 of subtitle D of title II of the Help America Vote Act of 2002, and for department-wide coordination of policy and program activities that assist individuals with disabilities,* [$1,926,434,000] *$2,042,640,000*, together with [$51,902,000] *$52,115,000* to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to carry out section 4360 of the Omnibus Budget [Reconcilliation]*Reconciliation* Act of 1990: *Provided*, That amounts appropriated under this heading may be used for grants to States under section 361 of the OAA only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective: *Provided further*, That, notwithstanding section 206(g) of the OAA, up to one percent of amounts appropriated to carry out programs authorized under title III of such Act shall be available for conducting evaluations, training and technical assistance: *Provided further*, That none of the funds provided shall be used to carry out sections 1701 and 1703 of the PHS Act (with respect to chronic disease self-management activity grants), except that such funds may be used for necessary expenses associated with administering any such grants awarded prior to the date of the enactment of this Act: *Provided further*, That notwithstanding any other provision of this Act, funds made available under this heading to carry out section 311 of the OAA may be transferred to the Secretary of Agriculture in accordance with such section: *Provided further*, That, of the amounts provided under this heading, [$448,251,000] *$380,000,000* shall be available for carrying out title V of the OAA: *Provided further*, That, with respect to the previous proviso, such funds shall be available through June 30, [2014]*2015*, and may be recaptured and reobligated in accordance with section 517(c) of the OAA.

Note.--A full-year 2013 appropriation for this account was not enacted at the time the budget was prepared; therefore, this account is operating under a continuing resolution (P.L. 112-175). The amounts included for 2013 reflect the annualized level provided by the continuing resolution.

Language Analysis

Administration for Community Living

Aging and Disability Services Programs

Language Provision	Explanation
"titles III and XXIX of the PHS Act"	Authorizes ACL to administer the Paralysis Resource Center and the Alzheimer's Disease Supportive Services Program.
"section 6021(d) of the Deficit Reduction Act of 2005,"	Authorizes ACL to administer the National Clearinghouse on Long-Term Care Information using discretionary funds.
"the Developmental Disabilities Assistance and Bill of Rights Act,"	Authorizes ACL to administer the programs of the Administration for Intellectual and Developmental Disabilities, including State Councils on Developmental Disabilities, Protection and Advocacy, University Centers for Excellence in Developmental Disabilities, and Projects of National Significance.
"parts 2 and 5 of subtitle D of title II of the Help America Vote Act of 2002,"	Authorizes ACL to administer the Voting Access for People with Disabilities program.
"and for department-wide coordination of policy and program activities that assist individuals with disabilities,"	Authorizes the use of ACL funds to support activities that were formerly part of the Office of Disability when it was created at the Office of the Secretary

Amounts Available for Obligation

Administration for Community Living
(Dollars in Thousands)

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (Annual)	1,473,700	1,479,920	1,481,462
Rescission	(2,785)	-	-
Subtotal, adjusted appropriation	1,470,915	1,479,920	1,481,462
Transfer of funds to Department of Agriculture	(2,025)	(2,542)	-
Comparable transfer from Administration for Children and Families	172,965	174,024	172,965
Comparable transfer from General Departmental Management	1,264	1,272	1,264
Comparable transfer from Centers for Disease Control	6,949	6,992	6,949
Comparable transfer from Department of Labor	448,251	450,994	380,000
Total, Discretionary Appropriation	2,098,319	2,110,660	2,042,640
Mandatory Appropriation:			
Appropriation (PPACA) ADRCs	10,000	10,000	10,000
Appropriation (PPACA) National Long-Term Care Clearinghouse	3,000	86	-
Appropriation (PPACA) Prevention Funds	20,000	1/	24,700
Appropriation (Taxpayer Relief Act) MIPPA	-	25,000	-
Subtotal, adjusted mandatory. appropriation	33,000	35,086	34,700
Offsetting collections from:			
Trust Funds: HCFAC 2/	10,710	10,710	10,710
Trust Funds: SHIPs HI/SMI Trust Fund Transfer	52,115	52,434	52,115
Subtotal, spending authority from offsetting collections	62,825	63,144	62,825
Unobligated balance, lapsing	(330)		
Total obligations	2,193,814	2,208,890	2,140,165

1/ The final FY 2013 allocation of the Prevention and Public Health Fund was not available during the development of the FY 2014 CJ.
2/ $10,710,000 is a placeholder amount for FY 2014. The Secretary and Attorney General will determine the final amount.

Summary of Changes

Administration for Community Living
(Dollars in Thousands)

2012	
Total budget authority	2,152,459
(Obligations)	2,152,129
2014	
Total estimated budget authority	2,094,755
(Obligations)	2,094,755
Net Change	(57,704)

	FY 2014 PB FTE	FY 2014 PB BA	FY 2014 +/- FY 2012 FTE	FY 2014 +/- FY 2012 BA
Increases:				
A. Built-in:				
1. FY 2014 pay inflation	196	30,035	3/	477
Subtotal, Built-in Increases			-	477
A. Program:				
1. Alzheimer's Disease Support Services Program	-	9,537	-	5,527
2. Adult Protective Services 1/	-	8,000	-	8,000
3. National Clearinghouse on Long-Term Care Information 2/	-	3,000	-	3,000
Subtotal, Program Increases			-	16,527
Total Increases			-	17,004
Decreases:				
A. Program:				
1. Senior Community Service Employment Program	-	380,000	-	(68,251)
2. Aging and Disability Resource Centers (Discretionary)	-	-	-	(6,457)
Subtotal, Program Decreases			-	(74,708)
Total Decreases			-	(74,708)
Net Change			-	(57,704)

1/ Funding for these activities was provided from the Prevention Fund in FY 2012, and is requested from discretionary funding in FY 2014.

2/ Funding for this activity was provided from ACA funding in FY 2012, and is requested from discretionary funding in FY 2014.

3/ FTE in FY 2012 do not include FTE for AIDD, SHIPS or SCSEP, for which accurate actual data is unavailable.

Budget Authority by Activity

Administration for Community Living

(Dollars in Thousands)

Program	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Health and Independence			
Home & Community-Based Supportive Services	366,916	369,162	366,916
Congregate Nutrition Services	439,070	441,757	439,070
Home-Delivered Nutrition Services	216,830	218,157	216,830
Nutrition Services Incentive Program	160,389	161,371	160,389
Preventive Health Services	20,944	21,073	20,944
Senior Community Service Employment Program	448,251	450,994	380,000
Native American Nutrition & Supportive Services	27,601	27,770	27,601
Aging Network Support Activities	7,873	7,921	7,873
Subtotal, Health and Independence	1,687,874	1,698,205	1,619,623
Caregiver Services			
Family Caregiver Support Services	153,621	154,561	153,621
Native American Caregiver Support Services	6,364	6,403	6,364
Alzheimer's Disease Supportive Services Program	4,010	4,035	9,537
Lifespan Respite Care	2,490	2,506	2,490
Subtotal, Caregiver Services	166,485	167,505	172,012
Protection of Vulnerable Adults			
Adult Protective Services [PPHF in FY 2012 & FY 2013]	--	--	8,000
Long-Term Care Ombudsman Program	16,761	16,864	16,761
Prevention of Elder Abuse & Neglect	5,036	5,067	5,036
Senior Medicare Patrol Program	9,402	9,460	9,402
Elder Rights Support Activities	4,088	4,113	4,088
Subtotal, Vulnerable Adults	35,287	35,504	43,287
Developmental Disabilities Programs			
State Councils on Developmental Disabilities	74,774	75,232	74,774
Protection and Advocacy	40,865	41,115	40,865
University Centers for Excellence in Developmental Disabilities	38,792	39,029	38,792
Projects of National Significance	8,317	8,368	8,317
Subtotal, Developmental Disabilities	162,748	163,744	162,748

Consumer Information, Access & Outreach			
Aging and Disability Resource Centers (Discretionary)	6,457	6,497	--
Voting Access for People with Disabilities (HAVA)	5,235	5,267	5,235
State Health Insurance Assistance Program	52,115	52,434	52,115
National Clearinghouse for Long-Term Care Information (Discretionary)	--	--	3,000
Paralysis Resource Center	6,700	6,741	6,700
Subtotal, Consumer Information, Access & Outreach	70,507	70,939	67,050
Program Administration	29,558	29,739	30,035
Subtotal, Discretionary Budget Authority	**2,152,459**	**2,165,636**	**2,094,755**
HCFAC Wedge Funds 1/	10,710	10,710	10,710
Affordable Care Act - Direct Appropriations			
Aging and Disability Resource Centers [ACA]	10,000	10,000	10,000
National Clearinghouse for Long-Term Care Information [ACA]	3,000	86	--
Prevention and Public Health Fund 2/			
Chronic Disease Self-Management Education [PPHF]	10,000	TBD	10,000
Alzheimer's Disease Initiative -- Services [PPHF]	--	TBD	10,500
Alzheimer's Disease Initiative--Communications Campaign [PPHF]	4,000	TBD	4,200
Adult Protective Services	6,000	TBD	--
Medicare Improvements for Patients and Providers Act (MIPPA)			
State Health Insurance Assistance Programs [TRA]	--	7,500	--
Aging and Disability Resource Centers [TRA]	--	5,000	--
Area Agencies on Aging [TRA]	--	7,500	--
National Center for Benefits Outreach Enrollment [TRA]	--	5,000	--
Total, Program Level	**2,196,169**	**2,211,432**	**2,140,165**

1/ $10,710,000 is a placeholder amount for FY 2014. The Secretary and Attorney General will determine the final amount.
2/ The final FY 2013 allocation of the Prevention and Public Health Fund was not available during the development of the FY 2014 CJ.

Authorizing Legislation

Administration for Community Living

	FY 2012 Amount Authorized	FY 2012 Appropriations Act	FY 2014 Amount Authorized	FY 2014 President's Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Expired	$366,916,000	Expired	$366,916,000
2) Nutrition Services Services: OAA Sections 331 and 336	Expired	$655,900,000	Expired	$655,900,000
3) Nutrition Services Incentive Program: OAA Section 311 1/	Expired	$160,389,000	Expired	$160,389,000
4) Preventive Health Services: OAA Section 502	Expired	$20,944,000	Expired	$20,944,000
5) National Family Caregiver Support Program: OAA Section 371	Expired	$153,621,000	Expired	$153,621,000
6) Community Service Employment for Older Americans Title V OAA Section 502	Expired	$448,251,000	Expired	$380,000,000
7) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Expired	$27,601,000	Expired	$27,601,000
8) Native American Caregiver Support Program: OAA Section 631	Expired	$6,364,000	Expired	$6,364,000
9) Long-Term Care Ombudsman Program: OAA Section 712	Expired	$16,761,000	Expired	$16,761,000
10) Prevention of Elder Abuse and Neglect: OAA Section 721	Expired	$5,036,000	Expired	$5,036,000
11) Senior Medicare Patrol Program OAA Sections 201 and 202, as amended	Expired	$9,402,000	Expired	$9,402,000
12) Elder Rights Support Activities OAA Sections 201, 202, and 411, as amended	Expired	$4,088,000	Expired	$4,088,000
13) Aging Network Support Activities: OAA Sections 202, 215 and 411	Expired	$7,873,000	Expired	$7,873,000
14) Alzheimer's Disease Demonstration Grants PHSA Section 398	Expired	$4,010,000	Expired	$9,537,000

15) Lifespan Respite Care				
Lifespan Respite Care Act of 2006..	Expired	$2,490,000	Expired	$2,490,000
Title XXIX of the Public Health Service Act.......................				
16) Program Administration:				
OAA Section 205...	Expired	$29,558,000	Expired	$30,035,000
17) Aging and Disability Resource Centers				
OAA Section 202b...	Expired	$6,457,000	Expired	$0
18) State Health Insurance Assistance Program:				
Omnibus Budget Reconciliation Act of 1990.......................				
Section 4360...	Expired	$52,115,000	Expired	$52,115,000
19) Adult Protective Services				
Social Security Act, Title XX-B, Section 2042	$129,000,000	$0	$129,000,000	$8,000,000
& OAA Sections 751 and 752..	Expired			
20) State Councils on Developmental Disabilities				
DD Act Section 129(a)...	Expired	$74,774,000	Expired	$74,774,000
21) Protection and Advocacy				
DD Act Section 145...	Expired	$40,865,000	Expired	$40,865,000
22) University Centers for Excellence in Developmental Disabilities				
DD Act Section 156...	Expired	$38,792,000	Expired	$38,792,000
23) Projects of National Significance				
DD Act Section 163...	Expired	$8,317,000	Expired	$8,317,000
24) Voting Assistance for People with Disabilities				
Help America Vote Act Section 291.....................................	Expired	$5,235,000	Expired	$5,235,000
25) Paralysis Resource Center				
PHSA Sections 311 and 317(k)(2)..	N/A	$6,700,000	N/A	$6,700,000
25) National Clearinghouse on Long-Term Care Information				
Deficit Reduction Act of 2005 Section 6021(d)....................	Expired	$0	Expired	$3,000,000
Total Request Level..		$2,152,459,000		$2,094,755,000

Unfunded Authorizations:

1) Legal Assistance:				
OAA Section 731...	Such Sums	$0	Such Sums	

Appropriations History

Administration for Community Living

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2005	1,376,527,000	1,403,479,000	1,395,117,000	1,404,634,000
FY 2005 Rescission /1	--	--	--	-11,292,624
FY 2006	1,369,028,000	1,376,217,000	1,391,699,000	1,376,624,000
FY 2006 Rescission	--	--	--	-13,766,240
FY 2006 Transfer	--	--	--	-936,197
FY 2007	1,334,835,000	1,390,306,000	1,380,516,000	1,383,007,000
FY 2008 /2	1,335,146,000	1,417,189,000	1,451,585,000	1,438,567,000
FY 2008 Rescission	--	--	--	-25,131,765
FY 2009 /3	1,381,384,000	1,492,741,000	1,478,156,000	1,491,343,000
FY 2009 ARRA /5	--	--	--	100,000,000
FY 2010 /4	1,491,343,000	1,530,881,000	1,495,038,000	1,516,297,000
FY 2010 Transfer				-224,298
FY 2011	1,624,733,000	1,651,178,000	1,659,383,000	1,500,323,000
FY 2011 Recission				-3,000,646
FY 2012 /6	2,237,944,000	1,471,324,000	1,534,701,000	1,473,703,000
FY 2012 Recission				-2,785,299
FY 2013 /7	1,978,336,000	N/A	1,708,105,000	1,479,919,717
FY 2014	2,140,165,000			

1/ Reflects two separate rescissions of - $11,236,624 and -$56,000.
2/ Includes $2,659,000 in FY 2008 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
3/ Includes $2,681,000 in FY 2009 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
4/ American Recovery and Reinvestment Act of 2009, Public Law 111-5.
5/ Includes $2,544,103,000 in FY 2010 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
6/ Includes $2,025,445 in FY 2012 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 112-74.
7/ Final appropriation for FY 2013 is not available, the appropriation figure for FY 2013 reflects an annualized continuing resolution.

Appropriations Not Authorized By Law

Administration for Community Living

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations Requested in FY 2014
Alzheimer's Disease Suppoertive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$9,537,000
Older Americans Act 1/	FY 2011	Such Sums	$1,927,486,000	$1,864,957,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,495,000	$2,490,000
State Health Insurance Assistance Programs: Omnibus Budget Reconciliation Act of 1990	FY 1996	$10,000,000	N/A	$52,115,000
Developmental Disabilities Assistance and Bill of Rights Act	FY 2007	Such Sums	$155,115,000	$162,748,000
National Clearinghouse for Long-Term Care: Deficit Reduction Act of 2005 section 6021(d)	FY 2010	$1,000,000	$3,000,000	$3,000,000

Health and Independence

Summary of Request

The Administration on Aging's Health and Independence Programs, authorized primarily by the Older Americans Act, provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive institutional care. These programs include home and community-based supportive services, nutrition services (meals in both congregate settings and those delivered to seniors in their homes), preventive health and chronic disease self-management services, and community employment services.

The U.S. population over age 60 is projected to increase by 26 percent between 2012 and 2020, from 61 million to 77 million.[9] In addition, the number of seniors age 65 and older with severe disabilities (defined as 3 or more limitations in activities of daily living), who are at greatest risk of nursing home admission, is projected to increase by more than 30 percent over the same period.[10] Health and Independence Programs are vital to helping seniors remain in their homes and communities for as long as possible. For example, 60 percent of congregate and 92 percent of home-delivered meal recipients reported that the meals allowed them to continue living in their own homes. Additionally, 53 percent of seniors using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[11]

The FY 2014 funding request for Health and Independence services is $1,629,623,000; a reduction of -$68,251,000 from the comparable FY 2012 enacted level. For FY 2014, specific program requests include:

- $366,916,000 for Home and Community-Based Supportive Services (HCBSS), the same as the FY 2012 enacted level. HCBSS provides grants to States to fund a broad array of services that enable seniors to remain in their homes for as long as possible, including adult day care, transportation, case management, personal care services, chore services, and physical fitness programs. These services also aid caregivers, who might otherwise

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[9] U.S. Census Bureau, "2012 National Population Projections," Table 1. Projected Population by Single Year of Age (0-99, 100+), Sex, Race, and Hispanic Origin for the United States: July 1, 2012 to July 1, 2060 released December 2012, < http://www.census.gov/population/projections/data/national/2012/downloadablefiles.html> Accessed 29 March 2013.

[10] [10] Data extrapolated by AoA from Ibid and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2010." < http://www.cdc.gov/nchs/hdi.htm > Accessed 28 August 2012.

[11] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

have to be even more intensively relied upon to provide care for their loved ones, taking more time away from their work and other family responsibilities.

- $816,289,000 for three Nutrition Services programs (Congregate Nutrition Services, Home-Delivered Nutrition Services and the Nutrition Services Incentives Program), the same as the FY 2012 enacted level. Nutrition Services help over 2.5 million older adults receive the meals they need to stay healthy and decrease their risk of disability. In FY 2014, these funds will support an estimated 214 million meals.

- $20,944,000 for Preventive Health Services, the same as the FY 2012 enacted level. These services support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help prevent, delay, or enable seniors to better cope with and manage chronic disease and disability, thereby reducing the need for more costly medical interventions. AoA is continuing to include appropriations language that requires States to use their Preventive Health Services funds for proven evidence-based prevention activities.

- $10,000,000 for Chronic Disease Self-Management Education (CDSME), requested again for FY 2014 from the Prevention and Public Health Fund (PPHF) appropriated under the Affordable Care Act. This would continue funding at the same level provided in FY 2012. CDSME programs have proven effective in helping people to better self-manage their chronic conditions and reduce their need for more costly medical interventions.

- $380,000,000 for the Senior Community Service Employment Program (SCSEP); a reduction of -$68,251,000 from the FY 2012 enacted level. SCSEP provides subsidized community-service employment and on-the-job training to low-income, unemployed older adults (to allow participants to enter or re-enter the workforce). Like the FY 2013 budget request, the FY 2014 budget proposes to transfer this program to ACL from the Department of Labor to allow it to be better integrated with other OAA community-based programs, while also enhancing participants' employment prospects. As part of the proposed transfer, ACL intends to make improvements to program performance by better targeting limited resources to individuals with the greatest need, which will include proposed reforms to better align the program's eligibility requirements with those of other HHS income maintenance programs by considering all sources of income for future enrollees.

- $27,601,000 for Native American Nutrition and Supportive Services, the same as the FY 2012 enacted level. These funds will provide approximately 4.5 million meals and

830,000 rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

- $7,873,000 for Aging Network Support Activities, the same as the FY 2012 enacted level. These funds support competitive grants and contracts for ongoing activities which help seniors and their families obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services carry out their mission to help older people remain independent and live in their own homes and communities.

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Home and Community-Based Supportive Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Home and Community-Based Supportive Services	$366,916,000	$369,162,000	$366,916,000	--

Authorizing Legislation: Section 321 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization .... Expired

Allocation Method .... Formula Grant

Program Description and Accomplishments:

The Home and Community-Based Supportive Services (HCBSS) program, established in 1973, provides grants to States and Territories based on their share of the population age 60 and over to fund a broad array of services that enable seniors to remain in their homes for as long as possible. AoA's programs, like the HCBSS program, serve seniors holistically; while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual, that ensures clients can remain in their own homes and communities instead of entering nursing homes or other types of institutional care.

The services provided to seniors through the HCBSS program include access services such as transportation, case management, and information and referral; in-home services such as personal care, chore, and homemaker assistance; and community services such as adult day care and physical fitness programs. In addition to these services, the HCBSS program also funds multi-purpose senior centers, which coordinate and integrate services for the elderly.

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 55 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 80 percent of seniors have at least one chronic condition and 50 percent have at least two. Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, and therefore to avoiding unnecessary, expensive nursing home care.

Services provided by the HCBSS program in FY 2011, the most recent available data, include:

- *Transportation Services* provided nearly 25 million rides to doctor's offices, grocery stores, pharmacies, senior centers, meal sites, and other critical daily activities (Output C).

- *Personal Care, Homemaker, and Chore Services* provided 27 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework) (Output D).

- *Adult Day Care/Day Health* provided 8 million hours of care for dependent adults in a supervised, protective group setting during some portion of a twenty-four hour day (Output E).

- *Case Management Services* provided over 3.6 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers (Output F).

Continuing AoA's commitment to provide services to those in most need, nearly 45 percent of riders on OAA-funded transportation are mobility impaired, meaning they do not own a car or if they do own a car they do not drive, and are not near public transportation. Many of these individuals cannot safely drive a car, as nearly 75 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:

- 66 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);

- 6 percent have Alzheimer's or dementia;

- 2 percent have Multiple Sclerosis;

- 16 percent have had a stroke;

- 5 percent have epilepsy; and

- 2 percent have Parkinson's disease.

Of the transportation participants, 95 percent take daily medications, with 14 percent taking 10 to 20 medications daily.[12] Data from AoA's national surveys of elderly clients show that services such as transportation are providing these seniors with the assistance and information they need

[12] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

to help them remain at home. For example, over half of seniors using transportation services rely on them for the majority of their transportation needs and would otherwise be homebound, while 80 percent of clients receiving case management reported that as a result of the services arranged by the case manager that they were better able to care for themselves.[13] In addition, a study published in the Journal of Aging and Health shows that the services provided by the HCBSS program, what the article calls "personal care services," are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[14]

Funding History:

Funding for Home and Community-Based Supportive Services during the past ten years is as follows:

FY 2004 ....$353,889,000
FY 2005 ....$354,136,000
FY 2006 ....$350,354,000
FY 2007 ....$350,595,000
FY 2008 ....$351,348,000
FY 2009 ....$361,348,000
FY 2010 ....$368,290,000
FY 2011 ....$367,611,000
FY 2012 ....$366,916,000
FY 2013 CR…………………$369,162,000

Budget Request:

The FY 2014 request for Home and Community-Based Supportive Services is $366,916,000, the same as the FY 2012 enacted level.

HCBSS helps to delay the need for potentially more expensive institutional services. In addition, the services funded by this program – particularly adult day care, personal care, and chore services – also aid caregivers, who otherwise might have to be even more intensively involved with the care of their loved ones, taking time away from work and their other family responsibilities and further straining family budgets. Many of these caregivers are doubly challenged, as members of the so-called "sandwich generation," by the need not only to care for their older loved ones, but also, in the current tight economy, to provide assistance to their adult

[13] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[14] Chen, Ya Mei and Elaine Adams Thompson. Understanding Factors That Influence Success of Home- and Community-Based Services in Keeping Older Adults in Community Settings. 2010. Journal of Aging and Health. V. 22: 267. Available: http://jah.sagepub.com/cgi/content/abstract/22/3/267.

children. The overall budget request will support 8.1 million hours of adult day care for older adults; 21.5 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and 24.8 million hours of assistance to seniors who are unable to perform daily activities.

AoA's core formula grant programs currently reach one in five seniors, serving over a half million seniors in their own communities who meet the disability criteria for nursing home admission and helping to keep them from joining the 1.7 million seniors who live in institutional settings. Nationally, about 26 percent of individuals 60 and older live alone, and in FY 2014 AoA projects 67 percent of the Older Americans Act transportation users will be individuals who live alone (Outcome 2.11). Living alone is a key predictor of nursing home admission, and HCBSS services are critical to their ability to remain at home, especially for those who do not have an informal caregiver to assist with their care. Recent research has also shown that childless seniors who live in a State with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[15]

Federal support for Older Americans Act programs is not expected to cover the cost of serving every senior. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute funding. States typically have leveraged resources of 2 or 3 dollars per every Older Americans Act dollar, significantly exceeding the programs' match requirements.

Nonetheless, AoA projects a decline in certain measures of performance for home and community-based services in FY 2014 compared to FY 2011, specifically transportation units provided and personal care, homemaker, and chore service units provided. Declines in outputs are projected to be largely attributable both to inflation and to stable or declining Federal, State, and local funding for these programs.

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[15] Muramatsu, Naoko. "Risk of Nursing Home Admission Among Older Americans: Does States' Spending on Home and Community-Based Services Matter?" May 2007. Journal of Gerontology: Psychological Sciences.

Outputs and Outcomes Table:

Home and Community-Based Supportive Services Outputs and Outcomes

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
2.9b: 90% of transportation clients rate services good to excellent. *(Outcome)*	FY 2011: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
2.11: Increase the percentage of transportation clients who live alone. *(Outcome)*	FY 2011: 64% Target: 70% (Target Not Met)	70%	67%	-3%

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output C: Transportation Services units *(Output)*	FY 2011: 24.7 M	23.5 M	21.5 M	- 2.0 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2011: 27.0 M	30 M	24.8 M	- 5.2 M
Output E: Adult Day Care/Day Health units *(Output)*	FY 2011: 8.0 M	8.0 M	8.1 M	+ 0.1 M
Output F: Case Management Services units *(Output)*	FY 2011: 3.6 M	3.7 M	3.7 M	--

Note: FY 2011 data are preliminary. For presentation within the budget AoA highlighted specific measures that are most directly related to Home and Community-Based Supportive Services; however multiple performance outcomes are impacted by this program because AoA’s performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Tables:

Home and Community-Based Supportive Services Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President’s Budget
Number of Awards	56	56	56
Average Award	$6,511,854	$6,526,257	$6,486,551
Range of Awards	$227,915 - $36,265,662	$228,419 - $36,439,718	$227,029 - $36,081,266

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Home and Community-Based Supportive Services (CFDA 93.044)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Request	FY 2014 +/- FY 2012
Alabama	5,571,772	5,533,296	5,478,865	-92,907
Alaska	1,823,319	1,827,352	1,816,234	-7,085
Arizona	7,406,195	7,481,386	7,407,792	1,597
Arkansas	3,502,121	3,500,996	3,500,996	-1,125
California	36,265,662	36,439,718	36,081,266	-184,396
Colorado	4,885,597	4,975,708	4,926,762	41,165
Connecticut	4,404,337	4,404,337	4,404,337	--
Delaware	1,823,319	1,827,352	1,816,234	-7,085
District of Columbia	1,823,319	1,827,352	1,816,234	-7,085
Florida	26,219,739	26,180,975	25,923,436	-296,303
Georgia	9,116,311	9,210,029	9,119,431	3,120
Hawaii	1,823,319	1,827,352	1,816,234	-7,085
Idaho	1,823,319	1,827,352	1,816,234	-7,085
Illinois	14,524,890	14,524,890	14,524,890	--
Indiana	7,109,911	7,074,080	7,004,493	-105,418
Iowa	4,260,878	4,260,878	4,260,878	--
Kansas	3,432,908	3,432,908	3,432,908	--
Kentucky	4,946,975	4,927,891	4,879,416	-67,559
Louisiana	4,795,898	4,795,898	4,795,898	--
Maine	1,823,319	1,827,352	1,816,234	-7,085
Maryland	6,117,674	6,130,691	6,070,384	-47,290
Massachusetts	8,209,095	8,209,095	8,209,095	--
Michigan	11,516,437	11,465,963	11,353,174	-163,263
Minnesota	5,744,649	5,762,674	5,705,988	-38,661
Mississippi	3,272,711	3,272,711	3,272,711	--
Missouri	7,118,429	7,118,429	7,118,429	--
Montana	1,823,319	1,827,352	1,816,234	-7,085
Nebraska	2,294,938	2,294,938	2,294,938	--
Nevada	2,835,544	2,860,091	2,831,957	-3,587
New Hampshire	1,823,319	1,827,352	1,816,234	-7,085

PROGRAM/CFDA NUMBER: Home and Community-Based Supportive Services (CFDA 93.044)

State/Territory	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	10,262,972	10,262,972	10,262,972	--
New Mexico	2,298,174	2,309,618	2,286,899	-11,275
New York	24,283,431	24,283,431	24,283,431	--
North Carolina	10,572,477	10,615,097	10,510,677	-61,800
North Dakota	1,823,319	1,827,352	1,816,234	-7,085
Ohio	13,816,810	13,816,810	13,816,810	--
Oklahoma	4,278,286	4,278,286	4,278,286	--
Oregon	4,591,896	4,629,903	4,584,360	-7,536
Pennsylvania	17,879,977	17,879,977	17,879,977	--
Rhode Island	1,823,319	1,827,352	1,816,234	-7,085
South Carolina	5,443,562	5,488,929	5,434,935	-8,627
South Dakota	1,823,319	1,827,352	1,816,234	-7,085
Tennessee	7,303,508	7,304,362	7,232,510	-70,998
Texas	22,531,556	22,754,142	22,530,312	-1,244
Utah	2,118,857	2,145,113	2,124,012	5,155
Vermont	1,823,319	1,827,352	1,816,234	-7,085
Virginia	8,467,596	8,495,438	8,411,869	-55,727
Washington	7,217,466	7,312,389	7,240,458	22,992
West Virginia	2,773,538	2,773,538	2,773,538	--
Wisconsin	6,509,748	6,488,260	6,424,436	-85,312
Wyoming	1,823,319	1,827,352	1,816,234	-7,085
Subtotal, States	357,605,672	358,451,423	356,284,568	-1,321,104
American Samoa	472,317	472,317	472,317	--
Guam	911,660	913,676	908,117	-3,543
Northern Mariana Islands	227,915	228,419	227,029	-886
Puerto Rico	4,534,616	4,490,869	4,446,692	-87,924
Virgin Islands	911,660	913,676	908,117	-3,543
Subtotal, States and Territories	364,663,840	365,470,380	363,246,840	-1,417,000
Undistributed 16/	2,252,160	3,691,620	3,669,160	1,417,000
TOTAL	**366,916,000**	**369,162,000**	**366,916,000**	**--**

16/ The undistributed line reflects the amount reserved from the HCBSS appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

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Nutrition Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Congregate Nutrition……..	$439,070,000	$441,757,000	$439,070,000	--
Home-Delivered Nutrition..	$216,830,000	$218,157,000	$216,830,000	--
Nutrition Services Incentive Program…………………..	$160,389,000	$161,371,000	$160,389,000	--
Total………………………	$816,289,000	$821,285,000	$816,289,000	--

Authorizing Legislation: Sections 311, 331, and 336 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method ....Formula Grant

Program Description and Accomplishments:

Nutrition Services help seniors remain healthy and independent in their communities by providing meals and related services in a variety of settings (including congregate facilities such as senior centers) and via home-delivery to seniors who are homebound due to illness, disability, or geographic isolation. Nutrition Services include:

- Congregate Nutrition Services (Title III-C1): Provides funding for the provision of meals and related services in a variety of congregate settings, which helps to keep older Americans healthy and prevents the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement and meaningful volunteer roles, which contribute to overall health and well-being.

- Home-Delivered Nutrition Services (Title III-C2): Provides funding for the delivery of meals and related services to frail seniors who are homebound. Established in 1978, home-delivered meals are often the first in-home service that an older adult receives and serve as a primary access point for other home and community-based services. Home-delivered meals also represent an essential service for many caregivers, helping them to maintain their own health and well-being.

- Nutrition Services Incentive Program (Title III-A): Provides additional funding to States, Territories, and eligible Tribal Organizations that is used exclusively to provide meals and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to States and Tribes based on the number of meals served in the prior Federal fiscal year. States and Tribes have the option to purchase commodities directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors. Seven States and two Tribes elected to spend just over $2.0 million on commodities, including $198,937 assessed by USDA as administrative expenses, in FY 2012.

Formula grants for Congregate Nutrition Services and Home-Delivered Nutrition Services are allocated to States and Territories based on their share of the population age 60 and over. Nutrition Services Incentive Program grants are provided to States, Territories, and Tribal organizations based on the number of meals served in the prior Federal fiscal year. The meals provided through these programs fulfill the standards set by the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

Nutrition Services help approximately 2.5 million older adults receive the meals they need to stay healthy and decrease their risk of disability. Studies have found that 50 percent of all persons age 85 and over are in need of assistance with instrumental activities of daily living (IADLs), including obtaining and preparing food. These nutrition programs help address their needs. *Serving Elders at Risk*, a national evaluation of AoA's nutrition program clients, found that nutrition services recipients are older, poorer, more likely to live alone, more likely to be minorities, are sicker, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, particularly homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants showed that nutrition program clients had significantly more social contacts than people who did not participate in the program.

Data from AoA's national surveys of elderly clients show that the Nutrition Services are effectively helping seniors to improve their nutritional intake and remain at home. For example, 77 percent of congregate and 83 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 60 percent of congregate and 91 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[17] In addition,

[17] 2012 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

home-delivered meal and congregate meal participants had significantly better food energy; protein; vitamins A, B_6 & D, Riboflavin, Calcium, Phosphorous, Potassium, Magnesium and Zinc intakes compared to matched non-participant group of senior citizens.[18] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

AoA's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Ninety percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled over 358,000 in 2011 (Outcome 3.2). This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs are helping seniors remain healthy and independent in their homes include:

- *Home-Delivered Nutrition Services* provided 139.1 million meals to nearly 860,000 individuals in FY 2011 (Output G).

- *Congregate Nutrition Services* provided over 88.6 million meals to over 1.7 million seniors in a variety of community settings in FY 2011 (Output H).

Funding History:

Comparable funding for Nutrition Services during the past ten years is as follows:

FY 2004 ....$714,462,000
FY 2005 ....$718,696,000
FY 2006 ....$714,578,000
FY 2007 ....$735,070,000
FY 2008 ....$758,003,000
FY 2009 ....$809,743,000
FY 2009 (ARRA).......................$97,000,000
FY 2010 ....$819,353,000
FY 2011 ....$817,835,000
FY 2012 ....$816,289,000
FY 2013 CR. $821,885,000

[18] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995*, pp.117-118

Budget Request:

The FY 2014 request for Nutrition Services is $816,289,000, the same as the FY 2012 enacted level. At this level, the budget request combined with state and local contributions will support 214 million home-delivered and congregate meals to approximately two million elderly individuals in a variety of community settings.

Nutrition Services must continue to be funded because they, like HCBSS, help to put off the need for much more expensive institutional services. Consistent with AoA's commitment to target services to those most in need to help them maintain their health and independence, approximately 72 percent of home-delivered meal recipients have annual incomes at or below $20,000. Meals are especially critical for the survival of the nearly 60 percent of recipients who report these meals as half or more of their food intake for the day and for the 320,000 home-delivered meal recipients with severe disabilities who are projected to be served in FY 2014 (Outcome 3.2). This population with severe disabilities is particularly important to serve since this level of disability is frequently an eligibility requirement for more costly nursing home admission.

Federal support for Nutrition Services is not expected to serve every senior. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donors that contribute funding. In FY 2011, State and local funding comprised approximately 63 percent of all the funding for home-delivered meals and congregate meals. Though all programs funded through OAA rely on State and local funding in some part, funding for congregate and home-delivered meals leverages more State and local financial support than many other OAA services.

In FY 2014 these programs are expected to continue to provide home-delivered meals that clients rate as good to excellent (Outcome 2.9a), ensuring that clients continue to receive high quality services. However, as State and local funding tightens, some providers may look at cost cutting measures such as reducing menu choices or the frequency of deliveries. This could affect client satisfaction with the quality of service.

Outcomes and Outputs Table:

Nutrition Services Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
1.1: For Home and Community-based Services including Nutrition Services, and Caregiver services increase the number of clients served per million dollars of AoA funding. *(Outcome)*	FY 2011: 8,881 Target: 8,350 (Target Exceeded)	8,600	8,600	Maintain
2.9a: 90% of home delivered meal clients rate services good to excellent. *(Outcome)*	FY 2011: 90% [19] Target: 90% (Target Met)	90%	90%	Maintain
3.2: Increase the number of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	FY 2011: 358,000 Target: 297,000 (Target Exceeded)	311,000	320,000	+9,000
Indicator	**Most Recent Result**	**FY 2012 Projection**	**FY 2014 Projection**	**FY 2014 +/- FY 2012**
Output G: Number of Home-Delivered meals served *(Output)*	FY 2011: 139.1 M	135 M	132 M	-3.0 M
Output H: Number of Congregate meals served *(Output)*	FY 2011: 88.6 M	86.0 M	82.0 M	-4.0 M
Outputs G& H: Total Number of Meals *(Outputs)*	FY 2011: 227.7 M	221 M	214 M	-6 M

Note: FY 2011 data are preliminary. For presentation within the budget ACL highlighted specific measures that are most directly related to Nutrition Services, however multiple performance outcomes are impacted by this program because ACL's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

[19] Based on upper range of survey confidence interval.

Grant Awards Tables:

Congregate Nutrition Programs Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$7,792,398	$7,809,633	$7,762,130
Range of Awards	$272,734 - $43,523,886	$273,337 - $43,739,401	$271,675 - $43,321,335

Home-Delivered Nutrition Programs Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$3,848,203	$3,856,704	$3,833,245
Range of Awards	$134,687 - $21,956,423	$134,985 - $22,127,048	$134,164 - $21,992,361

Nutrition Services Incentive Program Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	309	309	309
Average Award[20]	$515,913	$517,014	$513,868
Range of Awards	$462 - $15,385,495	$465 - $15,417,072	$462 - $15,323,269

[20] If the 254 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,839,008 in FY 2012, $2,844,836 in FY 2013 and $2,827,524 in FY 2014.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Congregate Nutrition Services (CFDA 93.045)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	6,686,908	6,641,737	6,578,255	-108,653
Alaska	2,181,871	2,186,697	2,173,397	-8,474
Arizona	8,888,476	8,980,074	8,894,241	5,765
Arkansas	4,203,036	4,170,837	4,163,564	-39,472
California	43,523,886	43,739,401	43,321,335	-202,551
Colorado	5,863,402	5,972,452	5,915,367	51,965
Connecticut	5,241,452	5,241,452	5,241,452	--
Delaware	2,181,871	2,186,697	2,173,397	-8,474
District of Columbia	2,181,871	2,186,697	2,173,397	-8,474
Florida	31,467,368	31,425,602	31,125,233	-342,135
Georgia	10,940,853	11,055,001	10,949,336	8,483
Hawaii	2,181,871	2,186,697	2,173,397	-8,474
Idaho	2,181,871	2,186,697	2,173,397	-8,474
Illinois	17,286,541	17,286,541	17,286,541	--
Indiana	8,532,891	8,491,175	8,410,015	-122,876
Iowa	5,081,501	5,081,501	5,081,501	--
Kansas	4,089,903	4,089,903	4,089,903	--
Kentucky	5,937,065	5,915,056	5,858,519	-78,546
Louisiana	5,734,142	5,735,891	5,681,067	-53,075
Maine	2,181,871	2,186,697	2,173,397	-8,474
Maryland	7,342,067	7,358,804	7,288,468	-53,599
Massachusetts	9,780,267	9,780,267	9,780,267	--
Michigan	13,821,341	13,762,848	13,631,302	-190,039
Minnesota	6,894,385	6,917,065	6,850,951	-43,434
Mississippi	3,891,114	3,891,114	3,891,114	--
Missouri	8,467,047	8,467,047	8,467,047	--
Montana	2,181,871	2,186,697	2,173,397	-8,474
Nebraska	2,738,802	2,738,802	2,738,802	--
Nevada	3,403,051	3,433,030	3,400,217	-2,834
New Hampshire	2,181,871	2,186,697	2,173,397	-8,474

PROGRAM/CFDA NUMBER: Congregate Nutrition Services (CFDA 93.045)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Request	FY 2014 +/- FY 2012
New Jersey	12,190,488	12,190,488	12,190,488	--
New Mexico	2,758,132	2,772,285	2,745,787	-12,345
New York	28,963,855	28,963,855	28,963,855	--
North Carolina	12,688,457	12,741,535	12,619,750	-68,707
North Dakota	2,181,871	2,186,697	2,173,397	-8,474
Ohio	16,393,785	16,393,785	16,393,785	--
Oklahoma	5,092,422	5,080,736	5,080,736	-11,686
Oregon	5,510,920	5,557,375	5,504,257	-6,663
Pennsylvania	21,279,716	21,279,716	21,279,716	--
Rhode Island	2,181,871	2,186,697	2,173,397	-8,474
South Carolina	6,533,039	6,588,483	6,525,509	-7,530
South Dakota	2,181,871	2,186,697	2,173,397	-8,474
Tennessee	8,765,235	8,767,587	8,683,785	-81,450
Texas	27,041,031	27,312,299	27,051,245	10,214
Utah	2,542,925	2,574,826	2,550,216	7,291
Vermont	2,181,871	2,186,697	2,173,397	-8,474
Virginia	10,162,304	10,197,261	10,099,795	-62,509
Washington	8,661,973	8,777,222	8,693,328	31,355
West Virginia	3,305,947	3,305,947	3,305,947	--
Wisconsin	7,812,612	7,788,002	7,713,563	-99,049
Wyoming	2,181,871	2,186,697	2,173,397	-8,474
Subtotal, States	427,882,662	428,894,063	426,300,420	-1,582,242
American Samoa	594,843	594,843	594,843	--
Guam	1,090,936	1,093,349	1,086,698	-4,238
Northern Mariana Islands	272,734	273,337	271,675	-1,059
Puerto Rico	5,442,176	5,390,489	5,338,966	-103,210
Virgin Islands	1,090,936	1,093,349	1,086,698	-4,238
Subtotal, States and Territories	436,374,287	437,339,430	434,679,300	-1,694,987
Undistributed 21/	2,695,713	4,417,570	4,390,700	1,694,987
TOTAL	**439,070,000**	**441,757,000**	**439,070,000**	**--**

21/ The undistributed line reflects the amount reserved from the Congregate Nutrition Services appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Home-Delivered Nutrition Services (CFDA 93.045)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	3,373,334	3,359,946	3,339,494	-33,840
Alaska	1,077,497	1,079,877	1,073,309	-4,188
Arizona	4,483,954	4,542,871	4,515,219	31,265
Arkansas	2,120,299	2,109,958	2,097,115	-23,184
California	21,956,423	22,127,048	21,992,361	35,938
Colorado	2,957,901	3,021,365	3,002,975	45,074
Connecticut	2,564,007	2,540,425	2,524,962	-39,045
Delaware	1,077,497	1,079,877	1,073,309	-4,188
District of Columbia	1,077,497	1,079,877	1,073,309	-4,188
Florida	15,874,292	15,897,697	15,800,929	-73,363
Georgia	5,519,314	5,592,544	5,558,503	39,189
Hawaii	1,077,497	1,079,877	1,073,309	-4,188
Idaho	1,077,497	1,079,877	1,073,309	-4,188
Illinois	8,216,052	8,196,365	8,146,474	-69,578
Indiana	4,304,574	4,295,546	4,269,399	-35,175
Iowa	2,243,949	2,225,744	2,212,196	-31,753
Kansas	1,895,772	1,890,763	1,879,255	-16,517
Kentucky	2,995,061	2,992,330	2,974,116	-20,945
Louisiana	2,892,693	2,901,693	2,884,031	-8,662
Maine	1,086,279	1,087,335	1,080,716	-5,563
Maryland	3,703,841	3,722,698	3,700,038	-3,803
Massachusetts	4,599,080	4,588,199	4,560,271	-38,809
Michigan	6,972,430	6,962,399	6,920,020	-52,410
Minnesota	3,477,999	3,499,230	3,477,930	-69
Mississippi	1,954,691	1,946,834	1,934,984	-19,707
Missouri	4,231,795	4,215,199	4,189,541	-42,254
Montana	1,077,497	1,079,877	1,073,309	-4,188
Nebraska	1,235,914	1,232,321	1,224,820	-11,094
Nevada	1,716,732	1,736,714	1,726,143	9,411
New Hampshire	1,077,497	1,079,877	1,073,309	-4,188

PROGRAM/CFDA NUMBER: Home-Delivered Nutrition Services (CFDA 93.045)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	6,019,557	5,974,276	5,937,911	-81,646
New Mexico	1,391,391	1,402,454	1,393,917	2,526
New York	13,307,414	13,214,954	13,134,515	-172,899
North Carolina	6,400,925	6,445,734	6,406,499	5,574
North Dakota	1,077,497	1,079,877	1,073,309	-4,188
Ohio	8,262,220	8,229,813	8,179,719	-82,501
Oklahoma	2,568,966	2,557,373	2,541,806	-27,160
Oregon	2,780,085	2,811,385	2,794,272	14,187
Pennsylvania	9,761,855	9,677,307	9,618,401	-143,454
Rhode Island	1,077,497	1,079,877	1,073,309	-4,188
South Carolina	3,295,711	3,333,005	3,312,718	17,007
South Dakota	1,077,497	1,079,877	1,073,309	-4,188
Tennessee	4,421,784	4,435,378	4,408,381	-13,403
Texas	13,641,345	13,816,844	13,732,742	91,397
Utah	1,282,826	1,302,563	1,294,634	11,808
Vermont	1,077,497	1,079,877	1,073,309	-4,188
Virginia	5,126,561	5,158,627	5,127,227	666
Washington	4,369,691	4,440,252	4,413,225	43,534
West Virginia	1,527,382	1,513,574	1,504,361	-23,021
Wisconsin	3,941,216	3,939,822	3,915,841	-25,375
Wyoming	1,077,497	1,079,877	1,073,309	-4,188
Subtotal, States	211,405,279	211,897,109	210,607,309	-797,910
American Samoa	136,498	136,498	136,498	--
Guam	538,748	536,655	536,655	-2,094
Northern Mariana Islands	134,687	134,164	134,164	-523
Puerto Rico	2,745,406	2,734,732	2,734,732	-35,045
Virgin Islands	538,748	536,655	536,655	-2,094
Subtotal, States and Territories	215,499,366	215,975,430	214,661,700	-837,666
Undistributed 22/	1,330,634	2,181,570	2,168,300	837,666
TOTAL	**216,830,000**	**218,157,000**	**216,830,000**	--

22/ The undistributed line reflects the amount reserved from the Home-Delivered Nutrition Services appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

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PROGRAM/CFDA NUMBER: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	2,933,316	2,939,337	2,921,450	-11,866
Alaska	372,212	372,976	370,706	-1,506
Arizona	2,118,282	2,122,631	2,109,714	-8,568
Arkansas	2,637,872	2,643,287	2,627,202	-10,670
California	12,976,341	13,002,979	12,923,851	-52,490
Colorado	1,499,399	1,502,477	1,493,333	-6,066
Connecticut	1,441,776	1,444,736	1,435,944	-5,832
Delaware	711,968	713,430	709,088	-2,880
District of Columbia	505,439	506,477	503,395	-2,044
Florida	7,187,763	7,202,519	7,158,689	-29,074
Georgia	2,768,572	2,774,256	2,757,373	-11,199
Hawaii	483,221	484,213	481,266	-1,955
Idaho	728,541	730,036	725,594	-2,947
Illinois	6,902,253	6,916,422	6,874,333	-27,920
Indiana	1,788,180	1,791,850	1,780,946	-7,234
Iowa	2,119,990	2,124,342	2,111,415	-8,575
Kansas	2,244,365	2,248,972	2,235,286	-9,079
Kentucky	1,831,731	1,835,491	1,824,321	-7,410
Louisiana	3,277,072	3,283,799	3,263,816	-13,256
Maine	629,641	630,934	627,094	-2,547
Maryland	1,648,593	1,651,977	1,641,924	-6,669
Massachusetts	5,994,218	6,006,523	5,969,971	-24,247
Michigan	7,257,628	7,272,526	7,228,270	-29,358
Minnesota	1,956,106	1,960,121	1,948,193	-7,913
Mississippi	1,365,451	1,368,254	1,359,927	-5,524
Missouri	4,070,380	4,078,736	4,053,915	-16,465
Montana	1,201,609	1,204,075	1,196,748	-4,861
Nebraska	1,168,951	1,171,350	1,164,222	-4,729
Nevada	1,055,712	1,057,879	1,051,441	-4,271
New Hampshire	1,180,291	1,182,714	1,175,517	-4,774

PROGRAM/CFDA NUMBER: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	3,667,607	3,675,136	3,652,772	-14,835
New Mexico	2,015,026	2,019,162	2,006,875	-8,151
New York	15,385,495	15,417,072	15,323,269	-62,226
North Carolina	3,330,755	3,337,592	3,317,282	-13,473
North Dakota	814,498	816,170	811,203	-3,295
Ohio	5,706,031	5,717,744	5,682,949	-23,082
Oklahoma	2,337,289	2,342,087	2,327,834	-9,455
Oregon	1,793,200	1,796,881	1,785,946	-7,254
Pennsylvania	7,112,252	7,126,852	7,083,483	-28,769
Rhode Island	449,215	450,137	447,398	-1,817
South Carolina	1,589,875	1,593,139	1,583,444	-6,431
South Dakota	965,896	967,879	961,989	-3,907
Tennessee	1,675,968	1,679,408	1,669,188	-6,780
Texas	12,079,291	12,104,087	12,030,429	-48,862
Utah	1,368,532	1,371,342	1,362,996	-5,536
			776,795	
Vermont	779,950	781,551	2,271,534	-3,155
Virginia	2,280,760	2,285,442	2,085,296	-9,226
Washington	2,093,766	2,098,064	1,651,112	-8,470
West Virginia	1,657,818	1,661,222	2,678,324	-6,706
Wisconsin	2,689,202	2,694,722	776,795	-10,878
Wyoming	793,487	795,116	790,278	-3,209
Subtotal, States	152,642,789	152,956,124	152,025,340	-617,446
American Samoa	--	--	--	--
Guam	371,257	372,019	369,756	-1,501
Northern Mariana Islands	58,148	58,267	57,913	-235
Puerto Rico	2,893,190	2,899,129	2,881,487	-11,703
Virgin Islands	180,074	180,444	179,346	-728
Subtotal, States and Territories	156,145,455	156,465,983	155,513,842	-631,613
Tribal Organizations	3,271,693	3,291,307	3,271,268	-425
Undistributed 23/	971,852	1,613,710	1,603,890	632,038
TOTAL	**160,389,000**	**161,371,000**	**160,389,000**	--

23/ The undistributed line reflects the amount reserved from the NSIP appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

Preventive Health Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Preventive Health Services	$20,944,000	$21,073,000	$20,944,000	--

Authorizing Legislation: Section 361 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method ....Formula Grant

Program Description and Accomplishments:

Preventive Health Services, established in 1987, provides formula grants to States and Territories, based on their share of the population aged 60 and over, to support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help to prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions. Preventive Health Services gives States and Territories flexibility to allocate resources among the preventive health activities to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to almost 78 years today. On average an American turning age 65 today can expect to live an additional 18.6 years. The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, totaling 5.5 million in 2010 and projected to reach 8.7 million by the year 2030. One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression, as well as the greater probability of injury from a fall, which quickly limits physical activity.

In recent years, some States have increasingly shifted their funding to provide greater support to evidence-based approaches, especially to help individuals manage chronic diseases. In FY 2012, AoA requested and Congress enacted appropriations language requiring States to use their Preventive Health funds to support proven evidence-based models that enhance the wellness and fitness of the aging community. The same language is also proposed for FY 2014. Since evidence-based programs have demonstrated their effectiveness, AoA expects that States will be

able to maximize the impact of these limited dollars. At the same time, if States wish to continue funding other health services, such as health screenings, they still have the flexibility to continue to use funds provided under the Home and Community-Based Services program for this purpose.

Evidence-based programs are interventions that have been tested through randomized control trials and have been shown to be effective at helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits. Some examples of evidence-based interventions are:

- *Enhanced fitness and enhanced wellness programs:* Enhanced fitness is a multi-component group exercise program designed for community-based organizations and intended to promote physical activity among older adults. Strength training using soft wrist and ankle weights; cardiovascular workout using dancing, aerobics, or walking; and balance and posture exercises are used to increase the physical health of older adults. In addition, exercise has been proven to improve depression, which studies have shown that nearly 20 percent of U.S. adults 65 years and older experience. Exercise may also act as a buffer against many illnesses impacted by stress.

- *Falls prevention*: Falls prevention programs help participants to achieve improved strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. Recent studies have shown that in the United States more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit the ability of older adults to get around or live independently. Those who are not injured may develop a fear of falling, which may increase their actual risk of falling. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[24]

- *Medication management:* Medication management programs focus on reviewing the multitude of medications that older adults are prescribed, focusing especially on high-risk medications. Medication management programs have been shown to reduce unnecessary duplication of prescriptions and cardiovascular problems. These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.

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[24] Even, Jennifer. 2009. *Senior Series.* The Ohio State University Extension. 20 May 2009.

Funding History:

Funding for Preventive Health Services during the past five years is as follows:

FY 2009 ....$21,026,000
FY 2010 ....$21,026,000
FY 2011 ....$20,984,000
FY 2012 ....$20,944,000
FY 2013 CR. $21,073,000

Budget Request:

The FY 2014 budget request for Preventive Health Services is $20,944,000, the same as the FY 2012 enacted level. AoA continues to request appropriations language that was included by Congress for FY 2012 which requires States to use their Preventive Health Services funds to support proven evidence-based models that enhance the wellness and fitness of the aging community.

Recognizing that the development of evidence-based programs is ongoing, AoA will continue to provide guidance regarding what meets the evidence-based requirement. AoA uses a graduated or tiered set of criteria for defining evidence-based interventions implemented through the OAA. The OAA Title IIID webpage contains AoA's definition of evidence-based interventions, frequently asked questions, and program examples.[25] Thirty-nine evidence-based DPHP programs have been added to the OAA Title IIID webpage in the last year, and grantees can use this site to search the 35+ highest-level criteria programs listed.

Underscoring the need for these programs, the 2012 National Survey of Older Americans Act Participants found that 68.64% of respondents take three or more different prescription medications every day. In addition, 24.29% reported they had to stay overnight in a hospital in the past 12 months. Preventive Health Services funding has enabled the Aging Services Network to help older adults control their medications and health through the implementation of evidence-based DPHP programs. Eleven percent of respondents reported that a group class had taught them about taking care of their chronic illnesses or medical condition.

Each of the evidence-based programs for which States could use these funds has been rigorously evaluated and found to be effective. By requiring States to use funding for one or more of these proven programs, AoA seeks to maximize the impact of this funding on providing benefits to individuals and on achieving savings due to reduced medical costs. At the same time, States

[25] http://www.aoa.gov/AoARoot/AoA_Programs/HPW/Title_IIID/index.aspx

would continue to have the flexibility to use funding provided under the Home and Community-Based Supportive Services program to fund related health services, such as health screenings and physical fitness programs that do not meet these evidence-based requirements.

Output Table:

Preventive Health Services Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output AB: The number of people served with health and disease prevention programs *(Output)*	N/A	N/A	N/A (baseline set in FY 2013)	N/A

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$374,006	$376,304	$374,000
Range of Awards	$13,090 - $2,123,744	$13,170 - $2,136,796	$13,090 - $2,123,711

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	331,874	333,913	331,869	-5
Alaska	104,722	105,365	104,720	-2
Arizona	403,699	406,179	403,693	-6
Arkansas	210,763	212,058	210,760	-3
California	2,123,744	2,136,796	2,123,711	-33
Colorado	255,177	256,744	255,173	-4
Connecticut	260,160	261,758	260,156	-4
Delaware	104,722	105,365	104,720	-2
District of Columbia	104,722	105,365	104,720	-2
Florida	1,551,522	1,561,053	1,551,497	-25
Georgia	485,765	488,749	485,757	-8
Hawaii	104,722	105,365	104,720	-2
Idaho	104,722	105,365	104,720	-2
Illinois	837,894	843,042	837,881	-13
Indiana	425,464	428,077	425,457	-7
Iowa	231,350	232,771	231,346	-4
Kansas	190,952	192,125	190,949	-3
Kentucky	291,198	292,987	291,193	-5
Louisiana	294,553	296,362	294,548	-5
Maine	104,924	105,568	104,922	-2
Maryland	359,750	361,960	359,744	-6
Massachusetts	463,658	466,506	463,650	-8
Michigan	691,299	695,546	691,288	-11
Minnesota	337,777	339,852	337,771	-6
Mississippi	195,489	196,690	195,486	-3
Missouri	421,608	424,198	421,601	-7
Montana	104,722	105,365	104,720	-2
Nebraska	124,415	125,179	124,413	-2
Nevada	151,173	152,101	151,170	-3
New Hampshire	104,722	105,365	104,720	-2

PROGRAM/CFDA NUMBER: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	618,534	622,334	618,524	-10
New Mexico	126,899	127,680	126,897	-2
New York	1,371,257	1,379,680	1,371,234	-23
North Carolina	575,417	578,952	575,408	-9
North Dakota	104,722	105,365	104,720	-2
Ohio	832,633	837,747	832,619	-14
Oklahoma	256,429	258,005	256,425	-4
Oregon	253,923	255,483	253,919	-4
Pennsylvania	1,014,597	1,020,829	1,014,580	-17
Rhode Island	104,722	105,365	104,720	-2
South Carolina	294,285	296,093	294,281	-4
South Dakota	104,722	105,365	104,720	-2
Tennessee	415,196	417,747	415,190	-6
Texas	1,248,379	1,256,048	1,248,359	-20
Utah	114,654	115,358	114,652	-2
Vermont	104,722	105,365	104,720	-2
Virginia	483,047	486,014	483,039	-8
Washington	396,147	398,580	396,141	-6
West Virginia	152,542	153,479	152,540	-2
Wisconsin	389,928	392,323	389,922	-6
Wyoming	104,722	105,365	104,720	-2
Subtotal, States	20,544,739	20,670,946	20,544,405	-334
American Samoa	13,090	13,170	13,090	--
Guam	52,361	52,682	52,360	-1
Northern Mariana Islands	13,090	13,170	13,090	--
Puerto Rico	268,699	270,350	268,695	-4
Virgin Islands	52,361	52,682	52,360	-1
Subtotal, States and Territories	20,944,340	21,073,000	20,944,000	-340
TOTAL	**20,944,000**	**21,073,000**	**20,944,000**	--

Chronic Disease Self-Management Education

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
CDSME	$10,000,000	1/	$10,000,000	--
FTE	0	1/	2	+2

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

Allocation Method ....Competitive Grants/Co-operative Agreements and Contracts

Intended Recipients…………………………………………………………………….States

Program Description and Accomplishments:

The Chronic Disease Self-Management Education (CDSME) program is a low-cost evidence-based disease prevention model that uses state-of-the-art techniques to help those with chronic disease address issues related to the management and treatment of their condition, improve their health status, and reduce their need for more costly medical care.

Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. CDSME has been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Studies indicate that the program significantly improves participant health status, reduces the use of hospital care and physician services[26], and reduces health care costs.

[26] Sobel, DS, Lorig,KR, Hobbs,M. Chronic Disease Self-Management Program: From Development to Dissemination. *Permanente Journal*; Spring 2002.

CDSME emphasizes an individual's role in managing his/her illness. The program consists of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries, YW/MCAs, senior centers, public housing projects, community health centers and cooperative extension programs. People with different chronic health problems attend together, and the workshops are facilitated by two leaders who are certified trainers. One or both of the leaders are non-health professionals or lay people with chronic diseases themselves. Topics covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals; and 5) nutrition.

Funding for CDSME is awarded in the form of competitive grants to states. External experts review project proposals, and project awards are made for periods of one to three years. In FY 2010 AoA funded 47 State grants for CDSME programs, with an average award of $574,468 for a two year project period, using funding provided under the Recovery Act. AoA also funded a Technical Assistance Resource Center through a grant to the National Council on Aging. Competitive grants and contracts are also used to support evaluation and technical assistance activities.

Through these grants, as of January 31, 2012, 61,902 people had completed CDSME courses across the country, well ahead of the programmatic goal to reach 50,000 completers within two years from the award date. A new round of grants, funded in FY 2012 from PPHF resources, provided grants to States to continue these activities. These three-year grants will allow states to provide CDSME to approximately 87,000 adults to help them better manage chronic conditions.

Funding History:

FY 2009 ....[27]
FY 2010 ....[28]
FY 2011 ....$0
FY 2012 ....$10,000,000
FY 2013 CR. ....N/A[29]

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[27] In FY 2010, $30 million in Recovery Act funding was provided in coordination with the Centers for Disease Control and Prevention as part of its Recovery Act funding. An additional $2.5 million was also transferred from CDC to CMS for related evaluation and quality improvement purposes. No standalone funding was provided in FY 2011. Stand-alone funding for the nationwide deployment of CDSME through the aging services network was requested for the first time in FY 2012 and provided from the Prevention and Public Health Fund

[28] See above.

[29] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Budget Request:

AoA requests FY 2014 funding totaling $10,000,000 for CDSME from the Prevention and Public Health Fund, the same as the FY 2012 enacted level. The Prevention and Public Health Fund (Section 4002) is designed to target resources to activities that invest in prevention and public health programs to improve our nation's health while also restraining the rate of growth in public and private sector health care costs. CDSME, by emphasizing an individual's role in managing his/her illness, helps participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Studies indicate that the program significantly improves participant health status, reduces the use of hospital care and physician services, and reduces health care costs.[30] This continued investment of resources will allow AoA, in coordination with its existing HHS partners and private philanthropy, to continue to build on past investments in CDSME and on AoA's existing service delivery infrastructure as it pursues its goal of taking CDSME to scale nationwide.

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. Over 80 percent of adults 65 and over have at least one chronic condition, and roughly half suffer from two.[31] Nearly half of older adults have hypertension and roughly one in five has heart disease, with a similar proportion having some type of cancer.[32] The average 75-year old has three chronic conditions and takes 4.5 medications.[33] More than 65 percent of Americans aged 65 and over have some form of cardiovascular disease. One million adults age 75+ have diabetes, a number that is expected to grow to 4 million by 2050 if nothing changes current growth rates.[34] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. For example, among adults age 65+, 65% of African-Americans had hypertension, compared to 47% of Whites; and 25% of Hispanics have diabetes, compared to 14% of Whites.

CDSME serves this population and is especially well suited for delivery through AoA's network of community based organizations, including senior centers, congregate meal programs, faith-based organizations and senior housing projects. In FY 2011 alone, 40,430 individuals with chronic conditions completed the CDSME program through AoA's network (Output CD1). At the community level, aging services provider organizations work in collaboration with public

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[30] Sobel, DS, Lorig,KR, Hobbs,M. Chronic Disease Self-Management Program: From Development to Dissemination. *Permanente Journal*; Spring 2002.

[31] NCCDPHP. Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans. Available at www.cdc.gov/nccdphp/aag/aag_aging.htm. Accessed September 14, 2004.

[32] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Health Interview Survey, 2000-2001.

[33] Alliance for Aging Research. Ten Reasons Why America Is Not Ready for the Coming Aging Boom. 2002.

[34] NCCDPHP. Available at www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.

health agencies and health care providers. Participant referrals to the CDSME program come from both clinical and community-based organizations. Clinical referrals come from community-health centers, physicians, hospitals, managed care organizations, and other health system components. Community referrals come from a variety of sources, including the Aging and Disability Resources Centers. Funds will support competitive grants to States, as well as related technical assistance and evaluation activities such as:

- A proposed interagency agreement with the CMS Center for Strategic Planning to evaluate the impact of CDSME on participant health care utilization and cost by linking Medicare claims data to CDSME Medicare participants (both elderly and younger people with disabilities);

- A survey of participants (pre- and post) to evaluate the impact of CDSME on behaviors, health status, and quality of life; and

- Continued funding for a National Technical Assistance Center on Evidence-Based Prevention Programs.

Accountability and quality assurance will include tracking a combination of inputs and outputs. AoA will track the number of programs being conducted and the number of participants completing the program. Participant surveys (pre and post) will be used to track self-reported behavioral change and health status. AoA and CMS will establish protocols and mechanisms to track CDSME participants' Medicare claims data to assess the impact of CDSME on health care utilization.

Grant Awards Table:

Chronic Disease Self-Management Education Grant Awards

	FY 2012 Actual	**FY 2013 Annualized CR**	**FY 2014 President's Budget**
Number of Awards	15-20	15-20	15-20
Average Award	N/A	N/A	N/A
Range of Awards	$200,000 - $575,000	$200,000 - $575,000	$200,575 - $575,000

Outputs and Outcomes Table:

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output CD1: Total number of individuals with chronic conditions completing the CDSME program *(Output)*	FY 2011: 40,430	20,000	20,000	Maintain
Output CD2: Percentage of individuals that report 1 or more health benefits (e.g. improved health status, increased physical activity, less fatigue, greater mobility, etc.) after completing the CDSME program *(Outcome)*	N/A	Baseline	TBD	TBD

Evaluation

In its initial evaluation design work, ACL partnered with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to determine the most promising approach for rigorously evaluating the effectiveness of employing CDSME in the Aging Services Network. In FY 2010, ACL initiated a design contract through AHRQ for recommendations on how to best carry-out an evaluation. The evaluation design recommendations were completed in the spring of 2011. Using the recommendations as a foundation, ACL awarded a contract in fall 2011 for the conduct of an evaluation of how the CDSME program is being implemented through the aging network and its partners (i.e., a process evaluation) and a more detailed outcome evaluation design. The contract was modified in 2012 to eliminate the detailed outcome evaluation design as ACL is working with CMS to match CDSME participants with their Medicare records, and to identify a matched comparison group of similar Medicare recipients, in order to analyze changes in health care utilization between the two groups. The process evaluation is expected to be completed during the summer of 2013 and the results of the work with CMS are expected to be completed during the fall of 2013.

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Senior Community Service Employment Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Senior Community Service Employment Program…….	$448,251,000	$450,994,000	$380,000,000	-$68,251,000
FTE………………………	16	16	16	--

Authorizing Legislation: Section 502 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method .... Formula & Competitive Grants

Program Description and Accomplishments

The Senior Community Service Employment Program (SCSEP) provides time-limited, subsidized community service positions and employment training to low-income, unemployed older adults to allow them to earn additional income in order to maintain their economic independence. Participants must be currently unemployed adults aged 55 and older whose income, including pensions and other income, is below 125% of the federal poverty level. The program's emphasis is on assisting those with the greatest social and economic needs and those living in rural areas. SCSEP's goals are to provide opportunities for older individuals to serve their communities while gaining the marketable skills needed to obtain unsubsidized employment and to foster economic self-sufficiency. Community service employment assignments are based at 501(c)(3) non-profits or government agencies (also referred to as "host agencies"), and are chosen based on their ability to prepare participants to enter or re-enter the workforce. Participants are paid the highest of the Federal, state, or local minimum wage. SCSEP is currently administered by the Department of Labor but is proposed for transfer to ACL in FY 2014.

In addition to wages and benefits, SCSEP provides the following programmatic services to participants:

- Orientation and assessments;
- Supportive services;

- Participant training (e.g., on the job or in a classroom setting); and

- Placement assistance into unsubsidized employment.

While enrolled in the program, all participants must be covered by workers' compensation and offered an annual physical examination. Each participant's skills and interests are assessed at least twice a year, leading to the development of an Individual Employment Plan (IEP). Under ACL's administration, SCSEP's focus on assuring that older individuals are equipped with the skills and knowledge necessary to succeed will remain in place while better aligning it with programs that provide other supportive services to seniors.

SCSEP grants are based on a funding formula which allocates funds to every state, the District of Columbia (DC), and Puerto Rico (PR) based on U.S. Census data on the number of individuals in that jurisdiction who are 55 and older with low per-capita income. Currently, funds are reserved for purposes including pilots, demonstration and evaluation projects; grants to territories; and grants to national public or non-profit agencies to serve eligible American Indian and Pacific Island /Asian American individuals.

The latest competition for national grantees was conducted in 2012. AoA collaborated with DOL on this competition to ensure a smooth transition if Congress authorizes the transfer of the program. Through this collaboration, AoA has provided input and suggestions related to priorities and targeting.

In general, 75 percent of Federal funds under SCSEP must be spent on wages and benefits to participants with the remaining funds used for other participant costs. There is a cap on administrative expenses of 13.5 percent. The Federal funds provided to each of the 74 grantees can be no more than 90 percent of the total project amount, with the non-federal matching requirement either in cash or in-kind.

Funding History

Funding for the Senior Community Service Employment Program at the Department of Labor during the past five years is as follows:

FY 2009 ....$571,925,000
FY 2010 ....$825,425,000[35]
FY 2011 ....$449,100,000
FY 2012 ....$448,251,000
FY 2013 CR. $450,994,000

Budget Request

The FY 2014 request for SCSEP is $380,000,000, a reduction of -$68,251,000 from the FY 2012 enacted level. Funds will continue to be used to provide formula grants to States and competitive grants to national organizations. This funding will also provide necessary administrative support, monitoring, and technical assistance; including funding for staff 16 FTE in FY 2014.

This request continues to propose to transfer responsibility for SCSEP from the Department of Labor to the Administration for Community Living. SCSEP helps older individuals maintain their economic independence by providing much-needed employment income and training. The proposed transfer to ACL will allow for the placement of the program in an agency that has as one its priorities the mission of helping older Americans maintain their independence (both economic independence and living arrangements) and active participation in communities. This shift reflects the recognition that the SCSEP participants can benefit immensely from the strong integration of the program with the supports provided by AoA's existing Aging Services programs and ACL's service network connections. As a part of the proposed transfer to ACL's administration, ACL will make improving program performance, including targeting the SCSEP program to people with the greatest need, a priority. This process is expected to include better aligning the program's eligibility, income, and other requirements with those of other HHS income maintenance programs, in particular by considering all sources of income for future enrollees.

Demographic analysis indicates that older workers will account for an increasingly large portion of the available workforce in the decades ahead. Seniors' participation in SCSEP helps employers recognize the value of older workers as both needed employees and mentors to younger workers. ACL will leverage the experience of the Department of Labor to continue encouraging and expanding job opportunities for aging workers, and work with the One-Stop Career Center system to place job-ready older workers in unsubsidized employment, helping to

[35] Includes a one-time special appropriation of $225,000,000 to serve low-income seniors affected by the recession.

break down the barriers to fair and diverse workplaces for these senior workers. ACL will use the requested funds to continue the vital work done by SCSEP as well as create program efficiencies within the context of the aging services network. Millions of hours of community service are provided by SCSEP participants each year to non-profit organizations and government agencies; more than 45,000,000 hours in each of the last few years. Community service is an equally valuable aspect of SCSEP funding that is inextricably linked to the public service employment wages and training that seniors receive while in the program. In FY 2014, ACL, in partnership with the DOL, the aging services network, and the workforce investment system, will continue to explore creative ideas that highlight opportunities for seniors to serve their communities while accessing employment training options.

Outcome Table

Measure	Most Recent Result	PY 2012 Projection	PY 2014 Projection	FY 2014 +/- FY 2012
Output 1.1: Average earnings in the second and third quarters after exit (Outcome)	PY 2011: $7,580	$7,580	TBD	TBD
Output 1.3: Percent of participants employed in the first quarter after exit (Outcome)	PY 2011: 40.6%	40.6%	TBD	TBD
Output 1.4: Percent of participants employed in the first quarter after exit still employed in the second and third quarters after exit (Outcome)	PY 2011: 72.9%	72.9%	TBD	TBD

These outcomes were developed and the data collected by the Department of Labor. Under the proposal to transfer SCSEP, ACL will work with all relevant parties to develop and refine performance measures and collect performance data.

Native American Nutrition and Supportive Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Native American Nutrition & Supportive Services…….	$27,601,000	$27,770,000	$27,601,000	--

Authorizing Legislation: Sections 613 and 623 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method ....Formula Grant

Program Description and Accomplishments:

Native American Nutrition and Supportive Services provides grants to eligible Tribal organizations to promote the delivery of nutrition and home and community-based supportive services to Native American, Alaskan Native, and Native Hawaiian elders. According to the 2010 Census, 282,917 people age 60+ identified as American Indian and Alaska Native alone and 377,479 people age 60+ identified as American Indian and Alaska Native alone or in combination with another racial group.

Native American Nutrition and Supportive Services grants support a broad range of services to older Native Americans, including adult day care; transportation; congregate and home-delivered meals; information and referral; and personal care, chore, and other supportive services. Currently AoA's congregate meal program reaches 32 percent of eligible Native American seniors in participating Tribal organizations, home-delivered meals reach 14 percent of such persons, and supportive services reach 52 percent of such persons. These programs, which help to reduce the need for costly nursing home care and medical interventions, are responsive to the cultural diversity of Native American communities and represent an important part of each community's comprehensive services.

Services provided by this program in FY 2011, the most recent year for which data are available, include:

- *Transportation Services*, which provided over 794,775 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities (Output L).

- *Home-Delivered Nutrition Services,* under which 2.6 million meals were provided to nearly 29,007 homebound Native American elders. The program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders (Output M).

- *Congregate Nutrition Services*, which provided 2.3 million meals to more than 52,164 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs (Output N).

- *Information, Referral and Outreach Services*, which provided over 1.3 million hours of outreach and information on services and programs to Native American elders and their families, thereby empowering them to make informed choices about their service and care needs (Output O).

The Native American Nutrition and Supportive Services program also provides training and technical assistance to Tribal organizations to support the development of comprehensive and coordinated systems of services to meet the needs of Native American elders. Training and technical assistance is provided through national meetings, site visits, e-newsletters, telephone and written consultations, and through the Native American Resource Centers (funded under Aging Network Support Activities).

Eligible Tribal organizations receive nutrition and supportive services formula grants based on their share of the American Indian, Alaskan Native, and Native Hawaiian population age 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. In addition, Tribes may decide the age at which a member is considered an elder and thus eligible for services. In FY 2012 grants were awarded to 256 Tribal organizations (representing 400 Tribes), including two organizations serving Native Hawaiian elders, with an average award of $105,593 and a range of grant awards from $72,220 to $1,505,000.

Funding History:

Funding for Native American Nutrition and Supportive Services during the past five years is as follows:

FY 2009 ....$27,208,000
FY 2009 (ARRA)....................................$3,000,000
FY 2010 ....$27,704,000
FY 2011 ....$27,653,000
FY 2012 ....$27,601,000
FY 2013 CR..$27,770,000

Budget Request:

The FY 2014 request for Native American Nutrition and Supportive Services is $27,601,000, the same as the FY 2012 enacted level.

Native American Nutrition and Supportive Services, like the same services that HCBSS and Nutrition Services fund for States, help to put off the need for much more expensive institutional services. The services provided using these funds, particularly adult day care, personal care, chore services, and home-delivered meals, also aid Native American caregivers, who might otherwise have to be even more intensively involved with the care of their loved ones, at the risk of their own health and careers.

At the FY 2014 request level, these services will provide 830,000 rides (Output L), 2.5 million meals at home (Output M), and 2.0 million meals at congregate sites (Output N) to approximately 69,500 Native American seniors. Services will allow Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation for as long as they desire.

In FY 2014 the targeted number of units of service, such as home-delivered meals and transportation trips, provided to Native Americans per thousand dollars of AoA funding is projected at 300, a 36 percent increase over the FY 2002 base of 220 (Outcome 1.3). Over the past several years Native American services have met or exceeded their efficiency and output targets for meals and trips due in part to increased contributions from tribal organizations.

Outcome and Outputs Table:

Native American Nutrition & Supportive Services Outcome and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Output 1.3: For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of AoA funding. *(Outcome)*	FY 2011: 312 Target: 300 (Target Exceeded)	300	300	Maintain
Indicator	**Most Recent Result**	**FY 2012 Projection**	**FY 2014 Projection**	**FY 2014 +/- FY 2012**
Output L: Transportation Services units *(Output)*	FY 2011: 795,000	830,000	830,000	--
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2011: 2.6 M	2.5 M	2.5 M	--
Output N: Congregate Nutrition meals *(Output)*	FY 2011: 2.28 M	2.0 M	2.0 M	--
Output O: Information, Referral and Outreach units *(Output)*	FY 2011: 1.3 M	1.0 M	1.0 M	--

Grant Awards Table:

Native American Nutrition & Supportive Services Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	256	256	256
Average Award	$105,593	$108,205	$107,547
Range of Awards	$72,220 - $1,505,000	$74,130 - $1,505,000	$73,650 - $1,505,000

Resource and Program Data:

Native American Nutrition and Supportive Services
(Dollars in Thousands)

	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	256	27,046	256	27,135	256	26,957
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	1	534	1	561	1	570
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		21		74		74
Total Resources		27,601		27,770		27,601

1/ Program Support -- Includes funds for Older Americans Act statutory requirements, grant systems and review, and information technology support costs.

Aging Network Support Activities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Aging Network Support Activities……………...	$7,873,000	$7,921,000	$7,873,000	--

Authorizing Legislation: Section 201, 202, 215, and 411 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method ....Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

Aging Network Support Activities programs provide competitive grants and contracts to support ongoing activities of national significance which help seniors and their families to obtain information about their care options and benefits, and which provide technical assistance to help States, Tribes, and community providers of aging services to develop service systems that help older people remain independent and able to live in their own homes and communities. These activities provide critical and ongoing support for the national aging services network and help support the activities of AoA's core service delivery programs.

Competitive grants, cooperative agreements, and contracts for Aging Network Support Activities are awarded to eligible public or private agencies and organizations, States, and Area Agencies on Aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project's total cost. Project proposals are reviewed by external experts and project awards are made for periods of one to four years. In FY 2012, Aging Network Support Activities funded 23 grants with an average award of $301,070.

National Eldercare Locator and Engagement

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator, created in 1991, helps seniors and their families navigate this complex environment by connecting those needing assistance with State and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line

and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving over 647,867 individuals per year.

This program also supports efforts to enhance discovery, documentation, and support for locally-developed program models and volunteer engagement strategies. Eighteen model programs launched in FY 2011 involved older adults in civic engagement projects aimed at increasing services to frail elders, families of children with special needs, and grandparents raising grandchildren. These model programs also partnered with the Corporation for National and Community Service.

National Alzheimer's Call Center

The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. In the 12-month period ending January 31, 2012, the National Alzheimer's Call Center handled over 257,000 calls through its national and local partners, and its on-line message board community recorded over 12 million page views and over 110,000 individual postings. The National Alzheimer's Call Center is available to people in all States, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and masters degree social workers are available at all times. The Call Center is accessible by telephone, website, or e-mail at no cost to the caller. Information provided may include basic information on caregiving, handling legal issues, resources for long-distance caregiving, and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

Pension Counseling and Information

The Pension Counseling program, first funded in 1993, assists older Americans in accessing information about their retirement benefits and helps them negotiate with former employers or pension plans for due compensation. Currently there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Given that an employee may have worked for several employers, and these employers may have merged, sold their plans, or gone bankrupt, it is very difficult for the average person to know where to go to get help in finding out whether he or she is receiving all of their pension benefits. AoA currently funds six regional counseling projects covering 29 States. Data for the program shows that:

- Pension Counseling projects have successfully obtained a return of more than seven dollars for every Federal dollar invested in the program.

- Projects have directly served over 40,000 individuals by providing hands-on assistance in pursuing claims through administrative appeals processes, helping seniors to locate pension plans "lost" as a result of mergers and acquisition, answering queries about complex plan provisions, and making targeted referrals to other professionals for assistance.

By producing fact sheets and other publications; hosting websites; and conducting outreach, education and awareness efforts, Pension Counseling projects also provide indirect services to tens of thousands of seniors and their families.

National Education and Resource Center on Women and Retirement Planning

The National Education and Resource Center on Women and Retirement Planning, established in 1998, provides women with access to a one-stop gateway that integrates financial information and resources on retirement, health, and planning for long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including average-income and low-income women, women of color, women with limited English speaking proficiency, rural, and other "underserved" women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and publications in hard copy and Web-based formats. Since its establishment, the Center has conducted more than 20,000 workshops on strategies to access financial and retirement planning information for women and disseminated financial and retirement planning information tailored to the specific needs of hard-to-reach women.

National Resource Centers on Native American Elders

The National Resource Centers on Native American Elders enhance knowledge about older Native Americans and thereby increase and improve the delivery of services to them. Each Resource Center addresses at least two areas of primary concern which are specified in the OAA. These include health issues, long-term care (including in-home care), elder abuse, mental health, and other problems and issues facing Native communities. The Resource Centers are administered under cooperative agreements by institutions of higher education. The Resource Centers partner with Native American organizations and communities, educational institutions including Tribal Colleges and Universities, and professionals and paraprofessionals in the field. Resource centers have specialized areas of interest. The University of North Dakota Resource Center has assisted Title VI grantees in assessing needs of tribal elders to determine program planning and direction. This process has developed a database of information about American Indian, Alaska Native and Native Hawaiian Elders. The University of Hawaii Resource Center

has focused on long term care needs of Native Hawaiian Elders. The University of Alaska Resource Center has focused on elder abuse and neglect issues within Native communities.

National Minority Aging Organizations Technical Assistance Centers

The National Minority Aging Organizations (NMAO) Technical Assistance Centers Program works to reduce or eliminate health disparities among racial and ethnic minority older individuals. These Centers design and disseminate front line health promotion and disease prevention information that is culturally and linguistically appropriate for older individuals of African American, Hispanic, Asian American and Pacific Islander descent, American Indian and Alaska Native elders, as well as for older lesbian, gay, bisexual, and transgender (LGBT) adults.

For example, the Center for American Indian and Alaska Native elders is developing a culturally appropriate caregiver manual/toolkit for caregivers caring for elders with dementia. Each NMAO project pilots a practical, nontraditional, community-based intervention for reaching older individuals who experience barriers to accessing home and community-based services. Interventions are focusing on barriers due to language and low literacy as well as those directly related to cultural diversity. Strategies developed under this program incorporate the latest technology and facilitate the generation and dissemination of knowledge in forms that can assist racial and ethnic minority older individuals to practice positive health behaviors and strengthen their capacity to maintain active, independent life styles. Examples of products resulting from these grants include a chronic disease self management curricula and manual tailored for racial and ethnic minority seniors, a series of bilingual Influenza Vaccination Promotion materials, and a referral database of Chronic Disease Self-Management (CDSME) workshops.

LGBT elders face a number of unique challenges as they strive to maintain their independence. The LGBT Resource Center, established in 2010, strives to meet three primary objectives: to educate mainstream aging services organizations about the existence and special needs of LGBT elders, to sensitize LGBT organizations about the existence and special needs of older adults, and to educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national resource center formally began services in September 2010 with the launching of a website including training curricula and social networking tools. In 2014, with the groundwork and tools now in place and available, a primary Resource Center focus will be on the provision of training and technical assistance for community providers across the country.

Program Performance and Technical Assistance

This activity supports cooperative efforts between AoA and selected States and AAAs to develop various tools, performance measures, and best practices that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis. It also supports partnerships with National Aging Organizations to foster innovation and provide

technical assistance to States, AAAs, and Tribal organizations in strategic planning, program development, and performance improvement.

Funding History:

Comparable funding for Aging Network Support Activities is as follows:

FY 2009 ....$8,200,000
FY 2010 ....$8,198,000
FY 2011 ....$8,184,000
FY 2012 ....$7,873,000
FY 2013 CR. $7,921,000

Budget Request:

The FY 2014 request for Aging Network Support Activities is $7,873,000, the same as the FY 2012 enacted level. The programs funded by this request provide critical and ongoing support for the national aging services network and are needed to support the activities of AoA's core service delivery programs. Not only do they provide a variety of services, some of which – such as the National Alzheimer's Call Center and the National Eldercare Locator – are not the responsibility of any other government agency, these programs also considerably strengthen and streamline AoA's core services, and are critical to AoA's continuing success.

Aging Network Support Activities outcomes are reflected in performance targets for Health and Independence and Caregiver Services.

Aging Network Support Activities includes funding for the following projects (dollars in thousands):

Activity	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Aging Network Support Activities:			
National Eldercare Locator and Engagement	$ 2,151	$ 2,164	$ 2,151
National Alzheimer's Call Center	998	1,004	998
National Education & Resource Center on Women & Retirement	248	249	248
Pension Information and Counseling Program	1,713	1,723	1,713
National Resource Centers on Native Americans	691	695	691
National Minority Aging Organizations	1,230	1,237	1,230
Program Performance and Technical Assistance	843	849	843
Total, Aging Network Support Activities	**$ 7,873**	**$ 7,921**	**$ 7,873**

Grant Awards Table:

Aging Network Support Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	23	20-23	20-23
Average Award	$301,070	$301,070	$301,070
Range of Awards	$104,516 - $1,121,518	$104,516 - $1,121,518	$104,516 - $1,121,518

Resource and Program Data:

Aging Network Support Activities
(Dollars in thousands)

	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
Mechanism	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	1,627	11	4,614	2	1,039
Continuations	15	6,009	10	2,817	21	6,344
Contracts	1	48	3	142	3	142
Interagency Agreements	1	50	1	200	1	200
Program Support 1/		139		148		148
Total Resources		7,873		7,921		7,873

1/ Program Support -- Includes funds for Older Americans Act statutory requirements, grant systems and review, and information technology support costs.

Caregiver Services

Summary of Request

Families are the nation's primary provider of long-term care, but a number of factors including financial constraints, work and family demands, and the many challenges of providing care place great pressure on family caregivers. Caregiving responsibilities demand time and money from families who too often are already strapped for both. ACL's caregiver programs provide services that address the needs of unpaid, informal caregivers, allowing many of them to continue to work while providing critically needed care.

Better support for informal caregivers is critical because often it is their availability - whether they are informal family caregivers, paraprofessionals, or unrelated friends and neighbors who volunteer their time - that determines whether an older person can remain in his or her home. In 2009, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[36] AARP estimated the economic cost of replacing unpaid caregiving in 2009 to be about $450 billion, an increase from $375 billion in 2007 (cost if that care had to be replaced with paid services).[37]

The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. Caregivers suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[38] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy-eight percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[39]

At the same time, ACL recognizes that it must also address the growing need for more caregivers every day. By 2015, it is projected that there will be 12.9 million non-institutionalized seniors

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[36] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[37] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[38] Schulz R, Beach SR. Caregiving as a risk factor for mortality. The Caregiver Health Effects study. JAMA December 15, 1999;282:2215-9.

[39] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

age 65 and over with 1+ ADL deficits, an increase of almost 2 million seniors (or 18 percent since 2008) needing caregiver assistance.[40]

To address these caregiver-related needs, ACL requests a total of $182,512,000, an increase of +$16,027,000 over the FY 2012 enacted level. The request includes:

- $153,621,000 for Family Caregiver Support Services, the same as the FY 2012 enacted level. This program makes a range of support services available to family and informal caregivers in States, including counseling, respite care, and training, that assist family and informal caregivers to care for their loved ones at home for as long as possible. Studies have shown that these supports can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly nursing home care.

- $6,364,000 for Native American Caregiver Support Services, the same as the FY 2012 enacted level. This program makes a range of services available to Native American caregivers, including information and outreach, access assistance, individual counseling, support groups and training, respite care and other supplemental services.

- $9,537,000 for Alzheimer's Disease Supportive Services, an increase of +$5,527,000 over the FY 2012 enacted level. This program is currently the only program at HHS focused specifically on supportive services for those with Alzheimer's Disease (AD) and their caregivers. One critical focus of this program is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue living in the community. Another focus is to expand the availability of evidence-based diagnostic and support services to those with Alzheimer's.

- $10,500,000 for services to individuals with Alzheimer's Disease and their families under the President's Alzheimer's Initiative, funded from the Prevention and Public Health Fund. There were no funds allocated for this activity in FY 2012. Funds will be used to expand efforts to develop more AD-capable long-term services and supports systems designed to meet the needs of AD caregivers. Caregivers will be linked to interventions shown to decrease their burden and depression and thus improve their health outcomes.

[40] Data extrapolated by AoA from U.S. Census Bureau, "2008 National Population Projections," released August 2008, http://www.census.gov/population/www/projections/2008projections.html and Health Data Interactive, National Center on Health Statistics, Centers for Disease Control and Prevention, "Functional limitations among Medicare beneficiaries, ages 65+: US, 1992-2006." Accessed 31 August 2009.

- $2,490,000 for Lifespan Respite Care, the same as the FY 2012 enacted level. This program funds grants to improve the quality and access to respite care for family caregivers of children or adults of any age with special needs.

As a group, these programs support caregivers, elders, and people with disabilities by providing critical respite care and other support services for family caregivers, training and recruitment of care workers and volunteers, information and outreach, counseling, and other supplemental services.

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Family Caregiver Support Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Family Caregiver Support Services…………..........	$153,621,000	$154,561,000	$153,621,000	--

Authorizing Legislation: Section 371 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization .... Expired

Allocation Method .... Formula Grant

Program Description and Accomplishments:

Family Caregiver Support Services provides grants to States and Territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. The program includes five basic system components: information, access assistance, counseling and training, respite care, and supplemental services. These services work in conjunction with other OAA services - including transportation services, homemaker services, home-delivered meals, and adult day care - to provide a coordinated set of supports for seniors which caregivers can access on their behalf. Family Caregiver Support Services provide a variety of supports to family and informal caregivers. Based on FY 2011 data, the most recent available, services provided included:

- *Access Assistance Services* provided over 1.3 million contacts to caregivers assisting them in locating services from a variety of public and private agencies (Output I).

- *Counseling and Training Services* provided over 128,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

- *Respite Care Services* provided nearly 67,000 caregivers with 7 million hours of temporary relief - at home, or in an adult day care or nursing home setting - from their caregiving responsibilities (Output K).

Family and other informal caregivers are the backbone of America's long-term care system. On a daily basis, these individuals assist relatives and other loved ones with tasks ranging from

personal care and homemaking to more complex health-related interventions like medication administration and wound care. AARP estimated the economic cost of replacing unpaid caregiving in 2009 to be about $450 billion (the cost if that care had to be replaced with paid services).[41] Caregivers often experience conflicts between work and caregiving, with 25 percent reporting that they have had to make adjustments such as retiring or taking time away from work due to their caregiving responsibilities.

Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2012 National Survey of OAA Participants, 22 percent of caregivers are assisting two or more individuals. Seventy-one percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and twenty-nine percent describe their own health as fair to poor.[42] The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient.

Studies have shown that the types of supports provided through the Family Caregiver Support Services Program can reduce caregiver depression, anxiety, and stress and enable them to provide care longer while often continuing to work, thereby avoiding or delaying the need for costly institutional care for their loved ones. For example, one study indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home, at significantly less cost, for an additional year before being admitted to a nursing home.[43]

Additionally, data from AoA's national surveys of caregivers of elderly clients also shows that OAA services, including those provided through Family Caregiver Support Services, are effective in helping caregivers keep their loved ones at home. Approximately 77 percent of caregivers of program clients reported in 2012 that services enabled them to provide care longer than otherwise would have been possible.[44] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Forty-three percent of the caregivers of nursing home eligible care recipients indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 78 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see below).

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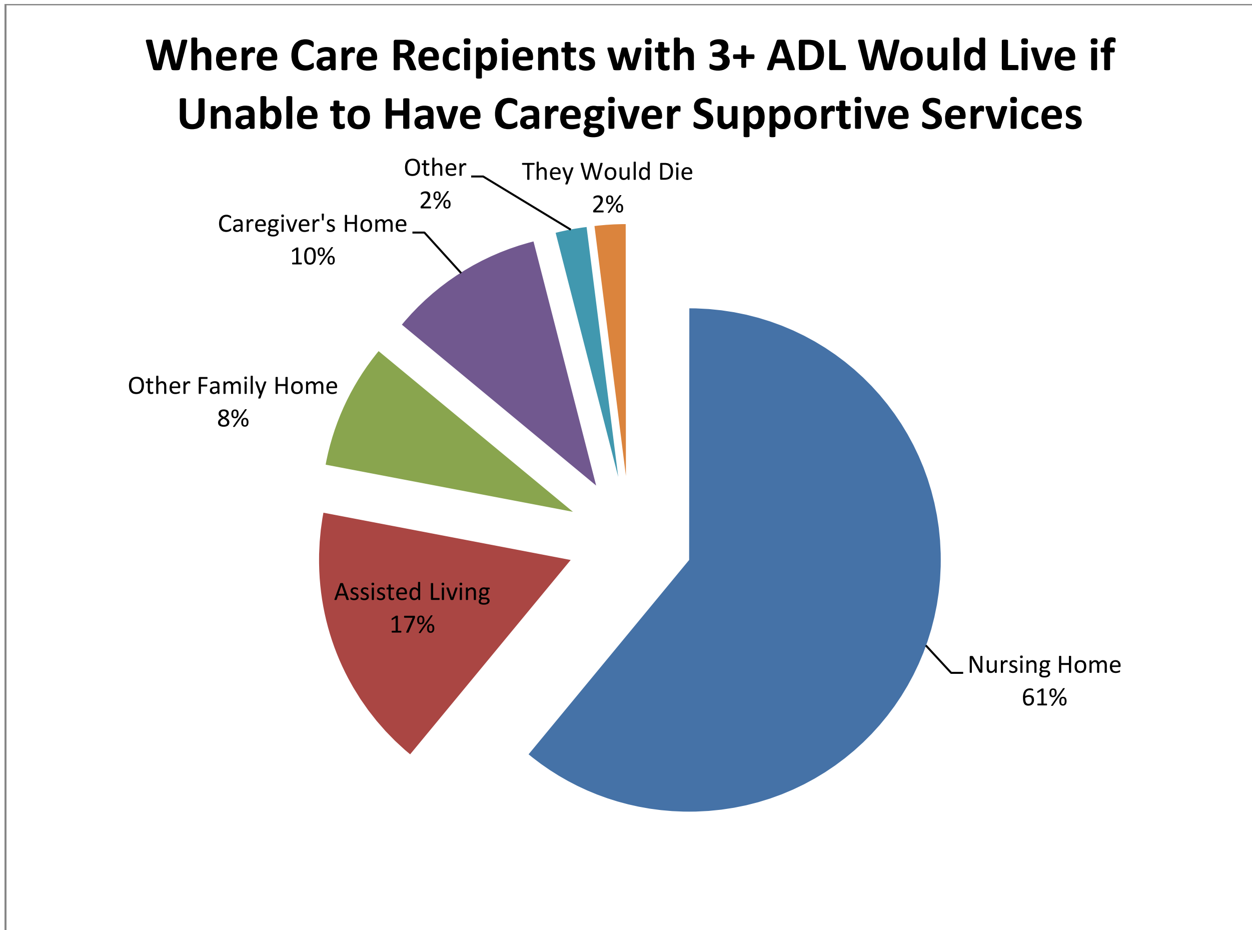
[41] *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[42] 2012 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[43] *A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease.* Aging and Dementia Research Center, New York University. Journal of the American Medical Association. December 4, 1996.

[44] 2012 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.



(based on responses from care recipients unable to live independently) [45]

Funding History:

Funding for Family Caregiver Support Services during the past five years is as follows:

FY 2009 ....$154,220,000
FY 2010 ....$154,197,000
FY 2011 ....$153,912,000
FY 2012 ....$153,621,000
FY 2013 CR. $154,561,000

Budget Request:

The FY 2014 request for Family Caregiver Support Services levels is $153,621,000, the same as the FY 2012 enacted level. With this proposed funding, 790,000 caregivers (Outcome 3.1) will

[45] 2012 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

be provided with supportive services, including respite care or temporary relief from their caregiving responsibilities. This represents 30,000 caregivers more than the level served in FY 2011. Respite care is the service rated by caregivers as the most helpful. Nearly 120,000 caregivers will also have the opportunity to participate in counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J). Caregivers state that these programs help keep their loved ones at home, as 83 percent of caregivers report these supportive services enable them to provide care longer.

In FY 2014, AoA expects the aging services network to meet or exceed the target of only 28 percent of caregivers experiencing difficulty obtaining services (Outcome 2.6). This is a substantial accomplishment that occurred at the State level as a result of ongoing program development, better coordination and integration of the Family Caregiver program into the array of State home and community-based services. Baseline levels from 2003 showed that 64 percent of caregivers had difficulty getting services, and by 2011 that rate had been reduced by more than half to 30 percent of caregivers reporting difficulty getting services.

For FY 2014, the performance target for Family Caregiver Support Services Program participants who rate services good to excellent is 90 percent (Outcome 2.9c). The substantive improvements in program performance can be attributed to the successful implementation of the program. Client-reported assessment of service quality and program outcomes is expected to remain at high levels, however some service outputs are expected to decline in FY 2014 compared to FY 2010. Declines are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.

Outcomes and Outputs Table:

Family Caregiver Support Services Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Outcome 2.6: Reduce the percent of caregivers who report difficulty in getting services. *(Outcome)*	FY 2011: 30% Target: 30% (Target Met)	28%	28%	Maintain
Outcome 2.9c: 90% of NFCSP clients rate services good to excellent. *(Outcome)*	FY 2011: 96% Target: 90% (Target Exceeded)	90%	90%	Maintain
Outcome 3.1: Increase the number of caregivers served. *(Outcome)*	FY 2011: 819,598 Target: 790,000 (Target Exceeded)	792,000	790,000	-2,000
Indicator	**Most Recent Result**	**FY 2012 Projection**	**FY 2014 Projection**	**FY 2014 +/- FY 2012**
Output I: Caregivers access assistance units of service. *(Output)*	FY 2011: 1.3 M	950,000	915,000	-35,000
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2011: 128,685	124,000	122,000	-2,000
Output K: Caregivers receiving respite care services. *(Output)*	FY 2011: 66,788	67,000	67,000	--

Note: FY 2011 data are preliminary. For presentation within the budget AoA highlighted specific measures that are most directly related to Family Caregiver Support Services, however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Table:

Family Caregiver Supportive Services Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$2,726,394	$2,732,418	$2,715,800
Range of Awards	$95,424 - $15,442,307	$95,635 - $15,553,918	$95,053 - $15,459,324

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Family Caregivers Support Services (CFDA 93.052)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	2,351,563	2,347,598	2,333,321	-18,242
Alaska	763,390	765,076	760,423	-2,967
Arizona	3,164,166	3,238,861	3,219,163	54,997
Arkansas	1,503,924	1,505,194	1,496,039	-7,885
California	15,442,307	15,553,918	15,459,324	17,017
Colorado	1,926,424	1,963,071	1,951,132	24,708
Connecticut	1,874,713	1,849,714	1,838,464	-36,249
Delaware	763,390	765,076	760,423	-2,967
District of Columbia	763,390	765,076	760,423	-2,967
Florida	12,070,518	12,187,704	12,113,581	43,063
Georgia	3,547,261	3,614,235	3,592,254	44,993
Hawaii	763,390	765,076	760,423	-2,967
Idaho	763,390	765,076	760,423	-2,967
Illinois	5,898,667	5,857,968	5,822,342	-76,325
Indiana	3,054,144	3,042,965	3,024,458	-29,686
Iowa	1,723,829	1,699,582	1,689,245	-34,584
Kansas	1,408,146	1,395,639	1,387,151	-20,995
Kentucky	2,059,860	2,062,117	2,049,576	-10,284
Louisiana	1,991,274	1,995,930	1,983,792	-7,482
Maine	766,439	765,076	760,423	-6,016
Maryland	2,524,149	2,535,834	2,520,412	-3,737
Massachusetts	3,349,110	3,315,526	3,295,361	-53,749
Michigan	4,947,620	4,919,406	4,889,488	-58,132
Minnesota	2,521,552	2,527,039	2,511,670	-9,882
Mississippi	1,363,666	1,360,029	1,351,757	-11,909
Missouri	3,049,893	3,041,877	3,023,377	-26,516
Montana	763,390	765,076	760,423	-2,967
Nebraska	933,179	921,876	916,269	-16,910
Nevada	1,095,922	1,125,972	1,119,124	23,202
New Hampshire	763,390	765,076	760,423	-2,967

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	4,381,530	4,331,860	4,305,515	-76,015
New Mexico	949,699	961,311	955,465	5,766
New York	9,679,695	9,582,512	9,524,234	-155,461
North Carolina	4,360,720	4,405,626	4,378,832	18,112
North Dakota	763,390	765,076	760,423	-2,967
Ohio	5,998,353	5,952,469	5,916,267	-82,086
Oklahoma	1,822,471	1,820,933	1,809,859	-12,612
Oregon	1,908,337	1,924,500	1,912,796	4,459
Pennsylvania	7,379,177	7,270,632	7,226,414	-152,763
Rhode Island	763,390	765,076	760,423	-2,967
South Carolina	2,184,482	2,225,118	2,211,585	27,103
South Dakota	763,390	765,076	760,423	-2,967
Tennessee	3,006,252	3,030,768	3,012,336	6,084
Texas	9,176,247	9,313,287	9,256,646	80,399
Utah	888,363	901,446	895,964	7,601
Vermont	763,390	765,076	760,423	-2,967
Virginia	3,445,502	3,479,460	3,458,299	12,797
Washington	2,923,761	2,968,845	2,950,790	27,029
West Virginia	1,079,225	1,065,973	1,059,490	-19,735
Wisconsin	2,887,461	2,864,463	2,847,042	-40,419
Wyoming	763,390	765,076	760,423	-2,967
Subtotal, States	149,800,281	150,107,246	149,194,333	-605,948
American Samoa	95,424	95,635	95,053	-371
Guam	381,695	382,538	380,212	-1,483
Northern Mariana Islands	95,424	95,635	95,053	-371
Puerto Rico	1,923,559	1,951,798	1,939,927	16,368
Virgin Islands	381,695	382,538	380,212	-1,438
Subtotal, States and Territories	152,678,078	153,015,390	152,084,790	-593,288
Undistributed[46]	942,922	1,545,610	1,536,210	593,288
TOTAL	**153,621,000**	**154,561,000**	**153,621,000**	--

[46] The undistributed line reflects the amount reserved from the Family Caregiver Support Services appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

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Native American Caregiver Support Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Native American Caregiver Support Services…………..	$6,364,000	$6,403,000	$6,364,000	--

Authorizing Legislation: Section 631 of the Older Americans Act of 1965, as amended

FY 2014 Authorization .... Expired

Allocation Method .... Formula Grant

Program Description and Accomplishments:

Native American Caregiver Support Services provide grants to eligible Tribal organizations to provide support for family and informal caregivers of Native American, Alaskan Native, and Native Hawaiian elders. This program, which helps to reduce the need for costly nursing home care and medical interventions, is responsive to the cultural diversity of Native American communities and represents an important part of each community's comprehensive services.

Native American Caregiver Support Services funding is allocated to eligible Tribal organizations based on their share of the American Indian, Alaskan Native, and Native Hawaiian population aged 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over and be receiving a grant under Title VI Part A or B to receive funding. There is no requirement for matching funds. Tribes may also decide the age at which a member is considered an elder and thus eligible for services. In addition, there is no limit on the percentage of funds that can be used for services to grandparents caring for grandchildren.

Grants assist American Indian, Alaskan Native and Native Hawaiian families caring for older relatives with chronic illness or disability and grandparents caring for grandchildren. The program provides a variety of direct services that meet a range of caregiver needs, including information and outreach, access assistance, individual counseling, support groups and training, respite care, and other supplemental services. Tribal organizations coordinate with other programs, including the Volunteers In Service To America (VISTA) program, to help support and create sustainable caregiver programs in Native American communities (many of which are geographically isolated). A core value of the Native American Caregiver Support Services program is that the program should not replace the tradition of families caring for their elders.

Rather, as expressed by multiple Tribal leaders, the program provides support that strengthens the family caregiver role.

Funding History:

Funding for the Native American Caregiver Support Services during the past five years is as follows:

FY 2009 ....$6,389,000
FY 2010 ....$6,388,000
FY 2011 ....$6,376,000
FY 2012 ....$6,364,000
FY 2013 CR. $6,403,000

Budget Request:

The FY 2014 request for Native American Caregiver Support Services is $6,364,000, the same as the FY 2012 enacted level. Support for caregivers is critical since often it is their availability, whether they are informal family caregivers, paraprofessionals or unrelated friends and neighbors who volunteer their time, that determines whether an older person can remain in his or her home.

In the 2009 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as American Indians or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as part American Indian or Alaskan Native. Caregiver support services help Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation for as long as possible and desired. Studies have shown that providing assistance to caregivers can help them cope with the emotional, physical and financial toll associated with caregiving, thereby enabling them to provide care for their loved ones longer and avoid or delay the need for costly nursing home care.

Performance data indicates that these programs are an efficient means to help Native American Elders remain independent and in the community. It should be noted that some service outputs for FY 2014 are expected to decline due to the economic downturn impacting Tribal government budgets.

In FY 2014 the Native American Caregiver Support Program will continue to assist family caregivers, whose assistance is critical to enabling Native American elders with disabilities to remain at home, in the community, and on the reservation. It is estimated that in FY 2014 more

than 320,000 units of caregiver-related services including respite care, information and referral, caregiver training, lending closets, and support groups will have been provided by Native American Tribal organizations.

Outcome Table:

Native American Caregivers Supportive Services Outcome

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Outcome 3.1: Increase the number of caregivers served. *(Outcome)*	FY 2011: 819,598 Target: 790,000 (Target Exceeded)	792,000	790,000	-2,000

Grant Awards Table:

Native American Caregivers Supportive Services Grant Awards

	FY 2012 Actual	FY 20123 Annualized CR	FY 2014 President's Budget
Number of Awards	218	218	218
Average Award	$29,119	$29,298	$29,120
Range of Awards	$13,360 - $54,689	$13,450 - $54,303	$13,360 - $54,740

Resource and Program Data:

Native American Caregiver Support Services

(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	218	6,362	218	6,387	218	6,348
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support		2		16		16
Total Resources		6,364		6,403		6,364

1/ Program Support -- Includes funds for Older Americans Act statutory requirements, grant systems and review, and information technology support costs.

Alzheimer's Disease Supportive Services Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Alzheimer's Disease Supportive Services Program……………..	$4,010,000	$4,035,000	$9,537,000	+$5,527,000

Authorizing Legislation: Section 398 of the Public Health Services Act, as amended

FY 2014 Authorization .... Expired

Allocation Method ....Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

The Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants to States to expand the availability of evidence-based interventions that help persons with dementia and their caregivers remain independent in the community as long as they desire it. The primary components of the ADSSP program include delivering evidence-based supportive services; translating and replicating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and advancing changes to a State's overall system of home and community-based care.

These changes are focused on expanding the aging services network's capacity to assist those with dementia and their families by providing individualized and public information, education, and referrals about diagnostic, treatment and related services. The program also provides sources of assistance for services and legal rights assistance for people affected by Alzheimer's disease throughout a state's long term services and support system.

Funding for ADSSP was reduced by the Congress in FY 2012 to a level that only allowed AoA to issue continuation grants to 11 grantees. Through projects funded in prior years, seven States are in the process of translating four evidence-based interventions into practice and nine States are offering innovative programming for caregivers and their loved ones with dementia. One example of these promising interventions is the New York University Caregiver Intervention, a spousal caregiver support program that in a randomized-control trial delayed institutionalization

of persons with dementia by an average of 557 days.[47] In 2009, the average nursing home cost was $219 daily ($79,935 annually), which would mean an average savings of nearly $122,000 in institutional costs per person with dementia.[48] Minnesota is translating this intervention now; early results appear to confirm the original study. Other grant projects are focused on innovations in areas of great need, such as programs to ensure that the States' long term services and supports system are dementia capable. Overall, these demonstrations offer direct services and other supports to thousands of families, as well as support the continuous quality improvement and evaluation of these services.

Family caregivers remain the major source of support for most people with Alzheimer's disease. The nature of the disease - a slow loss of cognitive and functional/physical independence - means that most people with Alzheimer's disease are cared for in the community for years. They may access a variety of services from many different systems including the aging, medical, and mental health service systems. As the number of people with Alzheimer's disease grows, it is increasingly important that service delivery and health care systems are responsive to persons with dementia and are effectively coordinated. It is also important to ensure the availability of dementia-capable community-based social and health care services.

Funding History:

Funding for the ADSSP program during the past five years is as follows:

FY 2009 ....$11,464,000
FY 2010 ....$11,462,000
FY 2011 ....$11,441,000
FY 2012 ....$4,010,000
FY 2013 CR $4,035,000

Budget Request:

The FY 2014 request for the Alzheimer's Disease Supportive Services Program is $9,537,000, an increase of +$5,527,000 compared to the FY 2012 enacted level. Continued funding will enable communities across the nation to continue implementing evidence-based interventions such as the New York University Caregiver Intervention referenced above. In addition, AoA will be

[47] Mittleman M, et al. (1996). "A Family Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease: a randomized, controlled trial," Journal of the American Medical Association, 276; 1725-1731.

[48] Metlife. (October 2009), "MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs", p. 4, Accessed August 17, 2010 from: http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf

unable to undertake subsequent translations of research funded by NIA, CDC and other science agencies. The need for cutting edge approaches to serving this population continues as both the population and prevalence continue to increase. One study estimates that there were 454,000 new cases of Alzheimer's disease in 2010; by 2030 the number of new cases annually is projected to be 615,000 and by 2050, 959,000. Currently over 5 million individuals have this disease. [49]

The FY 2014 funding request will allow ACL to continue to respond to this growing need by supporting new grants that provide direct services to approximately 35,000 persons with Alzheimer's disease and their family caregivers. Funds will be used to broadly disseminate those translated, evidence-based interventions that have proven successful over the past 4 years of funding and to test new evidence-based interventions as they are identified. In addition, funds will be used to expand the delivery of dementia-capable home and community-based services, thereby potentially impacting the much broader population of families struggling to cope with this disease.

Using FY 2011 and FY 2012 funding, ADSSP is currently supporting 15 states in field testing 9 evidence-based caregiver interventions, with the goal of embedding successful translations in state programs and funding streams. ACL is looking at how these interventions can be effectively provided through Aging Services Network programs while attempting to ensure fidelity to the original intervention. Successful translation of these research interventions to community settings will have a significant impact on supporting and sustaining family caregivers. [50]

By the close of FY 2013, ACL anticipates the release of evaluation results from a six-state translation effort of the New York University Caregiver Intervention (referenced above) which aims to significantly delay institutionalization of persons with dementia by providing education, support, and counseling to spousal and other family caregivers. In addition, ACL will have completed an evaluation of a three state translation of the *Savvy Caregiver Intervention. This intervention* trains caregivers to think about their situation objectively and provides them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively.

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[49] Alzheimer's Association, (2011). "Alzheimer's Disease Facts and Figures"., p. 17 and p. 34. Accessed August 30, 2011 from: http://www.alz.org/alzheimers_disease_facts_figures.asp

[50] The evidence-based projects have three year project periods to develop, implement and document fidelity of the translation to the original model. Actual dissemination/replication of the interventions occurs after the translations are shown to have proven fidelity to the original models in the new type of setting. Each of the States funded at the end of FY 2008 requested up to a 1-year no-cost extension to finalize their projects. Therefore, baselines to these and similar measures will be available starting in FY 2013 for the FY 2008 and subsequent grants after if/when the translation projects are proven successful.

Outcome and Outputs Table:

Alzheimer's Disease Supportive Services Program Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Outcome ALZ2. Increase number of individuals served with evidence-based interventions – cumulative[51] *(Outcome)*	FY 2011: 9,518 Target: Baseline	8,800	19,000	+10,200

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output AC: Number of individuals served – cumulative[52] *(Output)*	FY 2011: 19,562	20,000	35,000	+15,000
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	FY 2011: 23%	23%	24%	+1%

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Alzheimer's Disease Supportive Services Programs, however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Table:

Alzheimer's Disease Supportive Services Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	11	11	26
Average Award	$271,073	$271,073	$271,073
Range of Awards	$138,559 - $500,000	$138,559 - $500,000	$138,559 - $500,000

[51] Cumulative count began in 2008.

[52] Cumulative count began in 2008.

Resource and Program Data:

Alzheimer's Disease Supportive Services Program
(Dollars in thousands)

Mechanism	FY 2012 Enacted #	FY 2012 Enacted $	FY 2013 Annual CR #	FY 2013 Annual CR $	FY 2014 President's Budget #	FY 2014 President's Budget $
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	6	3,289	12	8,390
Continuations	13	2,982	--	--	--	--
Contracts	1	922	1	638	1	798
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		107		108		349
Total Resources		4,010		4,034		9,537

1/ Program Support -- Includes funds for Public Health Service Act statutory requirements, grant systems and review costs.

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Alzheimer's Disease Initiative - Services

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Alzheimer's Disease Initiative – PPHF……..	--	$10,500,000	1/	+$10,500,000

1/ The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

FY 2014 Public Health Service Act Authorization..Expired

Allocation Method ....Competitive Grants/Co-operative Agreements and Contracts

Intended Recipients……………………………………………………………………….States

Program Description and Accomplishments:

On February 7, 2012, the President announced a new effort to fight Alzheimer's Disease. As many as 5.1 million people in the United States may have Alzheimer's disease. The effects of Alzheimer's can be devastating, both for individuals afflicted with the disease and for their families. People with Alzheimer's may require significant amounts of health care and intensive long-term services and supports -- including, but not limited to, management of chronic conditions, help taking medications, round-the-clock supervision and care, or assistance with personal care activities, such as eating, bathing, and dressing.

Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2011 National Survey of OAA Participants, 24 percent of all seniors' caregivers are assisting two or more individuals. Sixty-eight percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and thirty-four percent describe their own health as fair to poor.[53] Caregivers also suffer from higher rates of depression than non-caregivers of the same age, and research indicates that caregivers suffer a mortality rate that is 63 percent higher than non-caregivers.[54] The demands of caregiving can

[53] 2011 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[54] Schulz R, Beach SR. Caregiving as a risk factor for mortality. The Caregiver Health Effects study. JAMA December 15, 1999;282:2215-9.

lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient.

Funding History:

FY 2009 ....$0
FY 2010 ....$0
FY 2011 ....$0
FY 2012 ....$0
FY 2013 CR ....N/A[55]

Budget Request:

The FY 2014 budget includes $10,500,000 from the Prevention and Public Health Fund for Alzheimer's Disease Services as part of the President's new efforts to fight Alzheimer's Disease. No funding was allocated for this program in FY 2012. This funding will allow AoA to undertake new efforts to develop more dementia capable long-term service and support systems designed to meet the needs of caregivers of individuals with Alzheimer's Disease and related dementias (AD). Through these efforts AoA will work with lead agencies across State, local, and tribal governments and with the Aging Network to identify and address Alzheimer's Disease caregivers' needs when they seek assistance for themselves or the individual with Alzheimer's Disease.

ACL will use the $10.5 million it is requesting in FY 2014 to expand one particular evidence-based pilot on dementia capability by building and strengthening the dementia capability of a handful of states, tribal entities, or large localities. This pilot on dementia capability shows particular promise for broader use. A "dementia capable" home and community-based services system is able to identify those with dementia and their caregivers, help them choose services that meet their needs, and provide supports to ease the burden on caregivers.

AoA will hold a competition to award cooperative agreements to States, tribes, or other localities. These entities will be charged with developing systems that coordinate or integrate access to a system-wide set of programs that are dementia capable including:

- information, effective screening, referral and access
- community-based and long-term care options counseling and assistance
- streamlined applications and eligibility determinations for public programs

[55] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

- person-centered, service coordination across multiple settings and across care transitions

The grantees will also be asked to develop three core components of a system for persons with dementia and their caregivers including:

- Comprehensive set of services
- Robust quality assurance system
- Sustainable service system

These systems will assist caregivers by ensuring that their needs, and the needs of their loved ones with Alzheimer's disease, are addressed. Since the focus of the cooperative agreements will be to facilitate permanent systems change, an emphasis will be placed on implementing systems that can operate out of ongoing funding streams and will not require new sources of funds to maintain.

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Lifespan Respite Care

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Lifespan Respite Care……..	$2,490,000	$2,506,000	$2,490,000	--

Authorizing Legislation: Lifespan Respite Care Act of 2006, Title XXIX of the Public Health Service Act

FY 2014 Authorization ....Expired

Allocation Method ....Competitive Grants

Program Description and Accomplishments:

Family caregiving is not just an aging issue. Family caregiving for persons with disabilities occurs across the age spectrum from birth to death. Family caregivers are often called upon to provide care to individuals of varying ages and disabilities and do so willingly, often for long periods of time and for many years. AARP estimated, in 2009, that 65.7 million people served as unpaid family caregivers to an adult or child with special needs. For many of these caregivers, providing care can take a toll: a majority of caregivers (51%) caring for someone over age 18 have medium or high levels of burden and 31% of all family caregivers indicated they experienced high levels of stress.[56]

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[57] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers. Even though respite services are often the preferred mode of family caregiver support, they are often under-used, difficult to find and access, unaffordable, or in short supply. A 2009 survey found that many caregivers reported difficulty managing both physical and emotional stress and balancing work and family responsibilities. Despite this, nearly 90% of family caregivers receive no respite at all.[58]
The barriers to accessing and using respite services are often significant for specific populations such as family caregivers of individuals with Multiple Sclerosis, persons with intellectual and

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[56] National Alliance for Caregiving and AARP. Caregiving in the U.S.: A Focused Look at Those Caring for the 50+. 2009. http://www.aarp.org/research/surveys/care/ltc/hc/articles/caregiving_09.html

[57] The Arc. (2011). *Still in the Shadows with Their Future Uncertain: A Report on Family and Individual Needs for Disability Supports (FINDS 2011).* Wash, DC: Author ; National Family Caregivers Association. (2011). *Allsup Family Caregiver Survey.* Kensington, MD

[58] National Alliance for Caregiving and AARP, 2009.

developmental disabilities, and for caregivers of veterans and individuals with Alzheimer's disease, spinal cord injuries, autism, and serious emotional disorders. [59]

The Lifespan Respite Care program focuses on easing the burdens of caregiving by providing grants to eligible State organizations to improve the quality of, and access to, respite care for family caregivers of children or adults of any age with special needs. In particular, this program provides ACL with another vehicle to address the needs of caregivers while considering the important contributions they make in the lives of all persons with disabilities. The goals of the Lifespan Respite Care program differ from the National Family Caregiver Support Program, which focuses on providing a variety of services to caregivers. Instead, Lifespan Respite Care programs focus on providing a testbed for needed infrastructure changes, and on filling gaps by putting in place coordinated *systems* of accessible, community-based respite care services for family caregivers of children and adults with special needs. These systems bring together and seek to coordinate respite care services for family caregivers; training and recruitment of respite care workers and volunteers; and provision of information, outreach, and access assistance.

Lifespan Respite also supports resource center activities designed to maintain a national database on lifespan respite care; provide training and technical assistance to grantees and State, community, and nonprofit respite care programs; and conduct public information, referral, and education programs on respite care.

Since 2009, thirty states have been awarded grants of up to $200,000 each for three year projects. Additionally, in FY 2011, eight states were awarded expansion grants to focus specifically on providing respite services to meet demand and fill gaps in service where identified. Examples of grantee accomplishments to date include:

- Development or enhancement of training programs for respite care providers to expand the cadre of trained respite professionals;

- Replication and expansion of respite delivery modalities with a particular focus on person-centered planning and consumer direction;

- Expansion of toll free "helplines" and dedicated websites to provide caregivers with information about available respite programs.

- Development and deployment of marketing and awareness campaigns designed to educate caregivers about the importance of their work and the necessity to take a break;

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[59] National Alliance for Caregiving. (2012). *Multiple Sclersosis Caregivers.* Washington, DC: Author; The Arc, 2011.

- The development of data collection methodologies to track service provision and outcomes development.

- Broadening stakeholder collaborations to ensure representation of all age and disability groups, as well as the broadest possible cross section of the provider network;

- Convening focus groups of respite consumers to inform project activities; and

- Capacity building and network development at the local level to recruit and train volunteers to fill gaps in respite services, particularly in rural areas through partnerships with programs such as the Corporation for National Service (e.g., VISTA, Service Learning, Senior Companions, etc.)

Grantee States work in collaboration with Aging and Disability Resource Centers and a public or private non-profit statewide respite care coalition or organization, and special emphasis is placed on implementing or enhancing lifespan respite care statewide and who are building or improving the capacity of their long-term care systems to respond to the comprehensive needs of care recipients.

Funding History:

Funding for the Lifespan Respite Care program during the past five years is as follows:

FY 2009 ....$2,500,000
FY 2010 ....$2,500,000
FY 2011 ....$2,495,000
FY 2012 ....$2,490,000
FY 2013 CR. $2,506,000

Note: Funding for the Lifespan Respite Care Act was appropriated in FY 2009 under the General Departmental Management Account in the HHS Office of the Secretary. Beginning in FY 2010 funding was appropriated directly to the Administration on Aging.

Budget Request:

The FY 2014 request for Lifespan Respite is $2,490,000, the same as the FY 2012 enacted level. ACL recognizes the unique opportunity the Lifespan Respite Care Program presents to consider the critical role family caregivers play in ensuring the health and independence of individuals across the age and disability spectrum. No other programs allows for the ability to focus on family caregivers and care recipients as they age and their needs change over time. By

continuing to invest in this program, ACL seeks to provide resources that will allow caregivers to continue to care for their loved ones longer and thereby allow more care recipients to remain at home and independent for longer periods at lower cost than could be realized if these same individuals had to be institutionalized.

The Lifespan Respite Care Program helps to ensure respite quality and choice; and allows for respite development, training and coordination regardless of age or disability. The Lifespan Respite Care program demonstrates ACL's commitment to include caregivers of children or adults of any age with special needs. According to the National Respite Coalition, nearly 90% of family caregivers of care recipients age 18 and older, and 81% of family caregivers of children with special needs currently are unable to access or use respite services. Caregivers report numerous barriers ranging from cost considerations and restrictive eligibility criteria to waiting lists, limited respite options, inadequate supply of trained providers or appropriate programs and gaps in service availability.[60]

The resources requested for FY 2014 will be used to address these issues by:

- Expanding and enhancing respite care services to family members;
- Improving the statewide dissemination and coordination of respite care; and
- Providing, supplementing, or improving access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

The request will also allow ACL to focus on program development in new States not funded in previous years, by enabling them to establish and/or strengthen infrastructures that offer targeted Respite Information and Referral services. Additionally, it will further enable all States funded to date to continue infrastructure development, recruitment, and training of respite providers and volunteers, thus reducing the percentages of caregivers who do not have access to or use respite.

[60] National Respite Coalition Written Testimony to the House subcommittee on Labor, Health and Human Services, and Education Appropriations. April 12, 2010

Output Table:

Lifespan Respite Care Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output AE: Increase the number of people served as a result of Lifespan Respite Care *(Output)*	N/A	N/A (baseline set in FY 2014	N/A (baseline set in FY 2013)	N/A

Grant Awards Table:

Lifespan Respite Care Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	11	11	11
Average Award	$220,456	$220,456	$220,456
Range of Awards	$135,000 - $250,000	$135,000 - $250,000	$135,000 - $250,000

Resource and Program Data:

Lifespan Respite Care Program
(Dollars in thousands)

	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
Mechanism	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	1,931	10	2,179	10	2,139
Continuations	3	494	1	250	1	249
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		65		77		102
Total Resources		2,490		2,506		2,490

1/ Program Support -- Includes funds for Public Health Service Act statutory requirements, grant systems and review costs.

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Protection of Vulnerable Adults

Summary of Request

Protection of Vulnerable Adults consists of several distinct but complementary programs designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. As the population of older Americans increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. A 2004 national survey of State Adult Protective Services (APS) programs conducted by AoA's National Center on Elder Abuse showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[61] According to a 1998 national incidence study (the only such study ever conducted), 84 percent of all elder abuse incidents go unreported, meaning that for every reported case of abuse there are over five that go unreported.[62] Consistent with these earlier findings, the most recent data on the prevalence of elder abuse, neglect, and exploitation suggest that at least 10 percent, or approximately 5 million, older Americans experience abuse each year, and many experience it in multiple forms.[63]

The negative effects of abuse, neglect, and exploitation on the health and independence of seniors is extensive. Research has demonstrated that older victims of even modest forms of abuse have dramatically higher (300 percent) morbidity and mortality rates than non-abused older people.[64] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress. The result of these unnecessary health problems is a growing number of seniors who access the healthcare system more frequently (including emergency room visits and hospital admissions), and are ultimately forced to leave their homes and communities prematurely.[65] Protection of Vulnerable Adults

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[61] Teaster, Pamela, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. http://www.ncea.aoa.gov/NCEAroot/Main_Site/pdf/2-14-06%20FINAL%2060+REPORT.pdf

[62] Tatara, Toshio, et al. *The National Elder Abuse Incidence Study Final Report*. 1998. http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf

[63] Beach SR, Schulz R, Castle NG, Rosen J. Financial Exploitation and Psychological Mistreatment Among Older Adults: Differences Between African Americans and Non-African Americans in a Population-Based Survey. Gerontologist 2010.

Acierno R, Hernandez MA, Amstadter AB, Resnick HS, Steve K, Muzzy W et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. American Journal of Public Health 2010; 100(2):292-297

[64] Lachs, M.S., Williams, C.S., O'Brien, S., Pillemer, K.A., & Charlson, M.E. (1998). "The Mortality of Elder Mistreatment." JAMA. 280: 428-432. and Baker, M.W. (2007). "Elder Mistreatment: Risk, Vulnerability, and Early Mortality." Journal of the American Psychiatric Nurses Association, Vol. 12, No. 6, 313-321.

[65] Lachs M. S., Williams C., O'Brien S., Hurst L., Kossack A., Siegal A., et al. (1997). "ED use by older victims of family violence." Annals of Emergency Medicine. 30:448-454.

programs address this problem through a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation, both at home and in institutional settings.

The total FY 2014 request for Protection of Vulnerable Adults is $43,287,000; an increase of +$2,000,000 over the FY 2012 enacted level. For FY 2014, specific program requests include:

- $8,000,000 for the Adult Protective Services (APS) program authorized by the Elder Justice Act of 2010 (included in Subtitle H of the Affordable Care Act). APS funding will provide demonstration grants to test innovative approaches to reducing and addressing elder abuse in States and in Tribal settings. This funding will generate knowledge that can then be used to inform State and local efforts across the country to design and implement better approaches to protect our Nation's older adults from abuse. Federal funding will also support evaluation of interventions designed to detect and prevent elder abuse, including financial exploitation; and improvement of the knowledge base about how to best implement these important activities. In FY 2012, an initial $6 million was provided for this program from the Prevention and Public Health Fund.

- $16,761,000 for the Long-Term Care Ombudsman Program, the same as the FY 2012 enacted level. This consumer advocacy program improves the quality of care for the residents of long-term care facilities in all States.

- $5,036,000 for Prevention of Elder Abuse and Neglect, the same as the FY 2012 enacted level. This program provides state formula grants to train, educate, and promote public awareness of elder abuse prevention efforts.

- $9,402,000 for the Senior Medicare Patrol Program, the same as the FY 2012 enacted level. SMP funds competitive grants to support a volunteer-based network that helps to prevent and combat healthcare fraud and abuse and helps to preserve the financial integrity of Medicare and Medicaid.

- $4,088,000 for Elder Rights Support Activities, the same as the FY 2012 enacted level. This program provides funding for resource centers and activities that provide information, training, and technical assistance on elder rights issues to the national Aging Services Network.

These elder rights and elder justice programs will build a foundation and establish best practices for States to develop programs to expand and improve the protection of individuals living in their communities and in long-term care settings; increase the information and technical assistance available to the public, States, and localities in preventing and addressing abuse; protect the

rights of older adults and prevent their exploitation; reduce health-care fraud and abuse; and provide assistance to Tribes in developing elder justice systems. This multifaceted approach to preventing, detecting, and resolving elder abuse, neglect, and exploitation is essential to successfully fulfilling the shared mission of the Older Americans Act and the Elder Justice Act to maintain the health and independence of older Americans and adults with disabilities.

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Adult Protective Services Demonstration Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Adult Protective Services BA…..	--	--	$8,000,000	+$8,000,000
Adult Protective Services (PPHF)	$6,000,000	N/A[66]	--	-$6,000,000
FTE………………………………	--	1	1	+1

Authorizing Legislation: Title XX of the Social Security Act, Subtitle B, Section 2042, as amended by the Affordable Care Act, Subtitle H – Elder Justice Act, Sections 6701-6703; Section 751 of the Older Americans Act, as amended

FY 2014 Social Security Act Authorization $25,000,000

Allocation Method ....Competitive Grants and Contracts

Program Description:

The Adult Protective Services (APS) Demonstration Program provides competitive grants to States to test and evaluate innovative approaches to preventing elder abuse, neglect, and exploitation. Current State and local APS programs provide a range of services designed to ensure the safety and well-being of elders who are in danger of being mistreated or neglected, are unable to take care of themselves or to protect themselves from harm, and who have no one to assist them. These services include:

- receiving and investigating reports of elder abuse, neglect, or exploitation;
- case planning, monitoring, evaluation, and other case work and services; and
- providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

The increasing complexity of elder and adult abuse cases, coupled with a rising older population and difficult State and local budget conditions have presented challenges to State, local, and

[66] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

Tribal APS programs, particularly when it comes to developing the most promising and effective interventions possible to prevent elder abuse, neglect, and exploitation.

A number of obstacles have prevented APS programs from evaluating their services, including a lack of resources, the increasing number and complexity of abuse cases, and the absence or inadequacy of consistent data systems and uniform reporting requirements needed to conduct meaningful program evaluations.

Many of these same challenges have limited efforts to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. The APS Demonstration Program focuses on translating promising prevention interventions from other violence prevention areas to elder abuse, and evaluating both the effectiveness of the intervention as well as the comparative effectiveness of the initiative across states in order to build more effective and efficient elder abuse prevention interventions.

Funding History:

FY 2012. ....$6,000,000
FY 2013 CR. ....N/A[67]

Note: No prior funding has been appropriated to this program. Funding in FY 2012 is being provided from the Affordable Care Act Prevention and Public Health Fund.

Budget Request:

The FY 2014 request for Adult Protective Services Program is $8,000,000, an increase of +$2,000,000 over the PPHF mandatory funding provided in FY 2012. FY 2014 represents the first time that this program would receive discretionary funding. The APS Demonstration funds will provide competitive grants to expand the number of states that are currently working to translate and evaluate promising elder abuse prevention interventions from promising violence prevention efforts in related fields such as interpersonal violence and child maltreatment.

The request will continue funding for demonstration grants and associated evaluations and provide funding for an APS resource center to support the coordination, communication, and information availability and dissemination. It also includes the funds to support one FTE to carry out these activities.

The budget request is consistent with the findings of the recent GAO report on Federal elder justice efforts, as well as an earlier HHS report to Congress assessing the feasibility of

[67] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

establishing uniform standards for data collection, reporting, and dissemination of best practices regarding Elder Abuse. This report to Congress included a detailed analysis of the significant level of effort required to address the data collection and reporting requirements for APS. Taken together, these activities will complement each other, and will advance efforts to develop innovative approaches and best practices that can then be disseminated to APS programs nationwide.

The FY 2014 discretionary request for $8 million includes approximately $5.9 million to fund competitive grants to test promising approaches to meeting the growing challenges that State and local APS programs face. Elder abuse, neglect, and exploitation present complex problems that require multidisciplinary solutions that use the most effective and efficient interventions available. These competitive grants will allow State and local APS programs to develop and evaluate innovative elder abuse prevention interventions and identify best practices that can then be disseminated to APS programs nationwide.

The ability of APS programs to employ tested, proven techniques is essential to ensuring that elders are able to receive protection and relief from abuse, neglect, and exploitation. Using the results of the APS State demonstrations, AoA will develop a compendium of best practices and lessons learned that APS programs across the nation can use to improve their programs. Additionally, AoA will present findings, conduct trainings and webinars to disseminate the results, and seek out ways to coordinate with other national, State and local entities to distribute the information. The cumulative results of these projects will allow AoA to establish a strong evidence-base for current and future projects.

Critical to the success of these efforts, AoA will provide APS State demonstration grantees with uniform definitions and reporting requirements to be used to track APS program results and compare them with other programs throughout the nation. Currently, APS programs have wide ranging definitions of elder abuse, neglect, and exploitation that make the combination of output data unreliable and comparative evaluations impossible to conduct.

Additionally, in FY 2014 AoA will provide $1 million to support research and demonstration programs to test approaches to addressing the unique challenge of preventing, identifying, and responding to elder abuse, neglect, and exploitation within Tribal nations. At listening sessions with Tribal grantees, elder abuse has been repeatedly raised as an issue of concern in these communities. In an effort to respond to these concerns, funds will provide competitive grants to eligible Tribal organizations, public agencies, and nonprofit organizations to support Tribes in the development of informational, legal, and supportive services to assist in the prevention, detection, and resolution of elder abuse, neglect, and exploitation. Funding will support coalition-building, training, and technical assistance; the development of statutes and codes;

elder rights program development; and research for effectively preventing and addressing elder abuse within Tribal nations.

Most of the balance of $1.1 million will fund contracts to evaluate these activities and support the continued development of data collection and reporting requirements associated with the state-level demonstration grants. These funds will also be used for the funding of an APS resource center, in keeping with a March 2011 GAO report on Elder Justice at the Federal level which indicated the need for additional resources that could provide more easily accessible and centrally available information on APS best practices. Lastly, a portion of the budget allocated for the evaluation and administration of APS State Demonstrations will be used to provide staff resources to support the grants management, technical assistance, coordination, and the development and dissemination of best practices that are essential to the success of the these demonstration projects.

Output Table:

Adult Protective Services Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output AP.1: Design Adult Protective Service evaluation to develop and test appropriate methods of addressing elder abuse, neglect and exploitation.	N/A	Contract Awarded	Ongoing	N/A

Resource and Program Data:

Adult Protective Service
(Dollars in thousands)

Mechanism	FY 2012 Enacted #	FY 2012 Enacted $	FY 2013 Annual CR #	FY 2013 Annual CR $	FY 2014 President's Budget #	FY 2014 President's Budget $
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	5,672	--	--	9	6,900
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	1	300
Interagency Agreements	1	288	--	--	1	700
Program Support 1/		40		--		100
Total Resources		6,000		N/A		8,000

1/ Program Support -- Includes funds for salaries and overhead and grant systems and review costs.

2/ Funding for this activity was provided from the Prevention and Public Health Fund in FY 2012. The FY

Long-Term Care Ombudsman Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Long-Term Care Ombudsman Program……………………	$16,761,000	$16,864,000	$16,761,000	--

Authorizing Legislation: Section 712 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization .... Expired

Allocation Method .... Formula Grants

Program Description and Accomplishments:

The Long-Term Care Ombudsman program is a consumer advocacy program that improves the quality of care for the estimated 2.9 million individuals who reside in 69,508 long-term care facilities.[68] Formula grants to States and Territories based on the number of individuals age 60 and older provide funding for the training, travel, and other operating costs of nearly 10,000 ombudsmen (both staff and certified volunteers) who resolve complaints on behalf of these residents and routinely monitor the condition of long-term care facilities.

A primary Ombudsman duty is to identify, investigate and resolve complaints that are made by, or on behalf of residents. These complaints relate to action, inaction, or decisions of providers, public agencies, and others that may adversely affect residents' health, safety, welfare or rights. Ombudsmen advocate on behalf of residents by representing their interests before government and administrative entities, providing information to residents and families about the long-term care system, and educating the general public about issues related to long-term care policies and regulations.

Much of the efficiency of the Ombudsman Program is due to the strong reliance on volunteers who make up the bulk of those who resolve resident issues.[69] All but four States have volunteer ombudsman programs. These certified volunteer ombudsmen donated over 735,411 hours in FY 2011, a six percent increase over FY 2009. FY 2011 output data for the Long-Term Care Ombudsman Program highlights the accomplishments achieved by this program and the

[68] National Ombudsman Reporting System (NORS) – Federal Fiscal 2011.

[69] Shaughnessy, Carol V. *The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet*. National Health Policy Forum. December 9, 2009.

important role that ombudsmen play in ensuring that the rights of long-term care facility residents are respected:

- 1,185 paid and 9,065 certified volunteer ombudsmen regularly visited residents in 28,982 facilities, more than 70 percent of all nursing home facilities and nearly 33 percent of all licensed board and care facilities (Output S). At least another 3320 volunteers support these paid staff and certified volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 204,044 complaints (Output Q).

- Ombudsmen provided over 405,466 consultations to individuals and facility managers and staff on such topics as residents' rights, staffing levels, malnutrition, dementia care, depression, discharge procedures, financial exploitation and strategies to reduce the use of restraints and prevent the abuse and neglect of residents (Output R).

Funding History:

Funding for the Long-term Care Ombudsman Program during the past five years is as follows:

FY 2009 ....$16,328,000
FY 2010 ....$16,825,000
FY 2011 ....$16,793,000
FY 2012 ....$16,761,000
FY 2013 CR. $16,864,000

Budget Request:

The FY 2014 request for the Long-Term Care Ombudsman program is $16,761,000, the same as the FY 2012 enacted level.

The number of older Americans is increasing rapidly. This is particularly true among the population age 85 and older. As a percentage of the population, the number of older Americans age 85 and older is growing faster than any other age cohort and is projected to reach nearly 20 million by the year 2030. As this population grows, the need for safe, high-quality long-term care services (including non-nursing home alternatives) will increase, even as we seek to help more people remain in the community for longer periods.

Outcome data (displayed in the summary tables at the end of this section) demonstrate the success of this program in protecting older Americans in an efficient and effective manner. The percentage of the complaints processed by ombudsmen that were fully or partially resolved to the

satisfaction of the resident has consistently remained near 73 percent,[70] demonstrating both the efficiency of the program and its ability to produce positive outcomes for residents. The average number of complaints per facility, at 2.93, is on track to meet the projected 2012 target. A new outcome measure was added to further evaluate the level of success in resolving resident problems. Outcome 2.14 will target a decrease in complaints that are not resolved to the satisfaction of the resident.

The FY 2014 request represents an important element of AoA's focus on elder rights, which expands and improves upon AoA's successful elder rights programs to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation. This request also supports Federal policy for quality alternatives to nursing home care. LTC Ombudsmen advocate for quality care and individual rights and well-being in other congregate long-term care settings, such as board and care and assisted living. In addition, LTC Ombudsmen serve individuals in these settings regardless of the individuals' eligibility for Medicaid or other public benefits. Ombudsmen are the only Federally-funded entity providing services to all of these residents. Outreach, access, complaint investigation and advocacy in board and care require Ombudsmen to employ new strategies compared to the work done in nursing home settings. Supporting volunteers to work in these often more intimate environments also requires additional support and training.

[70] NORS 2011 – Complaint resolution: 10% needing no further action; 4% withdrawn; 5% not resolved to the satisfaction of the resident; 6% referred to other agency for resolution.

Outcomes and Outputs Table:

Long-Term Care Ombudsman Program Outcomes and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
Outcome 2.12: Decrease the average number of complaints per LTC facility *(Outcome)*	FY 2011: 2.93 Target: 3.9 (Target Exceeded)	3.0	3.0	--
Outcome 2.14 : Decrease the number of complaints not resolved to the satisfaction of the resident *(Outcome)*	FY 2011: 10,642 Target: N/A	11,300	10,700	-600
Indicator	**Most Recent Result**	**FY 2012 Projection**	**FY 2014 Projection**	**FY 2014 +/- FY 2012**
Output Q: Decrease the Number of Complaints *(Output)*	FY 2011: 204,044	204,000	200,000	-4,000*
Output R: Number of Ombudsman Consultations *(Output)*	FY 2011: 405,466	400,000	425,000	+25,000
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2011: 28,982	35,000	29,000	-6,000

* Measure seeks a decrease in complaints. A negative change is the desired output.

Grant Awards Table:

Long-Term Care Ombudsman Program Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$298,628	$298,131	$296,311
Range of Awards	$10,452 - $1,703,874	$10,435 - $1,710,478	$10,371 - $1,700,035

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Long-Term Care Ombudsman Program (CFDA 93.042)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	261,779	259,733	258,147	-3,632
Alaska	83,616	83,477	82,967	-649
Arizona	347,967	351,176	349,032	1,065
Arkansas	164,541	163,105	162,109	-2,432
California	1,703,874	1,710,478	1,700,035	-3,839
Colorado	229,541	233,560	232,133	2,592
Connecticut	198,974	196,382	195,182	-3,792
Delaware	83,616	83,477	82,967	-649
District of Columbia	83,616	83,477	82,967	-649
Florida	1,231,886	1,228,935	1,221,429	-10,457
Georgia	428,313	432,319	429,678	1,365
Hawaii	83,616	83,477	82,967	-649
Idaho	83,616	83,477	82,967	-649
Illinois	637,587	633,601	629,731	-7,856
Indiana	334,046	332,057	330,029	-4,017
Iowa	174,136	172,056	171,005	-3,131
Kansas	147,117	146,161	145,268	-1,849
Kentucky	232,425	231,315	229,902	-2,523
Louisiana	224,480	224,309	222,939	-1,541
Maine	84,298	84,054	83,541	-757
Maryland	287,428	287,775	286,017	-1,411
Massachusetts	356,900	354,680	352,514	-4,386
Michigan	541,079	538,212	534,925	-6,154
Minnesota	269,902	270,500	268,848	-1,054
Mississippi	151,689	150,496	149,576	-2,113
Missouri	328,398	325,846	323,856	-4,542
Montana	83,616	83,477	82,967	-649
Nebraska	95,910	95,262	94,680	-1,230
Nevada	133,223	134,253	133,433	210
New Hampshire	83,616	83,477	82,967	-649

PROGRAM/CFDA NUMBER: Long-Term Care Ombudsman Program (CFDA 93.042)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	467,133	461,828	459,007	-8,126
New Mexico	107,975	108,413	107,751	-224
New York	1,032,690	1,021,552	1,015,312	-17,378
North Carolina	496,728	498,273	495,229	-1,499
North Dakota	83,616	83,477	82,967	-649
Ohio	641,170	636,187	632,301	-8,869
Oklahoma	199,358	197,692	196,484	-2,874
Oregon	215,742	217,328	216,000	258
Pennsylvania	757,545	748,082	743,513	-14,032
Rhode Island	83,616	83,477	82,967	-649
South Carolina	255,756	257,650	256,077	321
South Dakota	83,616	83,477	82,967	-649
Tennessee	343,142	342,867	340,773	-2,369
Texas	1,058,604	1,068,079	1,061,556	2,952
Utah	99,550	100,692	100,077	527
Vermont	83,616	83,477	82,967	-649
Virginia	397,834	398,776	396,340	-1,494
Washington	339,099	343,243	341,147	2,048
West Virginia	118,529	117,003	116,289	-2,240
Wisconsin	305,849	304,559	302,699	-3,150
Wyoming	83,616	83,477	82,967	-649
Subtotal, States	16,405,589	16,380,213	16,280,168	-125,421
American Samoa	10,452	10,435	10,371	-81
Guam	41,808	41,738	41,483	-325
Northern Mariana Islands	10,452	10,435	10,371	-81
Puerto Rico	213,051	210,801	209,514	-3,537
Virgin Islands	41,808	41,738	41,483	-325
Subtotal, States and Territories	16,723,160	16,695,360	16,593,390	-129,770
Undistributed 71/	37,840	168,640	167,610	129,770
TOTAL	**16,761,000**	**16,864,000**	**16,761,000**	--

71/ The undistributed line reflects the amount reserved from the Long-Term Care Ombudsman appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States..

Prevention of Elder Abuse and Neglect

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Prevention of Elder Abuse & Neglect………………………	$5,036,000	$5,067,000	$5,036,000	--

Authorizing Legislation: Section 721 of the Older Americans Act of 1965, as amended

FY 2014 Authorization .... Expired

Allocation Method .... Formula Grant

Program Description and Accomplishments:

The Prevention of Elder Abuse and Neglect program provides formula grants to States and Territories based on their share of the population 60 and over for training, education, and promoting public awareness of elder abuse. The program also supports State and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's focus on elder rights and elder justice. The program coordinates activities with State and local Adult Protective Services programs (over half of which are directly administered by State Units on Aging) and other professionals who work to address issues of elder abuse and elder justice. The importance of these services at the State and local level is demonstrated by the fact that States significantly leverage Older Americans Act (OAA) funds to obtain other funding for these activities. In FY 2009 over $35 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of approximately $7 of non-OAA funds for every $1 investment of AoA funds.

Examples of State elder abuse prevention activities include:

- In Kentucky, the local area agencies on aging participate in the Local Coordinating Councils on Elder Abuse, which have developed emergency elder shelters, developed informational cards for law enforcement officers to have in the patrol cars which contain crucial resource information for victims of elder abuse, provided training on a regular basis to first responders, provided a friendly visitor program for home-based seniors, and produced a prevention tool called the Kentucky Fraud Fighter Form.

- In Illinois, the Illinois Department on Aging utilizes its elder abuse funds to support volunteer community based multi-disciplinary teams (M-Teams) that serve in a technical

advisory role to more than 40 elder abuse provider agencies throughout the state. The objectives of the M-Team are to provide case consultation and assistance to caseworkers and to encourage cooperation among various service agencies. Each M-Team is composed of the M-Team Coordinator and representatives of the mental health, medical, legal, law enforcement, faith community, and financial professions.

The Prevention of Elder Abuse and Neglect program demonstrates AoA's ongoing commitment to protecting the rights of vulnerable seniors and promoting their dignity and autonomy. Through education efforts, exposing problems that would otherwise be hidden from view, and providing a voice for those who cannot act for themselves, the program helps ensure that all older Americans are able to age with dignity in a safe environment.

Funding History:

Funding for Prevention of Elder Abuse and Neglect during the past five years is as follows:

FY 2009 ....$5,056,000
FY 2010 ....$5,055,000
FY 2011 ....$5,046,000
FY 2012 ....$5,036,000
FY 2013 CR. $5,067,000

Budget Request and Anticipated Accomplishments:

The FY 2014 request for the Prevention of Elder Abuse and Neglect program is $5,036,000, the same as the FY 2012 enacted level. The FY 2014 request will maintain the ability of States and Territories to train law enforcement officials, develop and distribute educational materials, conduct public awareness campaigns, and create community coalitions and multidisciplinary teams to investigate and respond to elder abuse and neglect. States and AAAs also use this funding to coordinate their activities with fraud and crime prevention partnerships organized by sheriffs, police chiefs, and community organizations.

These activities are important elements of AoA's continued focus in FY 2014 on elder rights and elder justice, which seeks to improve upon AoA's successful elder rights programs, including the Prevention of Elder Abuse and Neglect program. This enhanced focus will allow the creation of a full array of services to protect elder rights and prevent, detect, and resolve elder abuse, neglect, and exploitation. Prevention of Elder Abuse and Neglect programs complement Adult Protective Services by funding the infrastructure on which best practices may be developed and evaluated.

Output Table:

Prevention of Elder Abuse and Neglect Output

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, results in thousands)*	FY 2011: $27,500	$27,000	$26,000	-$1,000

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$89,732	$89,577	$89,029
Range of Awards	$3,141 - $503,913	$3,135 - $502,632	$3,116 - $496,869

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Prevention of Elder Abuse & Neglect (CFDA 93.041)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	77,420	76,324	76,215	-1,205
Alaska	25,125	25,082	24,928	-197
Arizona	102,909	103,195	102,011	-898
Arkansas	48,662	48,157	48,157	-505
California	503,913	502,632	496,869	-7,044
Colorado	67,886	68,633	67,846	-40
Connecticut	59,907	59,907	59,907	--
Delaware	25,125	25,082	24,928	-197
District of Columbia	25,125	25,082	24,928	-197
Florida	364,324	361,129	356,989	-7,335
Georgia	126,671	127,039	125,583	-1,088
Hawaii	25,125	25,082	24,928	-197
Idaho	25,125	25,082	24,928	-197
Illinois	197,384	197,384	197,384	--
Indiana	98,793	98,224	98,224	-569
Iowa	55,927	55,927	55,927	--
Kansas	45,843	45,843	45,843	--
Kentucky	68,738	67,973	67,194	-1,544
Louisiana	68,518	68,518	68,518	--
Maine	25,125	25,082	24,928	-197
Maryland	85,005	84,564	83,595	-1,410
Massachusetts	109,606	109,606	109,606	--
Michigan	160,862	160,862	160,862	--
Minnesota	79,822	79,488	78,577	-1,245
Mississippi	45,198	45,198	45,198	--
Missouri	97,643	97,643	97,643	--
Montana	25,125	25,082	24,928	-197
Nebraska	29,770	29,770	29,770	--
Nevada	39,400	39,451	38,999	-401
New Hampshire	25,125	25,082	24,928	-197

PROTECTION OF VULNERABLE ADULTS

PROGRAM/CFDA NUMBER: Prevention of Elder Abuse & Neglect (CFDA 93.041)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	143,950	143,950	143,950	--
New Mexico	31,933	31,858	31,493	-440
New York	318,066	318,066	318,066	--
North Carolina	146,905	146,420	144,741	-2,164
North Dakota	25,125	25,082	24,928	-197
Ohio	197,185	197,185	197,185	--
Oklahoma	60,208	60,208	60,208	--
Oregon	63,805	63,863	63,131	-674
Pennsylvania	242,944	242,944	242,944	--
Rhode Island	25,125	25,082	24,928	-197
South Carolina	75,639	75,712	74,844	-795
South Dakota	25,125	25,082	24,928	-197
Tennessee	101,483	100,753	99,598	-1,885
Texas	313,077	313,861	310,262	-2,815
Utah	29,442	29,589	29,250	-192
Vermont	25,125	25,082	24,928	-197
Virginia	117,658	117,182	115,839	-1,819
Washington	100,287	100,864	99,708	-579
West Virginia	36,736	36,736	36,736	--
Wisconsin	90,453	90,309	90,309	-144
Wyoming	25,125	25,082	24,928	-197
Subtotal, States	4,930,597	4,923,033	4,893,245	-37,352
American Samoa	3,141	3,135	3,116	-25
Guam	12,563	12,541	12,464	-99
Northern Mariana Islands	3,141	3,135	3,116	-25
Puerto Rico	63,009	61,945	61,235	-1,774
Virgin Islands	12,563	12,541	12,464	-99
Subtotal, States and Territories	5,025,014	5,016,330	4,985,640	-39,374
Undistributed 72/	10,986	50,670	50,360	39,374
TOTAL	**5,036,000**	**5,067,000**	**5,036,000**	--

72/ The undistributed line reflects the amount reserved from the Prevention of Elder Abuse & Neglect appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

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Senior Medicare Patrol Program

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Senior Medicare Patrol Program………………	$9,402,000	$9,460,000	$9,402,000	--

Authorizing Legislation: Sections 201, 202, and 491 of the Older Americans Act of 1965, as amended

FY 2014 Authorization ....Expired

Allocation Method ....Competitive Grant

Program Description and Accomplishments:

The Senior Medicare Patrol (SMP) program provides competitive grants to 54 States and Territories to support a national volunteer-based network of retired seniors whose purpose is to educate older adults on preventing and identifying healthcare fraud and abuse. Projects use the skills of retired professionals as volunteers to conduct community outreach and education and provide information that empowers beneficiaries of Medicare and Medicaid and their families to prevent, identify and report fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

Data obtained from the SMARTFACTS Data Tracking System for calendar year 2011 shows that, compared to Calendar Year 2010, SMP projects:

- Maintained 5,896 active volunteers who worked over 97,156 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;
- Educated 436,775 beneficiaries in 11,256 group education sessions and held 71,880 one-on-one counseling sessions with or on behalf of beneficiaries;
- Conducted 8,856 community outreach education events (42% increase); and
- Resolved 81,390 inquiries for information or assistance from beneficiaries.

In addition, the SMARTFACTS data show that since the program's inception 15 years ago, SMP projects have:

- Educated over 4.6 million beneficiaries in 96,224 group education sessions and 1,184,767 one-on-one counseling sessions;

- Conducted 83,918 community outreach education events; and

- Documented over $106 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings as *directly* attributable to the project as a result of beneficiary complaints. This does not attempt to quantify the *total* savings that occur as a result of SMP program's sentinel effect, impact on fraud deterrence, or calls to fraud hotlines or other non-SMP contacts.

The SMP program historically has been supported by approximately $3.4 million in Health Care Fraud and Abuse Control (HCFAC) funding authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for infrastructure, technical assistance, and other SMP program support and capacity-building activities designed to enhance program effectiveness. Activities funded by HCFAC resources include support for project training and technical assistance provided by AoA's National Consumer Technical Resource Center (Center).

In the past three years, the critically important role of the SMP program continued to be recognized by partners in Medicare fraud prevention in the private and public sectors. In 2010, the Centers for Medicare & Medicaid Services (CMS) provided funding for the award of an additional $9 million in grants from its Program Integrity funding, administered by AoA, targeted to help more than 50 Senior Medicare Patrol (SMP) programs fight Medicare fraud in high fraud areas and expand the capacity of the program to reach more beneficiaries. In FY 2012 and FY 2013, SMP will receive an additional $7.3 million from HCFAC funds to again fight Medicare fraud in high-fraud areas.

In November 2010, the Administration on Aging received a national level commendation for the SMP program from the National Health Care Anti-Fraud Association (NHCAA), considered the leading national organization focused exclusively on the fight against health care fraud. The NHCAA's members comprise more than 100 private health insurers and those public sector law enforcement and regulatory agencies having jurisdiction over health care fraud committed against both private payers and public programs. The award, given annually by the NHCAA, recognizes an organization or individuals "who have done the most in the past year to raise public awareness about the problem of health care fraud in our nation's health care system." This organization's decision to award the Senior Medicare Patrol program the NHCAA 2010

Excellence in Public Awareness Award is a major achievement, and a notable acknowledgement of the value of the SMP program.

Funding History:

Funding for the SMP discretionary appropriations is as follows:

FY 2009 ....$9,439,000
FY 2010 ....$9,438,000
FY 2011 ....$9,420,000
FY 2012 ....$9,402,000
FY 2013 CR $9,460,000

Budget Request:

The FY 2014 request for the Senior Medicare Patrol (SMP) program is $9,402,000; the same as the FY 2012 enacted level. This amount will enable AoA to continue the proven fraud prevention activities of the SMP program.

Since the program's inception, SMP projects have educated over 4.6 million beneficiaries and received over 172,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. This has resulted in nearly $106 million in savings to Medicare, Medicaid, program beneficiaries, and others since 1997. While SMPs make numerous referrals of potential fraud to CMS program integrity contractors, there is no mechanism for tracking the actions (investigation, prosecution, collection) required to realize actual savings to the government as a result of these referrals. ACL is working to overcome this evaluation limitation by undertaking a variety of steps, including:

- A program evaluation contract to examine the program's performance metrics;
- An ongoing pilot program in cooperation with OIG to track fraud referrals and their outcomes; and
- Working with OIG to better align the criteria for calculating the program's savings with those used by both CMS and OIG for their respective performance reports.

Outcomes and Outputs Table:

Senior Medicare Patrol Program Outcomes and Outputs

Indicator	Most Recent Result	FY 2012 Projection	FY 2014 Projection	FY 2014 +/- FY 2012
Output W: Beneficiaries Educated and Served *(Output)*	FY 2011: 536,489	550,000	600,000	+50,000

Grant Awards Table:

Senior Medicare Patrol Grant Awards

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	54	54	54
Average Award	$174,114	$174,114	$174,114
Range of Awards	$75,000-$177,927	$75,000-$177,927	$75,000-$177,927

Resource and Program Data:

Senior Medicare Patrols
(Dollars in thousands)

	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
Mechanism	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	28	4,776	--	--	--	--
Continuations	26	4,626	54	9,460	54	9,402
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		--
Total Resources		9,402		9,460		9,402

Elder Rights Support Activities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Elder Rights Support Activities……………	$4,088,000	$4,113,000	$4,088,000	--

Authorizing Legislation: Sections 201, 202, and 411 of the Older Americans Act of 1965, as amended

FY 2014 Older Americans Act Authorization ....Expired

Allocation Method ....Competitive Grants/Cooperative Agreements and Contracts

Program Description and Accomplishments:

Elder Rights Support Activities consists of four activities and resource centers that provide information, training, and technical assistance to assist States and communities to prevent, detect, and respond to elder abuse, neglect, and exploitation. The combination of legal systems development and assistance programs, the National Center on Elder Abuse, and the National Long-Term Care Ombudsman Resource Center create a supportive framework for AoA's Protection of Vulnerable Adults programs. The Elder Rights Support Activities described below are essential components of AoA's ongoing elder rights programs:

Model Approaches to Statewide Legal Assistance Systems

Model Approaches to Statewide Legal Assistance Systems helps States develop and implement cost-effective, replicable approaches for integrating senior legal helplines into the broader tapestry of State legal service delivery networks. The cornerstone of these projects is legal helplines, which assist seniors in accessing quality legal services. By ensuring strong leadership at the State level, Model Approaches projects create linkages between the existing legal assistance community and service providers, and professionals in the broader community-based aging and elder rights networks, including Areas Agencies on Aging, Aging and Disability Resource Centers, State Long-Term Care Ombudsmen, and Adult Protective Services. These linkages leverage the strengths of both elder rights and aging service networks for the provision of quality service to seniors most in need.

National Legal Assistance and Support Projects

National Legal Assistance and Support grants fund a comprehensive national legal assistance support system serving professionals and advocates working in legal and aging services networks. These grants provide funding for the National Legal Resource Centers, which support the leadership, knowledge, and systems capacity of legal and aging provider organizations. These centers work to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. AoA is funding four projects which provide core support functions for aging and legal networks including case consultation, training, technical assistance on legal and aging systems development, and information development and dissemination.

National Center on Elder Abuse

To support and enhance the activities of State and local programs to prevent Elder Abuse, Neglect, and Exploitation, AoA funds the National Center on Elder Abuse (NCEA). NCEA disseminates information to professionals and the public; collaborates on research; provides consultation; identifies and provides information about promising practices and interventions; answers inquiries and requests for information; operates a listserv forum for professionals; and advises on program and policy development. NCEA also facilitates the exchange of strategies for uncovering and prosecuting fraud in areas such as telemarketing and sweepstakes scams. In 2012, the NCEA:

- Continued its outreach by serving 3,459 subscribers to its newsletter, 1,833 members to the Elder Abuse Listserv, and created and managed a new social media platform for the NCEA Clearinghouse and NCEA National Indigenous Elder Justice Initiative, with over 1,000 friends on Facebook.

- Responded to over 450 individual public inquiries and requests for information regarding elder abuse and elder abuse in Indian Country.

- Provided cost-effective trainings to over 600 professionals though live Webcast forums on issues relevant to elder justice, trained over 1,000 professionals through presentations at national conferences, and created and disseminated three research-themed training podcasts to promote continual learning.

- Continued to support systems change by:

    - Identifying 342 local elder justice community coalitions and beginning to reach out to those communities to learn how they leverage local resources and expertise to

prevent and combat elder abuse, neglect, and exploitation, as well as to offer technical assistance on operating, invigorating, and sustaining coalitions; and

- Compiling the first comprehensive inventory of tribal elder abuse codes, currently consisting of 48 codes from 17 states, the purpose of which is to provide best practice examples to other tribes in developing new codes to address elder abuse, neglect, and exploitation.

National Long-Term Care Ombudsman Resource Center

The National Long-Term Care Ombudsman Resource Center (NORC) provides training and technical assistance to support the activities of State and local long-term care ombudsmen. The Center works to enhance the skills, knowledge and management capacity of the statewide ombudsman programs to enable them to handle resident complaints and represent resident interests. The Center also provides information to consumers and links them to ombudsmen, who can help consumers navigate the long-term care system and resolve problems in nursing, board and care, and assisted living homes.

The NORC engages in numerous projects and activities in support of long-term care ombudsman programs. Highlights include supporting the success of CMS's Money Follows the Person (MFP) demonstration project by working with CMS, AoA, and National Association of State Long-Term Care Ombudsman Programs (NASOP) to promote ombudsman coordination with MFP grantees, Aging and Disability Resource Centers (ADRCs), Centers for Independent Living, and other single points of entry programs; and furthering Federal efforts to support consumer choice and access to alternatives to nursing home care. NORC also provides ombudsmen with training from national experts on such issues as: The Changing Long-Term Care System; Managing Program Goals and Priorities During Fiscal Crises; Minimum Data Set (MDS) 3.0 Section Q, Money Follows the Person, and Nursing Home Transition; Advocacy in Assisted Living. The Center's website continues high utilization *(over 40,000 monthly visits)* by ombudsmen, consumers, and agencies.

Funding History:

Comparable funding for Elder Rights Support Activities is as follows:

FY 2009 ....$4,104,000
FY 2010 ....$4,103,000
FY 2011 ....$4,096,000
FY 2012 ....$4,088,000
FY 2013 CR $4,113,000

Budget Request:

The FY 2014 request for Elder Rights Support Activities is $4,088,000, the same as the FY 2012 enacted level. This request reflects continuation of the current level of support services for elder rights and elder justice. These activities are a critical component of AoA's successful elder rights programs and help to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation.

The National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, and the Statewide Model Approaches and Legal Assistance programs provide the technical assistance, information, resources, referrals, and legal systems development and assistance activities that support the efforts of the entire spectrum of Protection of Vulnerable Adults programs. Continued support for these programs and resource centers will provide the best and most efficient services and supports possible to support AoA's efforts to promote elder rights and elder justice.

Elder Rights Support Activities includes funding for the following projects (dollars in thousands):

Activity	FY 2012 Enacted	FY 2013 President's Budget	FY 2014 Planning Level
Elder Rights Support Activities:			
Model Approaches to Statewide Legal Assistance	$ 1,992	$ 2,004	$ 1,992
National Legal Assistance and Support Projects	744	748	744
National Center on Elder Abuse	807	812	807
National Long-Term Care Ombudsman Resource Center	545	548	545
Total, Elder Rights Support Activities	**$ 4,088**	**$ 4,113**	**$ 4,088**

Grant Awards Table:

Elder Rights Support Activities Grant Awards

	FY 2012 Estimated	FY 2013 President's Budget	FY 2014 Planning Level
Number of Awards	27	27	27
Average Award	$147,261	$147,261	$147,261
Range of Awards	$50,000 - $561,000	$50,000 - $561,000	$50,000 - $561,000

Resource and Program Data:

Elder Rights Support Activities
(Dollars in thousands)

Mechanism	FY 2012 Enacted #	FY 2012 Enacted $	FY 2013 Annual CR #	FY 2013 Annual CR $	FY 2014 President's Budget #	FY 2014 President's Budget $
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	14	1,798	9	2,220
Continuations	28	4,001	10	2,220	14	1,773
Contracts	1	10	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		77		95		95
Total Resources		4,088		4,113		4,088

1/ Program Support -- Includes funds for grant systems and review and information technology support costs.

Programs for People with Developmental Disabilities
Summary of Request

Programs for people with developmental disabilities fund capacity-building and systems change efforts to assure that people with intellectual and developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, and integration and inclusion in all facets of community life.

The total FY 2014 request for Programs for People with Developmental Disabilities authorized under the Developmental Disabilities Assistance and Bill of Rights Act is $162,748,000, the same as the FY 2012 enacted level for these programs. For FY 2014, specific program requests include:

- $74,774,000 to continue funding for State Councils on Developmental Disabilities (DD Councils) in each State and Territory. DD Councils are charged with engaging in advocacy, capacity building, and systemic change activities that contribute to a coordinated and comprehensive system of community supports and services that promote self-determination, integration and inclusion for people with developmental disabilities.

- $40,865,000 to continue funding for State Protection and Advocacy systems in each State and Territory to protect the legal and human rights of all people with developmental disabilities. The Protection and Advocacy system has the authority to pursue legal, administrative and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect.

- $38,792,000 to continue funding for University Centers for Excellence in Developmental Disabilities (UCEDDs) in each state and territory. UCEDDs provide interdisciplinary pre-service training, community services, research, and information dissemination activities that promote opportunities for people with developmental disabilities to exercise self-determination and to be independent, productive, integrated, and included in the community.

- $8,317,000 for Projects of National Significance, to fund grants, cooperative agreements, and contracts to explore innovative opportunities for individuals with developmental disabilities to directly and fully contribute to, and participate in, all facets of community life. Funds will also be used to support the development of national and State policies,

including Federal interagency initiatives; for demonstration projects addressing innovative and emerging best practices; and for longitudinal data collection projects.

State Councils on Developmental Disabilities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
State Councils on Developmental Disabilities	$74,774,000	$75,232,000	$74,774,000	--

Authorizing Legislation: Section 129(a) of the Developmental Disabilities Assistance and Bill of Rights Act

FY 2014 Developmental Disabilities Assistance and Bill of Rights Act Authorization......Expired

Allocation Method ....Formula Grant

Program Description and Accomplishments:

State Councils on Developmental Disabilities (SCDDs) are in a strategic position in each State and Territory to set priorities and pursue systems change efforts designed to turn fragmented approaches into a comprehensive and effective statewide, person-centered and family-centered system that provides a coordinated array of culturally-competent services and other forms of assistance for people with intellectual and developmental disabilities, including individuals with autism, and their families.

SCDDs do not provide services directly, but rather examine and conduct in-depth analysis of the quantity and quality of services and supports that are provided at the State and local level. These studies help to identify the most pressing needs of people with developmental disabilities and their families and determine priority areas. Each SCDD develops a strategic State plan based on their analysis, with goals and objectives designed to move the State towards an effective, coordinated system of supports and services that advance community living for all people with developmental disabilities. Working in partnership with stakeholders, including people with developmental disabilities, each State Council implements activities based on the strategic state plan to:

- Shift the way an organization or community makes decisions about policies, programs, and the allocation of its resources - and, ultimately, in the way it delivers services and supports its citizens and constituencies;

- Support activities that expand and/or improve the ability of individuals with developmental disabilities, families, supports, services and/or systems to promote, support and enhance self-determination, independence, productivity and inclusion in community life; and

- Actively support policies and practices that promote self-determination and inclusion in the community and workforce for individuals with developmental disabilities and their families.

Councils also have a unique responsibility in supporting the growing self-advocacy movement. Each Council must ensure the State plan has activities aimed at:

- Establishing or strengthening a program for the direct funding of a State self-advocacy organization led by individuals with developmental disabilities;

- Promoting opportunities for individuals with developmental disabilities who are considered leaders to provide leadership training to individuals with developmental disabilities who may become leaders; and

- Supporting and expanding participation of individuals with developmental disabilities in cross-disability and culturally diverse leadership coalitions.

The State Councils have a significant impact upon promoting self sufficiency and community living for persons with developmental disabilities. In FY 2011, 13.66 percent of individuals nationwide with developmental disabilities were independent, self-sufficient, and integrated into the community as a result of SCDD efforts, exceeding the FY 2011 target of 13.45 percent. To receive funds, each State and Territory must have an established SCDD as prescribed under the Developmental Disabilities Assistance and Bill of Rights Act ("DD Act").

Examples of State Council activities include:

- The Pennsylvania Council monitors health services and changes to Medicaid and other health coverage systems and provides effective training to people with developmental disabilities and their families, including those with limited English proficiency and behavioral health issues, so that they can make informed decisions. This Council is promoting system change in mental health services provided to people with intellectual disabilities and addressing the need for accessible dental services.

- In Iowa, thanks in part to the efforts of the State Council, 110 individuals including self-advocates, family members, professionals and other advocates served as members of

workgroups created by the Iowa Legislature to develop recommendations for a complete system redesign to be considered during the 2012 legislative session.

- The Kansas Council provided funds for Project SEARCH, which is a collaborative project between local school districts, Vocational Rehabilitation, adult service providers and business to provide year-long internship opportunities for high school students with developmental disabilities to increase their job skills and build their resumes. The Council also provided start up funds for four individuals with developmental disabilities to start their own businesses. The businesses included lawn care services, original artwork production and sales, land-clearing services and a vending and food delivery business.

DD Council funding is allotted based on a formula that takes into account the population, the extent of need for services for persons with developmental disabilities, and financial need. There are 56 Councils. Council members are appointed by the Governor and serve in a volunteer capacity. Under current law, not less than 60 percent of the Council membership must be composed of persons with developmental disabilities and/or their family members. Councils engage in a range of activities including program and policy analysis, demonstration of new approaches, training, outreach, community support, and public education to effect systems change and build capacity.

Funding History:

Funding for the program during the last five years has been as follows:

FY 2009 ....$74,316,000
FY 2010 ....$75,066,000
FY 2011 ....$74,916,000
FY 2012 ....$74,774,000
FY 2013 CR. $75,232,000

Budget Request:

The FY 2014 budget request for State Councils is $74,744,000, the same as the FY 2012 enacted level. This request will provide continued support for advocacy, systems change and capacity building activities that improve services for people with developmental disabilities and their families. In FY 2014, the program expects to increase the percentage of individuals with developmental disabilities who are independent, self-sufficient and integrated into the community as a result of Council efforts by at least 0.1 percent over the previous year’s result.

Continued funding for State Councils is crucial as they are the entity in the States and Territories able to build and organize efforts aimed at turning fragmented approaches into innovative and cost-effective strategies that create opportunities for people with developmental disabilities and their families to:

- Make informed choices and decisions about their lives;

- Live in homes and communities in which they can exercise their full rights and responsibilities as citizens;

- Pursue meaningful and productive lives;

- Contribute to their families, their communities, their states, and the nation in multiple ways, including through competitive integrated employment;

- Have interdependent friendships and relationships with others;

- Live free of abuse, neglect, financial or sexual exploitation, and violations of their legal and human rights; and

- Achieve full integration and inclusion in society as individuals, consistent with their unique strengths, resources, priorities, concerns, abilities, and capabilities.

Advances in self-advocacy would be greatly impacted if funding were no longer available for State Councils. Councils such as the Indiana State Council would not be available to provide support as they did to Self Advocates of Indiana (SAI) in achieving the following accomplishments:

- Garnering financial support from the state Developmental Disabilities Services agency to support organizational operations;

- An SAI member becoming president of the national association of self-advocates, Self Advocates Becoming Empowered (SABE);

- 175 members participating in training to increase their knowledge of state and federal issues;

- Making nine presentations that facilitated at least 185 people to work with self advocates.

- Members becoming active participants in their communities through presentations, community service and fundraising activities with their groups and other organizations

The Administration on Intellectual and Developmental Disabilities (AIDD) is undertaking a comprehensive review of performance measurement and data reporting activities across all DD Act programs with an increased focus on outcomes. Steps taken to date include:

- Convening a performance measurement workgroup to devise a set of integrated performance measures that will provide measurable outcomes in the areas of health and wellness, community living, education, employment, and reduction of fraud and abuse for all parts of the Network.

- Utilizing the results of an independent study that provided information on potential performance criteria for specific programs, establishment of performance measurement workgroups and engagement with evaluation experts to recommend improvements.

- Convening a workgroup of Council representatives and an expert in performance evaluation to review and evaluate the current measurement system used by Councils to report progress on an annual basis.

When implemented in FY 2015, the new performance measures will provide measurable outcomes in the areas of health and wellness, community living, education, employment, and fraud and abuse reduction for all parts of the Network.

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8.1LT and 8A: Increase the percentage of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. (Outcome)	FY 2011: 13.66% Target: 13.45% (Target Exceeded)	Prior Result +0.1%	Prior Result +0.1%	N/A
8E: Increase the number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community per $1,000 of federal funding to the Councils. (Efficiency)	FY 2011: 9.08 Target: 8.59 (Target Exceeded)	Prior Result +1%	Prior Result +1%	N/A
8i: Number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. (Output)	FY 2011: 680,127 (Actual)	N/A	N/A	N/A
8ii: Number of all individuals trained by the Councils. (Output)	FY 2011: 84,697 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

State Councils on Developmental Disabilities Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$1,335,257	$1,343,429	$1,335,250
Range of Awards	$248,766 - $6,888,078	$249,344 - $6,888,429	$249,218 - $6,884,622

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: State Councils on Developmental Disabilities (CFDA 93.630)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	1,358,035	1,358,035	1,357,353	-682
Alaska	477,688	478,797	478,556	868
Arizona	1,476,807	1,476,807	1,476,066	-741
Arkansas	797,737	797,737	797,336	-401
California	6,888,078	6,888,429	6,884,622	-3,456
Colorado	911,313	928,928	910,855	-458
Connecticut	722,584	732,957	722,221	-363
Delaware	477,688	478,797	478,556	868
District of Columbia	477,688	478,797	478,556	868
Florida	3,710,543	3,789,410	3,708,681	-1,862
Georgia	2,164,614	2,187,580	2,163,528	-1,086
Hawaii	477,688	478,797	478,556	868
Idaho	477,688	478,797	478,556	868
Illinois	2,626,795	2,626,795	2,625,477	-1,318
Indiana	1,494,093	1,494,093	1,493,343	-750
Iowa	772,384	774,177	773,788	1,404
Kansas	613,166	614,589	614,280	1,114
Kentucky	1,267,881	1,267,881	1,267,244	-637
Louisiana	1,408,289	1,408,289	1,407,582	-707
Maine	477,688	478,797	478,556	868
Maryland	1,005,825	1,008,160	1,007,654	1,829
Massachusetts	1,400,096	1,421,535	1,399,393	-703
Michigan	2,586,883	2,634,817	2,585,619	-1,264
Minnesota	1,022,921	1,025,295	1,024,780	1,859
Mississippi	960,915	960,915	960,432	-483
Missouri	1,372,331	1,387,768	1,371,642	-689
Montana	477,688	478,797	478,556	868
Nebraska	477,688	478,797	478,556	868
Nevada	497,304	541,611	497,054	-250
New Hampshire	477,688	478,797	478,556	868

PROGRAM/CFDA NUMBER: State Councils on Developmental Disabilities (CFDA 93.630)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	1,582,970	1,588,525	1,582,175	-795
New Mexico	508,321	508,321	508,065	-256
New York	4,355,559	4,371,343	4,353,373	-2,186
North Carolina	2,118,636	2,142,778	2,117,573	-1,063
North Dakota	477,688	478,797	478,556	868
Ohio	2,858,499	2,858,499	2,857,064	-1,435
Oklahoma	895,172	897,250	896,799	1,627
Oregon	828,909	830,874	828,493	-416
Pennsylvania	3,137,182	3,137,182	3,135,608	-1,574
Rhode Island	477,688	478,797	478,556	868
South Carolina	1,137,865	1,137,865	1,137,294	-571
South Dakota	477,688	478,797	478,556	868
Tennessee	1,512,170	1,512,170	1,511,411	-759
Texas	5,084,018	5,172,582	5,081,467	-2,551
Utah	676,092	677,632	675,752	-340
Vermont	477,688	478,797	478,556	868
Virginia	1,498,451	1,501,929	1,501,175	2,724
Washington	1,254,427	1,254,427	1,253,797	-630
West Virginia	785,041	785,041	784,647	-394
Wisconsin	1,298,680	1,322,309	1,298,028	-652
Wyoming	477,688	478,797	478,556	868
Subtotal, States	71,278,218	71,727,693	71,271,455	-6,763
American Samoa	248,766	249,344	249,218	452
Guam	248,766	249,344	249,218	452
Northern Mariana Islands	248,766	249,344	249,218	452
Puerto Rico	2,501,126	2,506,931	2,505,673	4,547
Virgin Islands	248,766	249,344	249,218	452
Subtotal, States and Territories	**74,774,408**	**75,232,000**	**74,774,000**	-408
TOTAL	**$74,774,000**	**$75,232,000**	**$74,774,000**	**--**

Developmental Disabilities – Protection and Advocacy

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Developmental Disabilities – Protection and Advocacy	$40,865,000	$41,115,000	$40,865,000	--

Authorizing Legislation: Section 145 of the Developmental Disabilities Assistance and Bill of Rights Act

FY 2014 Developmental Disabilities Assistance and Bill of Rights Act Authorization ......Expired

Allocation Method ....Formula Grant

Program Description and Accomplishments:

The Developmental Disabilities Protection and Advocacy program (PADD) provides formula grants to establish and maintain a Protection and Advocacy (P&A) system in each State, the Territories, and the District of Columbia, as well as a Native American Consortium to protect the legal and human rights of all persons with developmental disabilities. P&A systems have the authority to pursue legal, administrative, and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect.

P&As provide legal support to traditionally unserved or underserved populations to help them navigate the legal system to achieve resolution and encourage systems change. P&As ensure that individuals with disabilities are able to exercise their rights to make choices, contribute to society and live independently.

While their focus is most often legal, P&As also engage in a full range of other efforts to promote the rights of individuals with developmental disabilities. P&As often provide information and referrals, as well as training and technical assistance to service providers, state legislators and other policymakers. They also conduct self-advocacy trainings and raise public awareness of legal and social issues affecting individuals with developmental disabilities and their families.

In addition, P&As provide substantial advocacy and legal services on educational issues, and work to ensure that students receive an appropriate education in an inclusive setting. P&As have

also made great strides in increasing the opportunities for individuals with developmental disabilities to make decisions for themselves about where and with whom they live.

P&As have been involved in a significant number of landmark cases and work closely with other entities, especially State Councils on Developmental Disabilities and University Centers for Excellence in Developmental Disabilities. P&As also work to implement the U.S. Supreme Court's 1999 decision in *Olmstead* v. *L.C.*, which requires states to eliminate unnecessary segregation of people with disabilities, and to ensure that they receive services in the most integrated setting possible.

There are 57 Protection and Advocacy systems. Funding for the program is allotted to States and Territories based on population and the extent of need for persons with developmental disabilities, weighted by the per capita income for each State and Territory.

Funding History:

Funding for the program during the last five years has been as follows:

FY 2009 ....$40,024,000
FY 2010 ....$41,024,000
FY 2011 ....$40,942,000
FY 2012 ....$40,865,000
FY 2013 CR. $41,115,000

Budget Request:

The FY 2014 budget request for PADD is $40,865,000, the same as the FY 2012 enacted level. This request will allow the P&A system to provide training, legal and advocacy services both to groups and to individuals with developmental disabilities, as well as information and referral services. Additionally, this request will support training and technical assistance to leadership and staff of the P&A system to improve their performance.

The P&As form a national system that serve a critical role of ensuring people with developmental disabilities are free of abuse and neglect. People with developmental disabilities are at an increased risk to experience abuse and neglect, including children.[73] A 2009 report from the U.S. General Accountability Office found hundreds of allegations of abuse and neglect at public and private schools across the nation between the years 1990 and 2009, almost all of

[73] Hibbard, R.A., Desch, L.W., Committee on Child Abuse and Neglect & Council on Children With Disabilities. (2007). *Maltreatment of Children With Disabilities.* Pediatrics, Vol. 119, No., pp. 1018 -1025

which involved children with disabilities.[74] The 57 P&As stay at the forefront of these issues. P&As maintain a presence in facilities that care for people with disabilities, where they monitor, investigate, and attempt to remedy adverse conditions. In FY 2011, the 57 P&As remedied 9,470 complaints of abuse and neglect.

Without the P&A presence, people with developmental disabilities and their families would have limited to no access to cost-effective, low level advocacy and legal interventions. Of the inquiries and issues received by the P&As:

- 38% were resolved using short-term assistance strategies;
- 22% were addressed through technical assistance in self-advocacy;
- 15% involved investigation and monitoring; and
- 12% were addressed through negotiation.

AIDD continues to analyze its tracking of the percentage of individuals who have their complaint of abuse, neglect, discrimination, or other human or civil rights resolved. For FY 2014, the program expects to further increase the result by one half of one percent over the previous year.

A performance measurement workgroup for the PADD program was established in FY 2012 to further analyze performance measurements and make recommendations for improvement. Developmental measures are planned for proposal in FY 2015 in collaboration with the AIDD performance measurement workgroup to address overarching performance measurements across AIDD Programs.

[74] U.S. General Accountability Office. (2009). Selected Cases of Death and Abuse at Public and Private Schools and Treatment Centers. Washington, DC: U.S. General Accountability Office.

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8B: Increase the percentage of individuals who have their complaint of abuse, neglect, discrimination, or other human or civil rights corrected compared to the total assisted. (Outcome)	FY 2011: 83.0% Target: 92.76% (Target Not Met)	Prior Result +0.5%	Prior Result +0.5%	N/A
8iii: Number of clients receiving professional individual legal advocacy for the Protection and Advocacy program. (Output)	FY 2011: 21,374 (Actual)	N/A	N/A	N/A
8iv: Number of people receiving information and referral from the Protection and Advocacy program. (Output)	FY 2011: 35,262 (Actual)	N/A	N/A	N/A
8ix: Number of people reached through University Centers for Excellence in Developmental Disabilities (UCEDD) community training and technical assistance activities. (Output)	FY 2011: 1.19 M (Actual)	N/A	N/A	N/A

Grant Awards Tables:

Developmental Disabilities – Protection and Advocacy Grant Awards[75]

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	56	56	56
Average Award	$711,456	$711,141	$711,462
Range of Awards	$205,808 - $3,415,127	$205,808 - $3,447,908	$205,888 - $3,449,927

[75] Excludes grants to tribal organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Developmental Disabilities – Protection and Advocacy (CFDA 93.630)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	658,233	654,350	654,731	-3,502
Alaska	384,693	384,693	384,693	--
Arizona	683,799	691,110	691,515	7,716
Arkansas	404,704	403,492	403,577	-1,127
California	3,415,127	3,447,908	3,449,927	34,800
Colorado	463,637	467,345	467,545	3,908
Connecticut	398,099	396,711	396,792	-1,307
Delaware	384,693	384,693	384,693	--
District of Columbia	384,693	384,693	384,693	--
Florida	1,906,955	1,934,863	1,935,995	29,040
Georgia	1,094,894	1,098,485	1,099,128	4,234
Hawaii	384,693	384,693	384,693	--
Idaho	384,693	384,693	384,693	--
Illinois	1,346,888	1,339,402	1,340,185	-6,703
Indiana	810,261	810,508	810,982	721
Iowa	395,039	393,891	393,970	-1,069
Kansas	384,693	384,693	384,693	--
Kentucky	620,005	614,825	615,183	-4,822
Louisiana	598,023	596,389	596,736	-1,287
Maine	384,693	384,693	384,693	--
Maryland	498,369	496,875	497,166	-1,203
Massachusetts	636,572	637,115	637,487	915
Michigan	1,310,947	1,313,495	1,314,262	3,315
Minnesota	541,679	540,829	541,145	-534
Mississippi	455,460	449,884	450,146	-5,314
Missouri	733,550	726,116	726,540	-7,010
Montana	384,693	384,693	384,693	--
Nebraska	384,693	384,693	384,693	--
Nevada	384,693	384,693	384,693	--
New Hampshire	384,693	384,693	384,693	--

PROGRAM/CFDA NUMBER: Developmental Disabilities – Protection and Advocacy (CFDA 93.630)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	789,686	787,223	787,682	-2,004
New Mexico	384,693	384,693	384,693	--
New York	1,973,384	1,957,037	1,958,178	-15,206
North Carolina	1,137,732	1,144,750	1,145,419	7,687
North Dakota	384,693	384,693	384,693	--
Ohio	1,438,540	1,425,051	1,425,884	-12,656
Oklahoma	442,376	444,943	445,204	2,828
Oregon	427,623	429,055	429,233	1,610
Pennsylvania	1,481,540	1,467,060	1,467,917	-13,623
Rhode Island	384,693	384,693	384,693	--
South Carolina	603,084	604,309	604,663	1,579
South Dakota	384,693	384,693	384,693	--
Tennessee	793,941	791,892	792,355	-1,586
Texas	2,518,653	2,547,232	2,548,724	30,071
Utah	384,693	384,693	384,693	--
Vermont	384,693	384,693	384,693	--
Virginia	773,699	770,509	770,959	-2,740
Washington	636,975	644,543	644,920	7,945
West Virginia	390,358	388,412	388,488	-1,870
Wisconsin	684,850	680,622	681,020	-3,830
Wyoming	384,693	384,693	384,693	--
Subtotal, States	37,989,156	38,020,705	38,038,132	48,976
American Samoa	205,808	205,808	205,808	--
Guam	205,808	205,808	205,808	--
Northern Mariana Islands	205,808	205,808	205,808	--
Puerto Rico	1,029,131	979,955	980,528	-48,603
Virgin Islands	205,808	205,808	205,808	--
Subtotal, States and Territories	39,841,519	39,823,892	39,841,892	373
Grants to Tribes	205,808	205,808	205,808	--
Training and Technical Assistance[76]	817,673	1,085,300	817,300	-373
TOTAL	**$40,865,000**	**$41,115,000**	**$40,865,000**	**--**

[76] This line reflects the amount reserved from the P&A appropriation for statutory related activities, including training, technical assistance, grant systems, and review costs

University Centers for Excellence in Developmental Disabilities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
University Centers for Excellence in Developmental Disabilities…..	$38,792,000	$39,029,000	$38,792,000	--

Authorizing Legislation: Section 156 of the Developmental Disabilities Assistance and Bill of Rights Act

FY 2014 Developmental Disabilities Assistance and Bill of Rights Act Authorization ......Expired

Allocation Method ....Competitive Grant

Program Description and Accomplishments:

University Centers for Excellence in Developmental Disabilities (UCEDDs), first established in 1963, are interdisciplinary education, research and public service units of a university system or public or not-for-profit entities associated with universities. UCEDDs provide leadership in advising Federal, State, and community policymakers about opportunities for individuals with developmental disabilities to exercise self-determination, be independent, productive, and integrated and included in all facets of community life. In FY 2012, the Administration on Intellectual and Developmental Disabilities (AIDD) plans to award 67 grants to continue funding for University Centers to engage in interdisciplinary pre-service training, community services, research, and information dissemination activities. The grant designates the Center and provides infrastructure support for UCEDDs to leverage additional funds for carrying out core activities.

UCEDDs provide unique contributions to the intellectual and developmental disabilities community in the area of pre-service preparation. UCEDDs provide an array of interdisciplinary instructional programs to improve the quality of services and supports for people with developmental disabilities. UCEDD interdisciplinary training programs are designed to:

- Integrate knowledge and methods from two or more distinct disciplines;
- Integrate direct contributions to the field made by people with disabilities and family members; and

- Examine and advance professional practice, scholarship and policy that impacts the lives of people with developmental and other disabilities and their families.

UCEDD trainees come from a wide array of professional backgrounds including, but not limited to, pediatrics, education, dentistry, nursing, allied health, and administration (e.g., public, health, education, etc.). On average, UCEDDs train nearly 2,800 future professionals each year.

In addition to advancing the field through pre-service preparation, UCEDDs make strategic connections across multiple sectors to ensure people with developmental and other disabilities attain maximum physical, emotional, social, and economic well-being; and are independent, productive and fully participating members of their community consistent with their cultural values. UCEDD community services cut across Federal, State, and local systems to improve capacity and quality of services by incorporating evidence-based practices. UCEDDs are at the forefront of ensuring appropriate evaluation of disabilities and the use of evidence-based interventions for children and adults with developmental and other disabilities, such as Autism Spectrum Disorders, for which rates have increased in recent years. New knowledge is generated by research and tied to practice using a variety of dissemination strategies.

Funding History:

Funding for the program during the last five years has been as follows:

FY 2009 ....$37,943,000
FY 2010 ....$38,943,000
FY 2011 ....$38,865,000
FY 2012 ....$38,792,000
FY 2013 CR. $39,029,000

Budget Request:

The FY 2014 request is $38,792,000, the same as the FY 2012 enacted level. This request will provide operational and administrative support to maintain the existing 67 UCEDDs. This funding also will provide continued support for the training and technical assistance to the UCEDDs, which supports improvements in the programs' performance and ability to meet performance targets.

Continued funding of the UCEDDs will support this network of independent but interlinked centers, representing an expansive national resource for addressing issues, finding solutions, and advancing research related to the needs of individuals with developmental disabilities and their families. At the local level, UCEDDs are vital to the training of future professionals with the

specialized expertise in developmental disabilities. Of the UCEDD trainees who graduated 5 to 10 years ago, 82% are in leadership positions with:

- 56% in academic leadership
- 48% in clinical leadership
- 25% in public health leadership
- 28% in public policy and advocacy leadership

It is estimated that 36.05% of people with developmental disabilities are receiving services from former UCEDD trainees.

In the absence of continued funding for UCEDDs, specialized services would no longer be available at the local level and local organizations as well as state agencies would not have the benefit of receiving technical assistance from UCEDDs to improve services and supports for people with developmental disabilities across the life span. A lack of funding would also create a tremendous gap in new knowledge generated by UCEDD-conducted research. For example, the M.I.N.D. Institute at the University of California, Davis has partnered with the Hmong Women's Heritage Association and the United Iu-Mien Community, Inc. to study barriers to quality care among Southeast Asian communities, with the goal of improving health care and access to services for children and adults with developmental disabilities. Based on the findings, project staff and community partners are undertaking a public service campaign aimed at increasing the awareness of developmental disabilities, early identification and services for the Southeast Asian communities.

UCEDD funds help to place these centers in a strategic position to lead national efforts such as *The National Gateway to Self-determination,* which is a collaborative effort of five UCEDDs and the National Self-Determination Alliance to establish a sustainable, evidence-based training system that enhances self-determination training programs that lead to quality of life outcomes for individuals with developmental disabilities throughout the lifespan. Another example is *The Consortium to Enhance Postsecondary Education for Individuals with Developmental Disabilities,* which is a project led by the Institute for Community Inclusion in Massachusetts in collaboration with seven UCEDDs (Delaware, Minnesota, Hawaii, South Carolina, Tennessee [Vanderbilt], Ohio, and California) and the Association of University Centers on Disabilities. The Consortium is conducting research, providing training and technical assistance, and disseminating information on promising practices that support individuals with developmental disabilities to increase their independence, productivity, and inclusion through access to

postsecondary education, resulting in improved long-term independent living and employment outcomes.

Funding for UCEDDs also provides infrastructure support for initiatives with effects felt internationally such as *The Border Project* at the Sonoran UCEDD, University of Arizona which is providing the Arizona-Mexico Border Region with low cost durable medical equipment and assistive technologies and training.

UCEDD designation and funding also aids these centers in seeking other sources of money to pursue activities that improve the lives of people with developmental disabilities. The grant from AIDD provides a critical infrastructure support that allows the UCEDD to leverage additional funds. There is a significant return on AIDD’s investment. In FY 2011, AIDD invested $35.8 million in UCEDD grant awards from which the UCEDDs leveraged $384.5 million to carry out their core activities.

A UCEDD performance measurement workgroup developed a UCEDD logic model that was used to make necessary updates to ensure meaningful program performance report outcome measurements. New performance measures were implemented in August 2012. In addition, the AIDD performance measurement workgroup plans to propose developmental measures in FY 2015.

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
8D: Increase the percentage of individuals with developmental disabilities receiving the benefit of services through activities in which professionals were involved who completed University Centers of Excellence in Developmental Disabilities (UCEDDs) state-of-the-art training within the past 10 years. (Outcome)	FY 2011: 37.67% Target: 36.38% (Target Exceeded)	Prior Result +1%	Prior Result +1%	N/A
8viii: Number of professionals trained by UCEDDs. (Output)	FY 2011: 5,594 (Actual)	N/A	N/A	N/A
8ix: Number of people reached through UCEDD community training and technical assistance activities. (Output)	FY 2011: 1.19 million (Actual)	N/A	N/A	N/A
8x: Number of people receiving direct or model demonstration services from UCEDDs. (Output)	FY 2011: 97,069 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

University Centers of Excellence in Developmental Disabilities Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	69[77]	67	67
Average Award	$550,782	$554,000	$554,000
Range of Awards	$442,988 - $554,000	$554,000 - $554,000	$554,000 - $554,000

[77] The two National Training Initiative grants will end in FY 2013.

Resource and Program Data:

University Centers of Excellence in Developmental Disabilities
(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	44	24,154	18	10,151	4	1,763
Continuations	25	13,850	50	28,088	64	36,544
Contracts	1	788	1	787	1	481
Interagency Agreements	--	--	1	3,150	1	3,150
Program Support /1		1		--		--
Total Resources		38,792		39,029		38,792

1/ Program Support -- Includes funds for grant systems and review costs.

Developmental Disabilities – Projects of National Significance

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Projects of National Significance	$8,317,000	$8,368,000	$8,317,000	--

Authorizing Legislation: Section 163 of the Developmental Disabilities Assistance and Bill of Rights Act

FY 2014 Developmental Disabilities Assistance and Bill of Rights Act Authorization......Expired

Allocation Method ....Competitive Grants and Cooperative Agreements/Contracts

Program Description and Accomplishments:

Projects of National Significance (PNS) is a discretionary program which provides grants, cooperative agreements, and contracts to public or private non-profit entities that support and supplement the work of the State Councils on Developmental Disabilities, the Protection and Advocacy systems for persons with Developmental Disabilities, and the University Centers for Excellence in Developmental Disabilities. PNS complements these other Developmental Disabilities (DD) programs by supporting the development of national and State policies, including Federal interagency initiatives; demonstration projects addressing innovative and emerging best practices to expand opportunities for individuals with developmental disabilities to contribute to, and participate in, all facets of community life; and longitudinal data collection projects.

In FY 2012, PNS resources funded systems change grants to improve access to competitive, integrated supported employment for people with intellectual and developmental disabilities, with a particular focus on youth and young adults, as well as the evaluation of such efforts. It also funded promising practices in states to promote competitive, integrated employment and family support activities. PNS funds continue to support the National Autism Resource and Information Center, as well as longitudinal research studies of trends in residential services and supports, employment, community supports, family supports, and quality indicators related to publicly funded DD services.

In FY 2014, AIDD will continue to prioritize these efforts to improve outcomes for individuals with developmental disabilities in competitive, integrated employment. AIDD will also continue to fund efforts to support promising practices for family support activities through training and

technical assistance. In addition, PNS funds will continue to support the National Autism Resource and Information Center as well as longitudinal research studies of trends in residential services and supports, employment, community supports, family supports, and quality indicators related to publicly funded DD services.

Funding History:

Funding for the program during the last five years has been as follows:

FY 2009 ....$14,162,000
FY 2010 ....$14,136,000
FY 2011 ....$14,134,000
FY 2012 ....$8,317,000
FY 2013 CR..$8,368,000

Budget Request:

The FY 2014 request for the Projects of National Significance program is $8,317,000, the same as the FY 2012 enacted level. The request will support continued funding for employment initiatives, technical assistance, longitudinal data collection and analysis, evaluation, and monitoring.

PNS projects reflect the current and emerging needs of individuals with developmental disabilities. For instance, AIDD will continue to fund the Partnerships in Employment Systems Change projects as they continue to work toward a current need of the intellectual and developmental disabilities community. In Wisconsin, individuals with intellectual and developmental disabilities enrolled in adult long-term care systems have community-based employment rates of only 9 to 14 percent. One of the project's goals is to implement policy and legislative changes that will increase the number of students in Wisconsin, and ultimately nationally who are employed in integrated, community based settings after leaving high school or a post-secondary institution and who become economically self-sufficient. Without this funding, progress will not be made on this project and others like it, which does a disservice to individuals with intellectual and developmental disabilities in Wisconsin and the other seven states.

The National Autism Information Resource Center (the Autism Now project), provides high quality resources and information related to community-based services that support independent living and self-determination, treatment protocols that promote community-based experiences (e.g. education, employment, recreation, transportation, early intervention and child care), and evidence-based interventions for Autism Spectrum Disorder (ASD) service providers,

researchers, families, and people with ASD. This project intends to provide more robust materials for the autism community and partner with relevant organizations to improve support to individuals with ASD, their families, professionals, and the general public. The impetus of the program was a Congressional directive through the 2010 Senate committee report, and it has a unique target audience. Therefore, a lack of funding will create a significant gap in the autism community's resources.

AIDD continues to undertake a comprehensive review of performance measurement and data reporting activities across all DD Act programs with an increased focus on outcomes, including, the establishment of performance measurement workgroups, enhancement and streamlining data collection, and engagement with evaluation experts to recommend improvements.

Grant Awards Tables:

Developmental Disabilities – Projects of National Significance Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	17	17	17
Average Award	$356,449	$356,449	$356,449
Range of Awards	$190,000 - $575,000	$190,000 - $575,000	$190,000 - $575,000

Resource and Program Data:

University Centers of Excellence in Developmental Disabilities
(Dollars in thousands)

	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget /2	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	2,962	6	201	2	500
Continuations	9	3,098	17	6,060	16	5,710
Contracts	6	1,508	5	1,348	5	1,348
Interagency Agreements	--	--	--	--	--	--
Program Support /1		750		760		760
Total Resources		8,317		8,368		8,317

1/ Program Support -- Includes funds for grant systems and review costs.

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Consumer Information, Access, and Outreach

Summary of Request

Older Americans and Americans with disabilities face a vast array of choices when trying to determine the right services and supports to assist them to remain active and independent in their communities. As the number of choices available to assist them grows, so too does the complexity of navigating these programs and selecting among them so as to determine which best suit the needs of each individual.

A key part of ACL's emphasis on community living is providing consumers with the information they need to make decisions about their independence and connecting them with the right services. Aging and Disability Resource Centers (ADRCs) and the State Health Insurance Assistance Programs (SHIPs) help to address this need by providing information, outreach, and assistance to seniors and people with disabilities, so that they can access the services necessary for their independence. ADRCs serve as community-level "one stop shop" entry points into long-term care - including home and community-based services that can enable people to remain in their homes - for people of all ages who have chronic conditions and disabilities. SHIPs provide one-on-one counseling to help aging and disabled beneficiaries understand and make optimal use of their Medicare benefits.

Equally important, however, are the programs that help disabled individuals and seniors to more fully participate in all aspects of community life. Grants provided under the Help America Vote Act (HAVA) assist States in making polling places accessible to individuals with the full range of disabilities. Further, the Alzheimer's Disease Initiative Communications Campaign, proposed to be funded from the Prevention and Public Health Fund, the National Clearinghouse for Long-Term Care Information, and the Paralysis Resource Center (proposed for transfer to ACL from CDC) each reach out to key populations to assist in accessing services and in planning for future needs.

The FY 2014 request for these programs is $81,250,000, a reduction of -$6,257,000 from the FY 2012 enacted level. This request would provide:

- $10,000,000 for ADRCs using mandatory funds provided by the Affordable Care Act. As in the FY 2013 President's Budget, no funding is requested from discretionary appropriations. ADRCs support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level. <u>FY 2014 is the final year that funding will be provided for this program under ACA.</u>

- $5,235,000 for HAVA grants to assist Protection and Advocacy systems in each state and territory to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places.

- $4,200,000 for the Alzheimer's Disease Initiative Outreach Campaign to inform people caring for people with Alzheimer's disease about the federal, state, local, and nonprofit resources available to help them. This funding is proposed from the Prevention and Public Health Fund.

- $52,115,000 for State Health Insurance Assistance Programs (SHIPs), proposed for transfer to ACL from the Centers for Medicare and Medicaid Services. SHIPs provide free, one-on-one counseling and assistance to help aging and disabled Medicare beneficiaries navigate the complexities of health and long-term care systems. The SHIPs, two-thirds of which are currently administered by State Units on Aging, fit naturally within ACL's mission of promoting community living, and will benefit from deeper connection to ACL's aging and disability services networks.

- $3,000,000 for the National Clearinghouse for Long-Term Care Information, which seeks to increase awareness of the need to plan ahead for long-term care. FY 2014 is the first year for which discretionary funding is being sought.

- $6,700,000 for the Paralysis Resource Center (PRC), proposed for transfer to ACL from the Centers for Disease Control and Prevention. The PRC provides comprehensive information and referral services for people living with paralysis and their families and caregivers. Under ACL's administration the PRC will benefit from extensive ties to ACL's disability networks.

Aging and Disability Resource Centers

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Discretionary.........................	$6,457,000	$6,497,000	--	-$6,457,000
Affordable Care Act………...	$10,000,000	$10,000,000	$10,000,000	--
Total………………..........	$16,457,000	$16,497,000	$10,000,000	-$6,457,000
FTE………………………	4	4	4	--

Authorizing Legislation: Section 202b of the Older Americans Act of 1965, as amended and Section 2405 of the Affordable Care Act, P.L. 111-148.

Mandatory Appropriation: Section 2405 of the Affordable Care Act of 2010

FY 2014 Older Americans Act Authorization ....Expired
FY 2014 Mandatory Authorization...$10,000,000

Allocation Method ....Competitive Grants/Co-operative Agreements and Contracts

Program Description and Accomplishments:

Aging and Disability Resource Centers (ADRCs) support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level. ADRCs grew out of best practice innovations known as "No Wrong Door"[78] and "Single Points of Entry" programs, where people of all ages may turn for objective information on their long-term services and support options. Since 2003, the Administration on Aging, along with the Centers for Medicare & Medicaid Services (CMS), have provided grants to States to develop the foundational infrastructure for delivering person-centered systems of information, one-on-one counseling, and access that make it easier for individuals to learn about and access their health and long-term services and support options.

[78] In a "No Wrong Door" entry system, multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity (Allison Armor-Garb, *Point of Entry Systems for Long-Term Care: State Case Studies,* prepared for the New York City Department of Aging, 2004).

ADRCs are a key component in transforming States' long-term supports and services programs. Services provided include:

- Targeted discharge planning, care transition and diversion support that integrates the medical and social service systems on behalf of older adults and individuals with disabilities to help them remain in their own homes and communities after a hospitalization, rehabilitation or skilled nursing facility visit;

- "One-on-one" options counseling and advice to help consumers, including private pay individuals, and their caregivers fully understand the options available to them.

- Streamlined access to all publicly supported long-term care services and support programs;

- Outreach and assistance to Medicare beneficiaries on their Medicare benefits including prevention and low-income subsidies; and

- Integrated options counseling and access-point to care transition and diversion support for Veterans served through the ACL/Department of Veterans Affairs (VA) Veteran-Directed Home and Community Based Services Program partnership.

With FY 2012 funds, it was estimated that ADRCs would respond to over four million contacts to help individuals make better informed decisions about their health and long-term care options, with the vast majority of these decisions resulting in referrals for community-based services.

ADRCs help States make better use of taxpayer dollars by streamlining access to community services and supports and diverting individuals from more costly forms of care, including institutional care and unnecessary hospital re-admissions. High performing ADRC programs funded under this announcement will satisfy two of three statewide system change requirements States must meet in order to qualify for enhanced Federal match under the CMS Medicaid Balancing Incentive Program.

AoA and CMS have invested over $100 million in the ADRC program since 2003. As a result of these investments:

- Over 492 ADRC sites have been established across 50 states, three territories, and Washington, DC, by increasing the coordination and capacity of existing infrastructure in the aging, disability and Medicaid networks. Together these ADRC sites can reach roughly 63 percent of the U.S. population.

- 24 States and Territories have achieved statewide coverage, and an additional 13 States have achieved 50 percent or more of statewide coverage.

- 40 states with ADRC programs sites currently conduct care transitions through formal intervention with an additional 10 states currently planning to conduct activities also through formal interventions

- 25 States have developed statewide web-based directories available to consumers and service providers which improve the quality and consistency of the aging services network information and assistance provided across the state.

Funding History:

Comparable discretionary funding for Aging and Disability Resource Centers is as follows:

FY 2009 ....$13,577,000
FY 2010 ....$13,684,000
FY 2011 ....$6,469,000
FY 2012 ....$6,457,000
FY 2013 CR. $6,497,000

Note: Discretionary funding for ADRC activities was provided under Aging Network Support Activities in FY 2009 and FY 2010 and requested under Health and Long-term Care Programs in FY 2011.

Comparable mandatory funding for Aging and Disability Resource Centers is as follows:

FY 2010	$10,000,000	3 FTE
FY 2011	$10,000,000	3 FTE
FY 2012	$10,000,000	4 FTE
FY 2013	$10,000,000	4 FTE

Note: Mandatory appropriations of $10 million for FY 2010 through FY 2014 for ADRCs are made under Section 2405 of P.L. 111-148, the Affordable Care Act of 2010.

Budget Request:

No discretionary funding is requested for Aging and Disability Resource Centers for FY 2014. Mandatory funding for ADRCs is currently appropriated ($10 million annually) through FY 2014 under the Affordable Care Act, P.L. 111-148. It should be noted that FY 2014 is the last year that funding under ACA is available without further action by the Congress.

ACL intends to use this funding for ADRCs to support States and communities to continue to build the infrastructure needed to advance the ongoing integration of the programs efforts into States' HCBS systems and create greater integration with the health care system. Special emphasis will be given to strengthening the capacity of existing ADRCs to carry-out options counseling, nursing home diversion, and care transitions that help reduce unnecessary hospital readmissions. Going forward, ACL will also continue to partner with CMS and the Veteran's Health Administration to assist States in reducing the growth in long-term care spending through effective and efficient increases in non-institutional services and supports.

ADRCs will also continue, with Department of Veteran's Affairs (VA) funding, to serve clients under the current ACL/VA partnership. In FY 2008, the VA and AoA began working together to develop the Veterans Directed Home and Community Based Services Program (VD-HCBS), which is designed to serve Veterans of any age who are at risk of admission to a nursing home by providing them the opportunity to self-direct their care and access services to help them remain in the community. Rather than build a separate infrastructure to serve Veterans, the VA made a strategic decision to use the aging network infrastructure – including using the ADRC as the integrated access point to empower the veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VD-HCBS. Since inception of the program the VA has invested $40.8 million to help expand this program nationwide. HHS and the VA have worked together to develop Program Guidelines/National Standards, web based tools to track and scale program, and implement a National Training program for the VD-HCBS. Currently, 19 states and the District of Columbia are operating VD-HCBS programs with 33 operational VAMCs, 82 operational AAA/ADRCs and over 775 veterans served (132 or 17% under age 60). In FY 2012, it is projected that additional 28 VAMCs will be added.

Outcome and Outputs Table:

Aging and Disability Resource Centers Outcome and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2014 Target	FY 2014 +/- FY 2012
LTC.2: Percent of individuals who indicate ADRC information and counseling contribute to informed decision making *(Outcome)*	FY 2011: 77.7% (note: only 13 sites reporting)	Target set FY 13	83%	N/A
Indicator	**Most Recent Result**	**FY 2012 Projection**	**FY 2014 Projection**	**FY 2014 +/- FY 2012**
Output AF: Total number of ADRC contacts *(Output)*	FY 2011: 4,655,944	3.75 M	3.6 M	-0.15 M
Output AG: Increase in the number of ADRC pilot programs *(Output)*	FY 2011: 367	310	280	-30

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Aging and Disability Resource Centers; however multiple performance outcomes are impacted by this program because AoA's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Resource and Program Data:

Aging and Disability Resource Centers (total)
(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	44	12,527	38	6,294	--	--
Continuations	2	600	9	6,759	8	6,407
Contracts	1	2,500	1	2,538	1	2,801
Interagency Agreements	--	--	1	100	--	--
Program Support 1/		830		807		792
Total Resources		16,457		16,496		10,000

1/ Program Support -- Includes funds for grant systems and review and information technology support costs.

Aging and Disability Resource Centers (Discretionary)
(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	36	3,344	38	3,559	--	--
Continuations	2	600	1	300	--	--
Contracts	1	2,500	1	2,538	--	--
Interagency Agreements	--	--	1	100	--	--
Program Support 1/		13		--		--
Total Resources		6,457		6,496		--

1/ Program Support -- Includes funds for grant systems and review and information technology support costs.

Aging and Disability Resource Centers (Mandatory)
(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	9,183	--	2,374	--	--
Continuations	--	--	8	6,459	8	6,407
Contracts	--	--	--	--	1	2,801
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		817		807		792
Total Resources		10,000		10,000		10,000

1/ Program Support -- Includes funds for grant systems and review and information technology support costs.

Voting Access for Individuals with Disabilities

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Voting Access for People with Disabilities	$5,235,000	$5,267,000	$5,235,000	--

Authorizing Legislation: Section 291 of the Help America Vote Act

FY 2014 Authorization ....Such Sums

Allocation Method ....Formula Grant

Program Description and Accomplishments:

The Voting Access for Individuals with Disabilities program is authorized by the Help America Vote Act (HAVA), P.L. 107-252. Funding currently supports Protection and Advocacy systems in each State and Territory, through formula grants, to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places. These funds provide services to individuals with disabilities within the State, as well as advocacy for and education about the electoral process and monitoring of the accessibility of the electoral process for people with disabilities. Additionally, training and technical assistance grants to assist the P&As in their promotion of full participation in the electoral process are provided through a competitive one-year award.

HAVA P&A grantees use funds to promote systematic efforts to ensure individuals with disabilities have the opportunity to participate in every step of the electoral process. For example, grantees support systems change efforts to improve information on the location of accessible polling places, and adopt voting procedures that enable individuals with disabilities to vote privately and independently. Grantees also work to educate election officials, poll workers, and election volunteers on the rights of voters with disabilities and best practices. P&As provide assistance to State and other government entities by surveying polling places, identifying potential modifications to make specific polling places accessible, and developing criteria for identifying accessible polling places.

Providing Training and Technical Assistance to the P&As

Through the program, AIDD also makes discretionary grants to eligible nonprofit organizations to assist P&A's in developing proficiency in the use of voting systems and technologies for

individuals with disabilities and demonstrating and evaluating the use of such systems and technologies. P&A's also receive training and technical assistance for providing non-visual access in the voting process. These grants are authorized under section 291 of HAVA as a seven percent set-aside of the total appropriation for P&As. After receiving training and technical assistance, P&A's may inform others on the availability of accessible voting equipment and its use.

Funding History:

Funding during the last five years has been as follows:

FY 2009 ....$17,410,000
FY 2010 ....$17,410,000
FY 2011 ....$17,375,000
FY 2012 ....$5,235,000
FY 2013 CR $5,267,000

Budget Request:

The FY 2014 budget request for Voting Access for Individuals with Disabilities to the Protection and Advocacy Systems and related technical assistance is $5,235,000, the same as the FY 2012 enacted level.

As an example of the activities undertaken with this funding, in Charleston, SC the P&A sponsored a site used by an Election Protection (EP) volunteer attorney to staff a hotline and train law student volunteers to canvass polling places in Charleston for accessibility issues. However, accessibility in voting continues to be an ongoing challenge throughout the country. A forthcoming report by the National Council on Disability identifies an incident in 2012 in Arizona where a voter who used a wheelchair could not get through the front door of her polling place to deliver an early ballot. The same report details a complaint from Bladensburg, MD where voters with disabilities were told that they had to "prove their disability" in order to be seated in line. Additionally, the Maryland P&A had to notify a Montgomery County judge to unlock the assigned accessible door to a polling place so that voters with disabilities could enter the building.

Being able to participate fully in the election process is a right, not a privilege, and funding for this activity helps to ensure that individuals with the full range of disabilities are not denied the right to the same opportunity for access and participation in the electoral process as voters with no disabilities.

Accessibility in voting continues to be an ongoing challenge. Being able to participate fully in the election process is a right, not a privilege, and funding for this activity helps to ensure that individuals with the full range of disabilities are not denied the right to the same opportunity for access and participation in the electoral process as voters with no disabilities.

Grant Awards Table:

Voting Access for Individuals with Disabilities Grant Awards

	FY 2012 Actual	**FY 2013 President's Budget**	**FY 2014 Planning Level**
Number of Awards	55	55	55
Average Award	$88,521	$89,060	$88,519
Range of Awards	$35,000 - $398,170	$35,000 - $404,612	$35,000 - $398,916

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

FY 2014 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Voting Access for Individuals with Disabilities (CFDA 93.618)

State/Territory	FY 2012 Actual	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
Alabama	70,000	70,000	70,000	--
Alaska	70,000	70,000	70,000	--
Arizona	70,000	70,000	70,000	--
Arkansas	70,000	70,000	70,000	--
California	398,170	404,612	398,916	746
Colorado	70,000	70,000	70,000	--
Connecticut	70,000	70,000	70,000	--
Delaware	70,000	70,000	70,000	--
District of Columbia	70,000	70,000	70,000	--
Florida	200,948	204,578	201,697	749
Georgia	103,541	105,364	103,880	339
Hawaii	70,000	70,000	70,000	--
Idaho	70,000	70,000	70,000	--
Illinois	137,133	138,148	136,203	-930
Indiana	70,000	70,000	70,000	--
Iowa	70,000	70,000	70,000	--
Kansas	70,000	70,000	70,000	--
Kentucky	70,000	70,000	70,000	--
Louisiana	70,000	70,000	70,000	--
Maine	70,000	70,000	70,000	--
Maryland	70,000	70,000	70,000	--
Massachusetts	70,000	70,715	70,000	--
Michigan	105,636	106,018	104,525	-1,111
Minnesota	70,000	70,000	70,000	--
Mississippi	70,000	70,000	70,000	--
Missouri	70,000	70,000	70,000	--
Montana	70,000	70,000	70,000	--
Nebraska	70,000	70,000	70,000	--
Nevada	70,000	70,000	70,000	--
New Hampshire	70,000	70,000	70,000	--

PROGRAM/CFDA NUMBER: Voting Access for Individuals with Disabilities (CFDA 93.618)

State/Territory	FY 2012 Estimate	FY 2013 Estimate	FY 2014 Estimate	FY 2014 +/- FY 2012
New Jersey	93,967	94,693	93,359	-608
New Mexico	70,000	70,000	70,000	--
New York	207,113	208,954	206,012	-1,101
North Carolina	101,915	103,659	102,199	284
North Dakota	70,000	70,000	70,000	--
Ohio	123,302	123,932	122,187	-1,115
Oklahoma	70,000	70,000	70,000	--
Oregon	70,000	70,000	70,000	--
Pennsylvania	135,763	136,792	134,865	-898
Rhode Island	70,000	70,000	70,000	--
South Carolina	70,000	70,000	70,000	--
South Dakota	70,000	70,000	70,000	--
Tennessee	70,000	70,000	70,000	--
Texas	268,755	275,611	271,730	2,975
Utah	70,000	70,000	70,000	--
Vermont	70,000	70,000	70,000	--
Virginia	85,515	86,915	85,691	176
Washington	71,872	73,319	72,286	414
West Virginia	70,000	70,000	70,000	--
Wisconsin	70,000	70,000	70,000	--
Wyoming	70,000	70,000	70,000	--
Subtotal, States	4,693,630	4,723,310	4,693,550	-80
American Samoa	35,000	35,000	35,000	--
Guam	35,000	35,000	35,000	--
Puerto Rico	70,000	70,000	70,000	--
Virgin Islands	35,000	35,000	35,000	--
Subtotal, States and Territories	4,868,630	4,898,310	4,868,550	-80
Training and Technical Assistance[79]	366,370	368,690	366,450	80
TOTAL	**$5,235,000**	**$5,267,000**	**$5,235,000**	**--**

[79] This line reflects the amount reserved from the HAVA appropriation for statutory related activities, including training, technical assistance, grant systems, and review costs

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Alzheimer's Disease Initiative - Outreach Campaign

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Alzheimer's Disease Initiative – Outreach (Prevention Fund)	$4,000,000	$4,200,000	$4,200,000	--

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act, [42 U.S.C. Sections 243 and 247b(k)(2)] as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

FY 2014 Public Health Service Act Authorization..Expired

Allocation Method ....Contracts

Program Description and Accomplishments:

On February 7, 2012, the President announced a new effort to fight Alzheimer's disease, and in FY 2012, the Department provided ACL with $4,000,000 in initial funding from the Prevention and Public Health Fund established under ACA to begin a public awareness Alzheimer's Disease Outreach Campaign. Building on the ongoing Long-Term Care Awareness Campaign, AoA has already begun research on specific topic areas and messages. Focus groups will help refine messages that will be used to develop print, television, radio, web banner, and other mechanisms, such as social media. AoA will explore distribution through various media at different levels of cost. AoA and partners at HHS will schedule public events featuring the Surgeon General and notable advocates for persons with Alzheimer's disease.

The campaign's goal is to inform people caring for people with Alzheimer's disease that there are Federal, state, local, and nonprofit resources available to help them. The campaign will feature a new government web site (alzheimers.gov). The campaign will also deploy television, radio and print advertisements as well as search engine optimization and advertisements on specific web sites. Traffic to the new web site will be studied to determine what information care givers appear to value most and to adjust outreach strategies accordingly.

This initiative is envisioned as a public-private partnership. As such, ACL will reach out to non-governmental entities such as philanthropic and other groups supporting persons with Alzheimer's disease and their families. The goal will be to learn from other similarly-focused efforts and to coordinate with these groups where possible.

Funding History:

FY 2009 ....$0
FY 2010 ....$0
FY 2011 ....$0
FY 2012 ....$4,000,000
FY 2013 CR ....N/A[80]

Budget Request:

The FY 2014 budget includes $4,200,000 in funding for the Alzheimer's Disease Initiative Outreach Campaign from the Prevention and Public Health Fund (PPHF) under the Affordable Care Act, an increase of +$200,000 over the amount allocated for this activity in FY 2012.

These funds will be used to continue to develop both the information available on the alzheimers.gov web site and the effectiveness of the media outreach. The experience of the first years of funding will be examined to determine if the new web site is indeed providing information of value to caregivers (analysis of web traffic and random surveys of users) and if the present media strategy is effective in reaching caregivers. Content on the web site will be refreshed and enhanced through a panel of subject matter experts using the results of the web traffic analysis. The media strategy will also be expanded to include social media elements such as blogs, Twitter feeds and social network posting and/or advertising.

A particular effort will be made in FY 2014 to examine the effectiveness of the content and the media for both Hispanic- and African-American populations both of which are at higher risk of Alzheimer's disease than other groups.[81] This may require development of specific additional outreach materials and further analysis to determine if content and messaging are culturally competent.

[80] The FY 2013 Prevention Fund resources are reflected in the Office of the Secretary.

[81] *Health Disparities and Alzheimer's Disease.* National Institute on Aging. Available at http://www.nia.nih.gov/alzheimers/publication/2011-2012-alzheimers-disease-progress-report/health-disparities-and#disparities.

State Health Insurance Assistance Programs

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
State Health Insurance Assistance Programs....	$52,115,000	$52,434,000	$52,115,000	--
FTE......................	10	10	10	--

Authorizing Legislation: Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-4).

FY 2014 Authorization .... Expired

Allocation Method .... Formula and Competitive Grants/Contracts

Program Description and Accomplishments:

The State Health Insurance Assistance Program (SHIP) provides grants to States to fund infrastructure, training, and outreach support to over 12,000 (mostly volunteer) counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Under the direction and support of State program directors and trainers, SHIP counselors receive extensive training and continuous ongoing information updates about health plan options, Medicare entitlement and enrollment, Medigap, long-term care insurance, Medicare Part D prescription drug benefits, preventive benefits, and programs for beneficiaries with limited income and resources such as the Medicare Part D Extra Help/Low-Income Subsidy, the Medicare Savings Programs, and Medicaid.

SHIPs provide free, one-on-one counseling and assistance to help aging and disabled Medicare and Medicaid beneficiaries as well as coming-of-agers navigate the complexities of health and long-term care systems. Services are provided via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. In FY 2010 SHIPs served 4.7 million clients. SHIP activities align with the objective of developing a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals and people with disabilities maintain their health and independence in their homes and communities.

The budget request would transfer the SHIP program from the Centers for Medicare and Medicaid Services to the Administration for Community Living. This transfer reflects the natural

synergies between the SHIP programs and the networks that ACL serves. About two-thirds of the 54 State SHIP programs are already administered by State Units on Aging, with most of the remaining programs administered by State Insurance Commissions. At the community level, many SHIPs are either housed in or create local partnerships with Area Agencies on Aging. Similarly, almost 50 percent of the SHIPs are co-located with the Senior Medicare Patrol program, which is also administered by ACL.

SHIP activities complement programs authorized through the Older Americans Act, including but not limited to Information and Referral/Assistance (I&R/A), Aging and Disability Resource Centers (ADRCs), and Benefits Counseling. SHIPs also have a long history of outreach and assistance to underserved populations, including people with limited incomes, under-65 Medicare beneficiaries with disabilities, dual eligibles, and people with cognitive and/or mental disabilities.

Funding History:

Comparable funding for the State Health Insurance Assistance Program is as follows:

FY 2009 ....$52,500,000
FY 2010 ....$46,960,000
FY 2011 ....$52,000,000
FY 2012 ....$52,115,000
FY 2013 CR $52,434,000

In addition, the following legislative action has taken place since FY 2008 which provided additional mandatory funding for the SHIPs:

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided the SHIPs with an additional $7.5 million in FY 2009.

- The Affordable Care Act provides a total of $15 million to be distributed to states via formula grants in FY 2010 – FY 2012.

- The American Taxpayer Relief Act of 2012 extends MIPPA to provide an additional $7.5 million for SHIPs in FY 2013.

Budget Request:

The SHIP budget request for FY 2014 is $52,115,000, the same as the comparable FY 2012 enacted level. This includes funding for 10 FTE and related administrative expenses to administer the program.

Funds will be used to continue SHIP grants at current levels. This funding will allow States to continue the personalized counseling that they have been providing and to make further improvements to better streamline the program. Funds will also be used to provide administrative support for the SHIPs program.

The needs of the over 46 million Americans who depend on Medicare for their health care are multifaceted and diverse. More than one-quarter of beneficiaries have cognitive impairments; almost one-third have limitations in activities of daily living such as eating and dressing; almost one-third have not graduated from high school; and more than one in ten are over 85 years of age. These beneficiaries can face any number of difficulties in trying to navigate the health care system. Recent and upcoming changes in the system as a result of the Affordable Care Act (ACA) will provide opportunities to beneficiaries for improved care, including increased Medicare preventive services. These opportunities will increase the responsibilities of the SHIP counselors in terms of training, outreach and one-on-one counseling. The counselor knowledge base will need to include the inter-relationship of Medicare, Early Retiree Insurance Program, Pre-Existing Condition Insurance Plan (PCIP), Medicare covered preventive benefits, state Medicaid programs, and planning for the State-based Exchanges in addition to other long-term care support options that beneficiaries need to remain in the community.

Research has consistently found that Medicare beneficiaries prefer to receive information about Medicare and other supports through one-on-one assistance rather than through other means, such as written materials, mass media, and the internet. Given the large number and variety of private plan options available in the Medicare program and the new opportunities for beneficiaries through the ACA, the type of one-on-one beneficiary counseling and decisions support provided by SHIPs is an essential component to the information provided more generally through www.Medicare.gov and 1-800-MEDICARE. ACL's unique connections to the aging services network as well as the greater efficiencies leveraged by a single point of management of these activities which are often co-located with ADRCs, makes transferring the SHIPs program to ACL a logical way to meet the needs of beneficiaries.

Grant Awards Table:

State Health Insurance Assistance Programs Grant Awards

	FY 2012 Actual	FY 2013 Annualized CR	FY 2014 President's Budget
Number of Awards	54	54	54
Average Award	$861,689	$861,689	$861,689
Range of Awards	$37,943 - $3,964,059	$37,943 - $3,964,059	$37,943 - $3,964,059

Outcomes and Outputs:

In FY 2009, the last year for which complete data are available, SHIPs reached over 4.7 million individuals through 54,656 public information and outreach events.

Funds will be used to make SHIP grants to States to continue the personalized counseling that they provide and to make further improvements, which are anticipated to include:

- Continuing the number of community outreach and public forums to raise awareness of long-term care options including prevention and relevant ACA opportunities.
- Continuing the number of individual client contacts to individuals on Medicare under the age of 65.
- Tracking the number of individual client contacts of pre-retirees.
- Continuing the number of local and field counselors (paid and unpaid).
- Continuing the number of individual personalized counseling sessions.

National Clearinghouse on Long-Term Care Information

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
National Clearinghouse on Long-Term Care Information…………..	$3,000,000	$85,523	$3,000,000	--
FTE……………………	1	*	1	--

Note: Funding for this program was provided by the Affordable Care Act in FY 2012 and FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act in FY 2013 (save for obligations through January 3, 2013). The FY 2014 request is for discretionary funding.

Authorizing Legislation: Section 6021(d) of the Deficit Reduction Act of 2005 (P.L. 106-224).
Mandatory Appropriation (FY 2012-2013): Title VIII of the Affordable Care Act, P.L. 111-148

FY 2014 Authorization $3,000,000
Allocation Method ....Contract

Program Description and Accomplishments:

The National Clearinghouse for Long-Term Care Information (Clearinghouse) provides objective information on how to plan ahead for their long-term care needs. First authorized by the Deficit Reduction Act of 2005, the Clearinghouse educates consumers about public and private options available to plan and pay for long-term care. Beginning with the "Own Your Future" direct mail campaign in 2005, the Clearinghouse has progressed toward a state-of-the-art strategy using broadcast and social media to direct consumers to a web site containing objective information on how to plan ahead for long-term care.

The American Taxpayer Relief Act repealed Title VIII of the Affordable Care Act (the Community Living Assistance Services and Supports or CLASS program), which included the mandatory funding for the Clearinghouse, save for amounts obligated through January 3, 2013. However, the Clearinghouse pre-dates the Affordable Care Act and has a separate and important purpose. Accordingly, ACL is requesting discretionary funding to continue the Clearinghouse's important educational and informative mission. Clearinghouse initiatives will include a more robust evaluation of both website content and outreach strategy and a refreshed web site that includes a decision tool that matches calls to action with user provided information.

Funding History:

Funding for the past 5 years is as follows:

FY 2009 1/ $3,000,000
FY 2010 1/ $3,000,000
FY 2011 1/ $3,000,000
FY 2012 .... $3,000,000
FY 2013 2/ .... …..$85,523

1/ Funding for the clearinghouse was first provided directly to ACL in FY 2012. Prior to FY 2012, the Administration on Aging received funding for this activity through an Intra-Agency Agreement (IAA) with CMS.
2/ Reflects obligations prior to January 3, 2013 when funding was rescinded.

Budget Request:

The FY 2014 President's Budget request for the National Clearinghouse on Long-Term Care is $3,000,000, the same amount as appropriated in FY 2012 and prior years by the Affordable Care Act. This funding is requested in FY 2014 from discretionary funding, as mandatory funding previously appropriated by the Affordable Care Act for FY 2014 was rescinded by the American Taxpayer Relief Act.

The need for a comprehensive, objective, and easy-to-use source for information on long-term care has never been greater. As Americans live longer lives, their need to plan for their long-term care increases dramatically. On average, someone who is 65 today will require some type of long-term services and supports for three years.[82] Costs for this care can range from $19,000 per year for a home health aide to assist three times per week to $83,585 per year for nursing home care.[83] Many consumers are not aware that Medicare does not cover long-term care needs, placing recipients of this care at high risk of spend-down to Medicaid. Americans need a reliable source of information about these costs and how to plan for and afford them, and the 415,039 visits to the site recorded during the last 9 months of 2012 indicate that there is a strong demand for this information.

In addition to the costs of operating the website, this request also supports activities designed to raise awareness of and direct traffic to the website. These activities include digital banner advertisements and search engine optimization, with extensive market research determining how best to reach prospective consumers. Additionally, as the Clearinghouse has grown, the amount

[82] http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/How_Much.aspx
[83] http://www.longtermcare.gov/LTC/Main_Site/Paying/Costs/Index.aspx

of information available can seem overwhelming. Requested funds will support the development of a decision tool to provide a streamlined set of calls to action and related information. This will assist consumers who are just starting the planning process without sacrificing the extensive detail that current consumers rely on for more in-depth issues.

Resource and Program Data:

National Clearinghouse for Long-Term Care Information
(Dollars in thousands)

	FY 2012 Enacted		**FY 2013 Annual CR /2**		**FY 2014 President's Budget**	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	1	2,496	--	--	1	2,872
Interagency Agreements	1	31	--	--	1	33
Program Support /1		473		86		95
Total Resources		3,000		86		3,000

1/ Program Support -- Includes funds for salaries and overhead and information technology support costs.

2/ Funding for this program was provided by the Affordable Care Act in FY 2012 and FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act in FY 2013 (save for obligations through January 3, 2013). The FY 2014 request is for discretionary funding.

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Paralysis Resource Center

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Paralysis Resource Center	$6,700,000	$6,741,000	$6,700,000	--

Note: For comparability purposes, only the transferred amount of direct grant funding is displayed here.

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act [42 U.S.C. 243 & 247b(k)(2)], as amended.

Allocation Method ....Competitive Grant

Program Description and Accomplishments:

The Paralysis Resource Center (PRC) promotes the health and well-being of people living with paralysis and supports their families and caregivers by providing comprehensive information and referral services. The PRC seeks to bridge a wide information gap experienced not only by newly-paralyzed individuals, but also by those who have lived for some time with paralysis. This information promotes better health, encourages community involvement, and improves quality of life.

The PRC provides information specialists fluent in English and Spanish to answer paralysis-related questions via a toll-free phone call or email. The PRC also operates an information clearinghouse that provides access to a variety of paralysis-related publications. Additionally, the PRC publishes and distributes a free Paralysis Resource Guide, as well as informational videos and training materials.

The PRC is operated via a cooperative agreement, currently with the Christopher and Dana Reeve Foundation. The Reeve Foundation is supported in its operation of the PRC by a network of 40 members of its "Paralysis Task Force." This task force is united in meeting the needs of people living with paralysis via research, information-gathering and dissemination, and advocacy efforts. The current cooperative agreement runs through May 2014.

With the formation of ACL, HHS has a new operating division focused on maximizing the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. Due to the natural synergies with the aims of the PRC, the FY 2014 President's Budget proposes to transfer funding and administrative responsibilities for the PRC from the Centers for Disease Control and Prevention to ACL. Under ACL, the PRC would benefit from extensive ties to disability networks and would provide a valuable source of information as ACL

continues to strengthen its policy and advocacy efforts in the field of disabilities. ACL anticipates that the PRC will be an early step in growing ACL as HHS' source of disability expertise and advocacy, and ACL looks forward to engaging with other programs both inside and outside HHS in order to present an expanded role in FY 2015.

Funding History:

Funding for the program during the last five years has been as follows:

FY 2009 ....$5,479,000
FY 2010 ....$6,610,000
FY 2011 ....$5,800,000
FY 2012 ....$6,700,000
FY 2013 C.R. $6,741,000

Note: Funding for this program at CDC included both grant and administrative funds. For comparability purposes, since ACL has separately requested increased administrative funding for this program, only grant funding amounts are displayed.

Budget Request:

The FY 2014 President's Budget request is $6,700,000, the same as the comparable FY 2012 enacted level. This reduction recognizes the tight budgetary environment while continuing to provide funding for the valuable information and referral work done by the PRC.

This work is vital for the support of the 6 million Americans currently living with paralysis. The average age of those reporting that they are paralyzed is 52 years old, and the average person reports having been paralyzed for 15.6 years.[84] Providing information, resources, and support to these individuals and their families is critical in avoiding adverse secondary health outcomes such as depression, infection, chronic pain issues, and upper extremity problems, all of which can seriously degrade quality of life and increase medical costs.

[84]http://www.christopherreeve.org/site/c.mtKZKgMWKwG/b.5184241/k.ACBD/Average_age_average_length_of_time_since_paralysis_and_SCI.htm

Resource and Program Data:

Paralysis Resource Center
(Dollars in thousands)

Mechanism	FY 2012 Enacted		FY 2013 Annual CR		FY 2014 President's Budget /2	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	1	6,465
Continuations	1	6,535	1	6,573	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		165		168		234
Total Resources		6,700		6,741		6,700

1/ Program Support -- Includes funds for Public Health Service Act statutory requirements, grant systems and review costs.

2/ Funding for this program was provided to the Centers for Disease Control and Prevention in FY 2012 and FY 2013. It is proposed for transfer to ACL in FY 2014.

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Program Administration

	FY 2012 Enacted	FY 2013 Annualized CR	FY 2014 President's Budget	FY 2014+/- FY 2012
Program Administration	$29,558,000	$29,739,000	$30,035,000	+$477,000
FTE[85]…………………	145	145	154	+9

Authorizing Legislation: Older Americans Act of 1965 (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the Help America Vote Act (HAVA), the Public Health Services Act (PHSA) and the Elder Justice Act.

FY 2014 Authorization .... All Expired Except the Elder Justice Act

Allocation Method ....Direct Federal/Contract

Program Description and Accomplishments:

Program Administration funds the direction of Administration for Community Living (ACL) programs established under the Older Americans Act (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the Help America Vote Act (HAVA), the Public Health Services Act (PHSA) and the Elder Justice Act. In addition, a small portion of these funds will be used to oversee and to close-out activities originally funded under the American Recovery and Reinvestment Act (ARRA) of 2009.

In FY 2012, ACL was created through the combination of three existing entities: the Administration on Aging (AoA), a freestanding HHS operating division; the Administration on Developmental Disabilities (ADD), part of the Administration for Children and Families (ACF);

[85] Overall FTE for ACL are projected at 184 in FY 2012, 187 in FY 2013, and 196 in FY 2014. FTE numbers for Program Administration only reflect those FTE funded from the Program Administration budget line, comparably adjusted to include FTE coming to ACL from the Office of Disability, the Administration on Developmental Disabilities, the Paralysis Resource Center, FTE related to funding provided via Intra-Departmental Delegations of Authority (IDDA) and Interagency Agreements (IAA). Not included are reimbursable FTE supported with HCFAC funds (8 FTE in each of FY 2012-FY 2014), FTE supported with mandatory funds (ADRCs and the National Clearinghouse on Long-Term Care Information-5 in FY 2012 and 4 in each of FY 2013-FY 2014), FTE related to transferred or new programs (SHIPs and SCSEP-26 in each of fiscal years 2012-2014) or FTE funded from the Prevention and Public Health Fund (CDSME) 1 FTE in FY 2012, 2 FTE in each of FY 2013 and FY 2014. These FTE are included in the appropriate narrative tables in other sections of this document.

and the Office of Disability (OD), part of the HHS Office of the Secretary (OS). FY 2014 is the first budget year in which the resources to administer ACL are requested in a single line item; amounts for FY 2012 and FY 2013 were provided through transfers of funding from ACF and OS, and are shown comparably. Funding totals in these years include comparable transfers from ACF of $4,982,000 in FY 2012 and $5,127,400 in FY 2013, and from OS of $1,264,000 in FY 2012 and $1,266,000 in FY 2013. ACL Program Administration funding will support the FTE overseeing the ACL programs currently funded with discretionary appropriations.

What Program Administration funding does not provide funding for is the FTE that will carry out many of the new programs that are proposed to come to, or to be funded under ACL beginning in FY 2014. Funding to support the 28 FTE in FY 2014 and related administrative expenses for these programs is requested separately as part of each program's respective request. These include 10 FTE for the State Health Insurance Assistance Program (SHIPs), proposed for transfer to AoA from the Centers for Medicare & Medicaid Services; 16 FTE for the Senior Community Service Employment Program, proposed for transfer from the Department of Labor; and 1 FTE for the Adult Protective Services Demonstration program. Funding also does not include resources for 14 additional FTE that will continue to be charged to these existing mandatory programs: Aging and Disability Resource Centers (ADRC) funding (4 FTE), Health Care Fraud and Abuse (HCFAC) funding (8 FTE), and Chronic Disease Self-Management Education (CDSME) (2 FTE).

Funding History:

Comparable funding for ACL Program Administration since the agency's creation in FY 2012 is as follows:

FY 2012 ....$29,309,000 145 FTE
FY 2013 CR. ....$29,653,000 145 FTE

FTE numbers have been adjusted to reflect comparable levels that include staff from the Office of Disability and the Administration on Developmental Disabilities. These numbers exclude FTE paid for with HCFAC funds and with direct mandatory appropriations, and FTE for three new or to be transferred programs.

Budget Request:

The FY 2014 request for Program Administration is $30,035,000, an increase of $477,000 over the FY 2012 comparable enacted level. This request will support 154 FTE, an increase of +9 FTE over the FY 2012 comparable level. This total reflects a comparable adjustment of

38 FTE in FY 2012 and 40 FTE in FY 2013 and FY 2014 for staff coming to ACL from ACF, from OS, and for one FTE related to the transfer of the Paralysis Resource Center.

The increase of $477,000 will be used to cover the estimated $192,300 cost of the projected FY 2014 pay raise as well as $133,000 in estimated costs for regional office moves. The balance, together with any funding not needed for moving costs, will be applied toward the cost of adding up to eight additional regional FTE as discussed below.

The FY 2013 President's Budget request for Program Administration includes $2,167,500 to cover headquarters move-related costs, specifically higher headquarters rent for ACL's existing building under the current extended lease, and additional rent that must be paid for the new headquarters location during the time that renovations are being made. Recent events have suggested that the move, previously anticipated to occur in late FY 2013, is likely to be delayed into the first or second quarter of FY 2014. Therefore, ACL requests that these funds be retained in its base to ensure that funding for the move continues to be available in FY 2014 as needed. Should these funds not be needed for the move, ACL will redirect these funds to hire up to eight additional staff in ACL's regional offices.

Various relocations of regional office space will also need to be funded in FY 2014. The Denver Regional Office currently occupies temporary space and is relocating back to the Federal building in Region VIII. The cost of this move is expected to be approximately $68,500. The Region X office in Seattle currently holds an expiring lease and will relocate to new office space in order to maximize space efficiencies.

Additional hires would address the continuing need in ACL regional offices for additional staff with sufficient expertise to conduct fiscal and programmatic oversight activities in ACL regional offices. These positions are critical to helping ensure that grantees understand and comply with laws, regulations, and program rules. Regional staff serve as the primary project officers for Older Americans Act formula grant programs (as well as for the related Tribal programs), conducting oversight and monitoring, as well as providing technical assistance.

ACL currently has only 33 regional staff overseeing 447 OAA State formula grants (across 8 different programs) as well as 727 OAA Tribal grants (across 3 different programs). Additional regional staff are needed to increase the level of oversight provided to these core programs, provide additional technical assistance to grantees, and enhance analysis of existing program and fiscal data. The need for additional regional staff is even greater as current regional staff are also being asked to take on new responsibilities related to programs serving persons with disabilities. By redirecting funding to address these staffing shortages, ACL will be able to begin to add the new FTE that the regional offices must have to support these efforts.

AoA Headquarters Lease Renewal Process

The ten-year lease on ACL's headquarters space ended on September 30, 2012, although ACL continues to occupy the same space under a temporarily extended lease at a significantly higher monthly cost. The new headquarters location will not only provide an opportunity to reduce ACL's physical footprint, but more importantly to also consolidate its staff from three locations to one central space. The new space is currently under lease through April 2013, after which ACL will be able to initiate renovations to meet its unique needs. ACL is working with the HHS Facilities and Logistics Service (FLS) to finalize the move once renovations are complete, with the move now estimated to occur by the end of calendar year 2013.

Remaining relocation costs are currently estimated to total approximately $3,000,000 to cover procurement of systems furniture and IT, the physical move and to surplus outdated furniture at the current location. Funding to cover these costs was included in a consolidated FY 2013 Departmental request for the Public Health and Social Services Emergency Fund associated with procuring new long term leases centrally. ACL will continue to work closely with FLS staff to refine our schedule and milestones and ensure that cost estimates are sufficient to cover all costs associated with the lease renewal, including build-out, moving, and rent.

Performance Measures

Improving program efficiency, improving client outcomes, and effective targeting of services to vulnerable elders are the three performance measures used to assess the effectiveness of the AoA's Aging Services programs as a whole. Program Administration is not directly measured by AoA's performance indicators, nor by specific outcomes, and it does not have specific output measures. Rather, the program provides the administrative resources that enable ACL to carry out its programmatic activities and achieve its performance goals.

Budget Authority by Object Class

Administration for Community Living

(Dollars in Thousands)

	FY 2012 Enacted	FY 2014 Budget	FY 2014 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	17,168	18,047	879
Other than full-time permanent (11.3)	330	332	2
Other personnel compensation (11.5)	148	149	1
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**17,646**	**18,528**	**882**
Civilian benefits (12.1)	4,655	4,683	28
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**22,301**	**23,211**	**910**
Travel and transportation of persons (21.0)	728	509	(219)
Transportation of things (22.0)	3	3	-
Rental payments to GSA (23.1)	3,334	3,354	20
Communication, utilities, and misc. charges (23.3)	181	181	-
Printing and reproduction (24.0)	16	16	-
Other Contractual Services:			
Advisory and assistance services (25.1)	19,882	23,722	3,840
Other services (25.2)	520	446	(74)
Purchase of goods and services from government accounts (25.3)	8,160	8,160	-
Operation and maintenance of facilities (25.4)	1	1	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**28,563**	**32,329**	**3,766**
Supplies and materials (26.0)	132	132	-
Equipment (31.0)	238	238	-
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,096,963	2,034,782	(62,181)
Interest and dividends (43.0)	-	-	-
Refunds (44.0)	-	-	-
Total Non-Pay Costs	**2,130,158**	**2,071,544**	**(58,614)**
Total Budget Authority by Object Class	**2,152,459**	**2,094,755**	**(57,704)**

Salaries and Expenses

Administration for Community Living

(Dollars in Thousands)

	FY 2012 Enacted	FY 2014 Budget	FY 2014 +/- FY 2012
Personnel compensation:			
Full-time permanent (11.1)	17,168	18,047	879
Other than full-time permanent (11.3)	330	332	2
Other personnel compensation (11.5)	148	149	1
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**17,646**	**18,528**	**882**
Civilian benefits (12.1)	4,655	4,683	28
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**22,301**	**23,211**	**910**
Travel and transportation of persons (21.0)	728	509	(219)
Transportation of things (22.0)	3	3	-
Rental payments to Others GSA (23.2)	3,334	3,354	20
Communication, utilities, and misc. charges (23.3)	181	181	-
Printing and reproduction (24.0)	16	16	-
Other Contractual Services:			
Advisory and assistance services (25.1)	19,882	23,722	3,840
Other services (25.2)	520	446	(74)
Purchase of goods and services from government accounts (25.3)	8,160	8,160	-
Operation and maintenance of facilities (25.4)	1	1	-
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**28,563**	**32,329**	**3,766**
Supplies and materials (26.0)	132	132	-
Total Non-Pay Costs	**32,957**	**36,524**	**3,567**
Total Salary and Expense	**55,258**	**59,735**	**4,477**
Direct FTE	111	179	188

FTE Detail

Administration for Community Living

	2012 Actual Civilian 1/	2012 Actual Military	2012 Actual Total	2013 Est. Civilian	2013 Est. Military	2013 Est. Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total
Immediate Office of the Administrator									
Direct:	15		15	17		17	17		17
Reimbursable:	0		0	0		0			0
Total:	15	0	15	17	0	17	17	0	17
Administration on Aging									
Direct:	25		25	34		31	34		34
Reimbursable:	3		3	3		3	3	3	6
Total:	28	0	28	37	0	37	37	0	37
Administration on Intellectual & Developmental Disabilities									
Direct:	0		0	24		24	25		25
Reimbursable:	0		0			0			0
Total:	0	0	0	24	0	24	25	0	25
Center for Management and Budget									
Direct:	24		24	33		33	33		33
Reimbursable:	0		0			0			0
Total:	24	0	24	33	0	33	33	0	33
Center for Disability and Aging Policy									
Direct:	19		19	26		26	26		26
Reimbursable:	0		0			0			0
Total:	19	0	19	26	0	26	26	0	26
Office of Regional Operations									
Direct:	28		28	45		45	53		53
Reimbursable:	5		5	5	0	5	5	0	5
Total:	33	0	33	50	0	50	58	0	58
OPDIV FTE Total	**119**	**0**	**119**	**187**	**0**	**187**	**196**	**0**	**196**

Average GS Grade

FY 2010	12.8
FY 2011	12.8
FY 2012	12.8
FY 2013	12.7
FY 2014	12.7

1/ FTE in FY 2012 do not include FTE for AIDD, SHIPS or SCSEP, for which accurate actual data is unavailable.

Detail of Positions

Administration for Community Living

	2012 Actual	2013 Base	2014 Budget
Executive level I			
Executive level II			
Executive level III			
Executive level IV	1	1	1
Executive level V			
Subtotal	1	1	1
Total - Exec. Level Salaries	$154,981	$155,578	$157,134
ES-6			
ES-5	2	2	2
ES-4			
ES-3			
ES-2	3	2	2
ES-1			
Subtotal	5	4	4
Total - ES Salary	$835,624	$655,924	$655,924
GS-15	24	26	26
GS-14	29	28	31
GS-13	51	52	77
GS-12	20	24	31
GS-11	7	7	9
GS-10	2	2	2
GS-9	6	9	9
GS-8	1	1	1
GS-7	3	2	2
GS-6	1	1	1
GS-5	0	0	0
GS-4	2	2	2
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	146	154	191
Total - GS Salary			
Average ES level	3.2	3.5	3.5
Average ES salary	$167,125	$163,981	$163,981
Average GS grade	12.8	12.7	12.7
Average GS salary	$101,032	$100,740	$100,897
Average GS salary/benefits	$129,321	$128,747	$129,148

Programs Proposed for Elimination

Administration for Community Living

ACL has no programs proposed for elimination.

Federal Employment Funded by ACA

Administration for Community Living

Program	Section(s)	FY 2011 $ /1	FY 2011 FTEs	FY 2011 CEs	FY 2012 $ /1	FY 2012 FTEs	FY 2012 CEs
New programs authorized and funded by PPACA							
Aging and Disability Resource Centers	Section 2405	$ 10,000	3	0	$ 10,000	4	0
New programs funded from the PPHF under PPACA							
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ -	0	0	$ 6,000	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$ -	0	0	$ 10,000	0	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ -	0	0	$ -	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ -	0	0	$ 4,000	0	0
Pre-existing programs funded by PPACA							
National Clearinghouse for Long-Term Care Information 2/	Title VIII	$ 3,000	0	0	$ 3,000	1	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$ -	0	0
Programs authorized by PPACA but funded by other sources		0	0	0	0	0	0
Oversight and administration activities		0	0	0	0	0	0

Program	Section(s)	FY 2013 $ /1	FY 2013 FTEs	FY 2013 CEs	FY 2014 $ /1	FY 2014 FTEs	FY 2014 CEs
New programs authorized and funded by PPACA							
Aging and Disability Resource Centers	Section 2405	$ 10,000	4	0	$ 10,000	4	0
New programs funded from the PPHF under PPACA							
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	N/A	0	0	$ -	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	N/A	0	0	$ 10,000	2	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	N/A	0	0	$ 10,500	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	N/A	0	0	$ 4,200	0	0
Pre-existing programs funded by PPACA							
National Clearinghouse for Long-Term Care Information 2/	Title VIII	$ 86	0	0	$ -	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ 25,000	0	0	$ -	0	0
Programs authorized by PPACA but funded by other sources		0	0	0	0	0	0
Oversight and administration activities		0	0	0	0	0	0

1/ Indicate total amount of funding for Program X under the denoted section(s) of PPACA.

2/ Funding for the clearinghouse was first provided directly to ACL in FY 2012. Prior to FY 2012, the Administration on Aging received funding for this activity through an Intra-Agency Agreement (IAA with CMS).

Significant Items in Appropriations Committee Reports

Item 1

***Mental Health*-** The Committee notes that approximately 20 to 25 percent of older adults have a mental or behavioral health problem, with white men aged 85 and older having the highest rates of suicide of any group in the United States. The Committee urges ACL to expand its efforts to address the mental and behavioral health needs of older adults, including implementation of the mental and behavioral health provisions in the OAA. The Committee also urges ACL to designate an officer responsible for administering mental health services for older Americans.

Action taken or to be taken

The Administration on Aging (AoA) within ACL is an active partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) on a variety of initiatives. AoA and SAMHSA entered into a Memorandum of Understanding in FY 2011 to formally collaborate on the Older Adult Targeted Capacity Expansion (TCE) Grant Program. Five grants were awarded to community organizations to provide services for older adults through aging-mental health partnerships. An Older Adults Technical Assistance Center was also established to provide assistance to the TCE grantees, State Units on Aging, Area Agencies on Aging, and other community aging and mental health providers to assist them in developing, implementing and sustaining effective mental health programs for older adults. Mental health screening, treatment services for older individuals and increasing public awareness and reducing the stigma associated with mental disorders in older individuals will be key components of the work of the grantees and the Center. AoA and SAMHSA will continue to collaborate on technical assistance activities for this program. In addition, AoA and SAMHSA have made two joint presentations at national conferences regarding older adults mental health programs.

AoA also participates in mental-health related workgroups and committees both inside and outside the Department of Health and Human Services (DHHS), including: the Federal Workgroup on Suicide Prevention; the Federal Mental Health Coalition; the Action Alliance for Suicide Prevention and its Clinical Care Workgroup; and the HHS Behavioral Health Coordinating Council and its Prescription Drug Abuse sub-committee. An Aging Services Program Specialist, with extensive knowledge in the prevention and treatment of mental health issues among older adults, has been designated to provide guidance both within and outside AoA, on behavioral health program and policy development. AoA also commissioned a study in FY2 011 through the National Council on Aging's Center for Health Aging entitled "*Advancing Older Adult Mental Health: Lessons Learned from Partnerships between State Units on Aging and State Mental health Authorities*". The purpose of this study was to learn from the experiences of five strong state partnerships that have increased or improved access to evidence-based or evidence-informed (EB/EI) interventions shown to improve the health of older adults

and adults with/or at risk of mental health or substance use disorders. The results of this study will help inform AoA program and policy development in the area of mental health.

Through its health programs, AoA has also encouraged States and Area Agencies on Aging to use evidence-based programs designed to reduce reduce/prevent depression and improve quality of life in older adults including Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and PEARLS (Program to Encourage Rewarding Lives for Seniors. State plan guidance developed by AoA for FY 2013, similar to past guidance, will direct States and Area Agencies on Aging to implement the provisions related to mental and behavioral health that were signed into law as part of the Older Americans Act Amendments of 2006.

Item 2

The Committee recognizes the essential role of family caregivers who provide a significant proportion of our Nation's health and long-term services and supports for the chronically ill and aging. Respite care can provide family caregivers with relief necessary to maintain their own health, bolster family stability and well being, and avoid or delay more costly nursing home or foster care placements. The Committee urges the Secretary to ensure that State agencies, as well as aging and disability research centers [ADRCs], use these funds to serve all age groups, chronic conditions, and disability categories equitably and without preference.

Action taken or to be taken

Family caregivers are the cornerstone of long term services and supports in the United States. Family members provide an estimated 80% of the assistance necessary to keep individuals of all ages independent in their homes and communities. In recognition of the critical role families play in the lives of older individuals with long-term care needs, Congress created the National Family Caregiver Support Program (NFCSP) as part of the 2000 reauthorization of the Older Americans Act. Under the NFCSP the following populations of family caregivers are eligible to be served: adult family members caring for individuals 60 years of age and older; adult family members caring for individuals of any age with Alzheimer's disease and related disorders; grandparents and other relatives (age 55 and older) providing care to children under the age of 18; and grandparents and other relatives (age 55 and older) providing care to adults, age 18 – 59 years of age, with disabilities.

For over twelve years, the Administration on Aging (AoA) has supported the Aging Network's implementation of the requirements of the NFCSP in a variety of ways. During that time, states and local communities have made tremendous progress in designing and administering flexible, accessible, and consumer-directed Caregiver Support Programs. To support program implementation efforts, in 2001 AoA funded 28 National Innovations Programs and 11 Projects of National Significance to foster the development and testing of new approaches for sustaining the efforts of families and other informal caregivers of those intended to be served by the

NFCSP. Those projects broke ground in several key areas including state/local caregiver coalition development; enhancing the capacity of the aging network to meet the needs of this new population of service recipient; and applying concepts of the NFCSP to persons with developmental disabilities through enhanced planning and coordinating of supportive services to older caregivers of children and adults with intellectual and developmental disabilities. In 2009, AoA once again funded targeted technical assistance to the aging network to further strengthen its ability to meet program objectives. As a result, the aging network was again supported in program and infrastructure development with targeted training, one-on-on guidance and the dissemination of best practices in program development.

Family caregiving is a lifespan issue. Many family members provide care for loved ones with special needs over the course of several years, or an entire lifetime. To address the specific respite and related needs of family caregivers across the lifespan, AoA began implementation of the Lifespan Respite Care Program in 2009. Lifespan respite programs are coordinated systems of accessible, community-based respite care services for family caregivers of children or adults of all ages with special needs. Such systems bring together disparate funding streams to help support, expand and streamline the delivery of respite services while providing a mechanism for the recruitment and training of a respite workforce and support and empower family caregivers.

Since 2009, 30 states and the District of Columbia have been actively engaged in implementing the requirements of the Lifespan Respite Program via grants from AoA. Each of the grantees has used their initial three-year grant to advance the following objectives: expand and enhance respite services, improve dissemination and coordination of respite services, and provide, supplement or improve access and quality of respite services. Specific activities have included the creation of dedicated respite web sites, worker registries and data bases of new and existing respite programs; development and deployment of new training programs for volunteer and paid respite workers; the creation of voucher respite programs to maximize consumer choice and control over how respite services are obtained; and the development and deployment of marketing and outreach campaigns to more effectively target and educate family caregivers about the need to take time for themselves.

Item 3

The Committee notes that falls are the leading cause of fatal and nonfatal injuries for those 65 and older. Each year, 1-in-3 Americans aged 65 and older falls. Every 15 seconds, an older adult is treated in the emergency room for a fall-related injury. Preventing falls will help seniors stay independent and in their homes, avoiding costly hospitalizations and hip fractures, which frequently lead to nursing home placement. The Committee intends that funds provided to ACL should be used for public education about the risk of these falls, as well as implementation and dissemination of community-based strategies that have been proven to reduce the incidence of falls among seniors.

Action taken or to be taken

No funding was provided by the Congress for this activity. However, AoA has recognized for some time that Elder Falls Prevention is one of many evidence-based approaches with the potential to make positive differences in outcomes for seniors. AoA will continue to encourage States to look at this approach in conjunction with available Preventive Health Services funds which beginning in FY 2012 must be spent on evidence-based activities similar to a discretionary funding opportunity AoA made available in 2006.

During 2006-2007, AoA initiated its state-based Evidence-Based Disease and Disability Prevention Program. Through both public and private partnerships, 27 states have deployed evidence-based interventions whose primary focus is to help enable adults to maintain their health, wellness, and independence. AoA required each state to implement the Stanford University Chronic Disease Self-Management Education (CDSME) program. In addition, each state participating in this grant program was required to select and implement one or more other evidence-based programs, including Falls Management programs such as Matter of Balance, which addresses fear of falling, and Stepping On and Tai Chi, which build muscle strength and improve balance to prevent falls.

Since 2004 AoA and CDC have partnered on three activities related to older adult falls:

- Supporting a collaborative initiative by the National Council on Aging (NCOA), the Archstone Foundation, the Home Safety Council, and other partners to address the growing problem of falls and fall-related injuries among adults aged 65 years and older. The Falls Free Coalition, formed in 2004 as a result of this initiative, includes more than 55 organizations and employs a collective approach to promoting a national fall prevention action plan.
- Assessing the long-term impact of *Matter of Balance*, a program designed to reduce fear of falling, increase self-efficacy and a sense of control in relation to fall risk, and increase physical and social activity.
- Estimating the average program implementation and maintenance costs and comparing these costs across three AoA-funded fall prevention programs: *Matter of Balance*, *Tai Chi: Moving for Better Balance*, and *Stepping On*.

Finally, AoA will continue to coordinate with the Centers for Disease Control and Prevention around efforts like CDC's Unintentional Injury Program.

Item 4

The Committee strongly supports the SMP program, administered by ACL with historical financial assistance from CMS. The Committee is concerned that the return on investment [ROI] calculation included in the performance metrics of the program does not adequately reflect outcome data on SMP fraud referrals. The Committee requests that a more accurate ROI

calculation be developed for this important program. The Committee requests that ACL, CMS, DOJ, and the HHS OIG work to improve the process of informing beneficiaries when their tips directly result in a conviction, a recovery, or a change to Medicare policies.

Action taken or to be taken

The Administration for Community Living's Senior Medicare Patrol (SMP) program fully agrees with the requests of the Committee. Much ground work has been done to better demonstrate the return on investment (ROI) for this program and more work is planned.

To accurately quantify the ROI for the SMP program, one must first understand some of the issues inherent in the program. The SMP program is a key part of the much larger fraud prevention and mitigation activities of HHS and DOJ. The mission of the program is to "*Empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report healthcare fraud, errors, and abuse through outreach, counseling, and education."* The SMP program accomplishes its mission by developing a network of nearly 5,000 volunteers to reach out to Medicare beneficiaries across the country. Annually, the SMP message directly reaches more than 2,000,000 people, plus untold others reached through media campaigns. While the SMP program does receive complaints of potential fraud which are properly provided to the OIG or to CMS, we also educate beneficiaries on how to go directly to law enforcement if they suspect fraud. While the direct link between the beneficiary and law enforcement is appropriate, it decreases the demonstrable impact of the SMP, because law enforcement is unaware of the important role played by the SMP program in effecting the referral.

Once a referral of potential fraud is provided to the OIG or CMS, it is outside the SMP program's authority to further pursue that matter, as the SMP program is not designed to be, nor should it be, investigative in nature. The decisions to pursue criminal investigation and any subsequent prosecution in these cases are made by the proper authorities at OIG, CMS, or DOJ. The SMP program is unable to reflect ROI for those referrals of potential fraud which law enforcement chooses not to pursue. In addition, SMP referrals may work in concert with other information sources or referrals received by law enforcement to prosecute a case. Yet, in such cases the SMP, as one of multiple contributors to a successful prosecution, does not receive attribution for the resulting monetary outcome.

While the above programmatic issues are inherent to this program, the SMP program has begun taking steps to mitigate these issues:

- The SMP program currently has a contract for a program evaluation. Part of the evaluation is to examine the performance metrics that are currently being tracked to identify if they are appropriate for the program and whether the metrics are accurately being reported from each of the 54 SMP projects. The results of this evaluation, anticipated in December 2013, will help the program better quantify ROI.

- The SMP program has been operating a pilot program with 20% of the states for nine months. When one of the pilot states has a potential fraud referral, they send it to the SMP national Program Managers who meet in person with OIG investigators in Washington, DC. This relationship has developed to the point that the SMP program has begun getting back much more detailed outcomes from fraud referrals. Due to the success of the pilot, the program will roll this out nationally on May 1st. This should provide the program the opportunity to better identify its ROI.
- The SMP program has been working with the OIG – Office of Evaluations to better align the criteria for calculating the program's savings with those used by both CMS and OIG for their respective performance reports. Starting with the upcoming OIG performance report on the SMP program (due May 2013), new standards enabling better reflection of the program's ROI will be in place.

The SMP program will continue to work with its partners at both HHS and DOJ to more accurately demonstrate the ROI of the program and ensure that the results of the referrals are being provided back to the beneficiaries when appropriate. It should be noted however, that any measure of the SMP program's return on investment would be necessarily understated because it would not include the deterrence effect of the program. ACL cannot calculate the amount of fraud that would have occurred but for the heightened scrutiny resulting from SMP's outreach and education efforts.

Prevention and Public Health Fund

Administration for Community Living

Activities proposed for funding from the Prevention and Public Health Fund are addressed more fully throughout the ACL FY 2014 Congressional Justification. A summary of these activities follows.

Chronic Disease Self-Management Education - ACL requests FY 2014 funding for Chronic Disease Self-Management Education totaling $10,000,000 from the Prevention and Public Health Fund, the same as the FY 2012 enacted level. CDSME, by emphasizing an individual's role in managing his/her illness, helps participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. Funds for CDSME will support competitive grants to states as well as an inter-agency agreement with CMS to evaluate the program's impact on healthcare utilization, a participant survey, and a technical resource center on evidence-based disease prevention programs.

Alzheimer's Disease Initiative – Services - The FY 2014 budget includes $10,500,000 for Alzheimer's Disease Services from the PPHF. No funding was allocated for this program in FY 2012. ACL will use these funds to award competitive cooperative agreements to states, tribes, and/or large localities to expand a proven evidence-based pilot on dementia capability. The demands of caregiving for a person with Alzheimer's disease can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient. The systems created through these grants will assist caregivers by ensuring that their needs, and the needs of their loved ones with Alzheimer's disease, are addressed. Since the focus of these cooperative agreements will be to facilitate permanent systems change, an emphasis will be placed on implementing systems that can operate out of ongoing funding streams and will not require new sources of funds to maintain.

Alzheimer's Disease Initiative – Outreach Campaign – ACL is requesting $4,200,000 from the PPHF in FY 2014 to continue its efforts on a public awareness Alzheimer's Disease outreach campaign. This represents an increase of +$200,000 over the FY 2012 amount received. The campaign's goal is to inform people caring for people with Alzheimer's disease about the federal, state, local, and nonprofit resources available to help them. These funds will be used in cooperation with the existing contractor to continue to develop both the information available on the alzheimers.gov web site and the effectiveness of the media outreach.