DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2015

Administration for Community Living

Justification of Estimates for Appropriations Committees

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I am pleased to present the Administration for Community Living's (ACL) FY 2015 President's Budget request. Like ACL's first budget request in FY 2014, this request includes our two main program components: the Administration on Aging and the Administration on Intellectual and Developmental Disabilities.

ACL's FY 2015 request matches the FY 2014 enacted level in nearly all respects, which reflects our first and highest priority: maintaining funding for ACL's core programs. The vast majority of ACL's funding is for direct services and supports, and the States, Tribes, and localities that depend upon these funds have limited options to offset losses of Federal funding. Maintaining funding for these programs is therefore critical to our efforts to help more people to have the option to live in their homes and to fully participate in their communities, including the more than 50 percent of home-delivered meal recipients who report that these meals represent the majority of their food in a given day.

This budget also includes several new initiatives. The first, recognizing the Administration on Aging's longstanding emphasis on elder justice, is funding for the Elder Justice Act (EJA) at HHS. The issues of elder abuse, neglect, and exploitation affect millions of Americans. Reflecting HHS' leadership of the Elder Justice Coordinating Council, funding the Elder Justice Act would firmly establish ACL as a federal resource on nationwide issues of elder justice and respond to the call from the Government Accountability Office (GAO) for Federal leadership.

Second, ACL proposes a new initiative addressing the transition from adolescence to adulthood for young people with developmental disabilities. This initiative would respond to GAO and Congressional inquiries seeking to develop best practices and an evidence base in supporting young people with developmental disabilities in this particularly important transition.

In addition, ACL is proposing renewed mandatory funding for the Aging and Disability Resource Centers (ADRC) program, which has demonstrated proven success in helping connect people to the resources they need to continue living independently in their communities. These successful systemic changes are ready to be expanded to the remaining States, but continued funding is vital to the program's nationwide expansion.

Finally, ACL is proposing new funding to hold a White House Conference on Aging, as well as the establishment of a Holocaust Survivors Fund that would assist elderly Holocaust survivors to remain in their homes and communities.

ACL's first year has been a time of growth, learning, and a rededication of our efforts to ensure that all people, regardless of age or disability, can live and thrive in their communities. This budget will allow us to continue serving our populations and position us for greater successes on their behalf.

Kathy Greenlee
Administrator and Assistant Secretary for Aging

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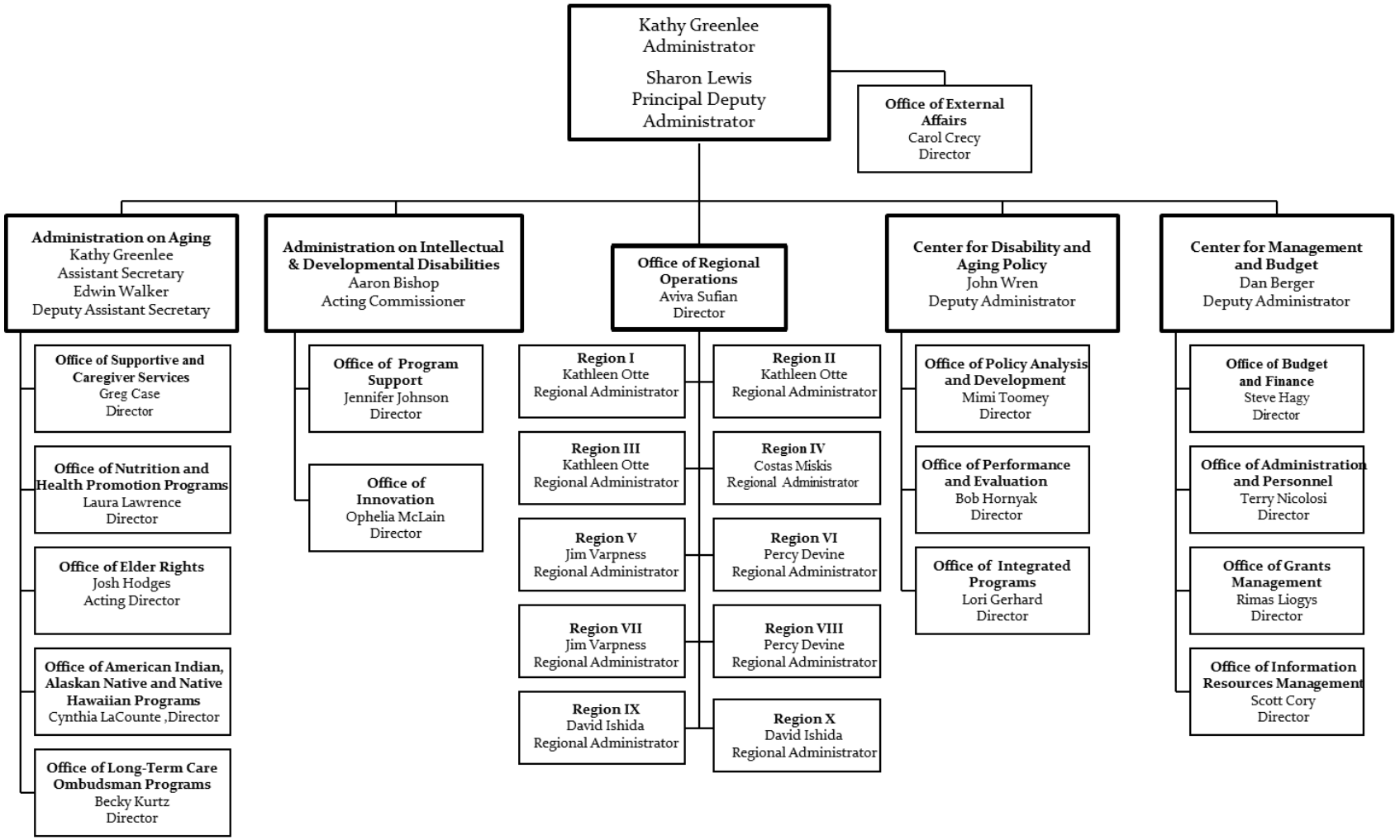
ADMINISTRATION FOR COMMUNITY LIVING ORGANIZATIONAL CHART



As of February 10, 2013

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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. ACL serves as a single agency charged to work with States, localities, Tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities 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 older adults 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), 618 Area Agencies on Aging (AAA), 246 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 older adults 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 meals. These programs also support family caregivers, address issues of exploitation, neglect and abuse of older adults, and adapt services to the needs of Native American elders.

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 such as rehabilitative services that

promote self-determination, independence, productivity, integration, and inclusion in all facets of community life.

ACL will continue to 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 older adults and people with disabilities. ACL's Center for Aging and Disability Policy provides a focal point for these efforts to develop new policies and initiatives that support both older Americans and persons with disabilities in accessing services and supports while fully participating in their communities.

Overview of Budget Request

The FY 2015 President's Budget discretionary request for the Administration on Community Living (ACL) is $2,062,279,000, a reduction of -$34,350,000 below the FY 2014 enacted level. This budget includes as its top priority the maintaining funding for ACL's core programs. The vast majority of ACL's funding is for direct services and supports, and the States, Tribes, and localities that depend upon these funds have limited options to offset losses in these areas. Maintaining this funding, which has the strongest impact on America's most vulnerable seniors, is critical to ensuring that they can continue to live in their homes and communities for as long as possible.

Under the request, the Senior Community Service Employment Program (SCSEP), currently housed at the Department Labor, continues to be proposed to transfer to ACL. SCSEP is the only program authorized under the Older Americans Act (OAA) that is not currently housed at ACL, and would benefit immensely from better integration with other OAA community-based programs.

This budget also includes several new initiatives. The first, recognizing the Administration on Aging's longstanding emphasis on elder justice, is for $25 million to fund the Elder Justice Act at HHS. The issues of elder abuse, neglect, and exploitation affect millions of Americans. Reflecting HHS' leadership of the Elder Justice Coordinating Council, funding the Elder Justice Act would firmly establish HHS as a Federal leader on nationwide issues of elder justice and respond to the call from the Government Accountability Office (GAO) for Federal leadership.

Second, ACL proposes a new $5 million initiative addressing the transition from adolescence to adulthood for young people with developmental disabilities. This initiative would respond to GAO and Congressional inquiries seeking coordinated services to develop best practices and an evidence base in supporting young people with developmental disabilities in this particularly fraught transition, with the aim of improving health, education, and employment outcomes and helping these youth to be contributing members of their communities.

The Budget includes $20 million each year, for five years, starting in FY 2015 in mandatory funding for the Aging and Disability Resource Centers. ACL will use these funds to strengthen the program nationwide and implement national standards that will help States develop more efficient, cost-effective, and consumer-centered systems of long-term services and services and supports.

Three additional programs are proposed for new funding in FY 2015. The budget includes $5,000,000 for the establishment of a Holocaust Survivor Fund, which will create a public-private partnership in order to address the unique needs of the country's aging Holocaust

survivor population. Holocaust survivors are an extremely vulnerable population, and they often experience unmet community support needs. This Fund would help bridge funding and service gaps, generating innovative approaches for the coordination of home and community-based services and supports to assist this population to age with dignity in their own homes and communities. ACL's request also includes $3,000,000 for the decennial White House Conference on Aging. The last Conference was held in 2005 and addressed the aging of the baby boomer generation, and ACL looks forward to working with the White House in 2015 to develop a conference that will address the needs of today's seniors. Finally, the request includes $1,000,000 to reestablish the National Clearinghouse on Long-Term Care, an outreach effort to help individuals plan for their future long-term care needs.

The FY 2015 program level also requests $27,700,000 from the Prevention and Public Health Fund authorized by the Affordable Care Act. Of this, $8,000,000 would support continued funding for Chronic Disease Self-Management Education programs across the nation, $5,000,000 would support falls prevention programs, and 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 individuals with Alzheimer's Disease and their caregivers. In addition, the overall budget includes $10,710,000 in mandatory funding for Health Care Fraud and Abuse Control activities.[1]

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 U.S. Census Bureau also estimates that 37.6 million people have a disability, representing 12.2 percent of the civilian noninstitutionalized population. Broken down by age group, this includes:

- 4.1 percent of children 5 to 17,
- 10.1 percent of people 18 to 64, and
- 35.9 percent of adults 65 and older. [4]

[1] $10,710,000 is a placeholder amount for FY 2015. The Secretary and Attorney General will determine the final amount.

[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, <http://www.census.gov/population/projections/data/national/2012/downloadablefiles.html> Accessed 09 February 2014.

[3] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 09 February 2014.

[4] U.S. Census Bureau, 2012 American Community Survey 1-Year Estimates. Table DP02: Selected Social Characteristics In The United States.

Studies indicate that individuals with developmental disabilities comprise between 1.2 and 1.65 percent of the U.S. population, or between 3.8 and 5.2 million individuals.[5]

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

For example, an 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 support 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 challenges of caregiving, the costs of providing this care will fall on other, more costly 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:

Administration on Aging (AoA)

The request includes $1,466,277,000, an increase of +$25,000,000 over the FY 2014 enacted level, for programs to maintain seniors' health and independence, support caregivers, and protect vulnerable older Americans. These include:

- *Health and Independence Programs ($1,228,848,000)*, 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.

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http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_DP02&prodType=table Accessed 09 February 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, 2013

[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

- *Caregiver Services ($168,277,000)*, 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 ($69,152,000)*, 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 $25 million for an initiative to begin funding the Elder Justice Act, specifically in the areas of Adult Protective Services and research and evaluation.

- *Senior Community Service Employment Program ($380,000,000)*, which 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. The FY 2015 budget continues to propose the transfer of SCSEP from the Department of Labor. SCSEP it 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 the difficult decision to reduce the Senior Community Service Employment program by -$54,371,000 from the FY 2014 enacted. 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.

Administration on Intellectual and Developmental Disabilities (AIDD)

The request includes $165,222,000, an increase of +$5,000,000 over the FY 2014 enacted level, for six programs that address the needs of those with developmental disabilities. These include:

- *State Councils on Developmental Disabilities ($70,876,000)*, 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.

[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.

- *State Protection and Advocacy Systems ($38,734,000),* 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.

- *University Centers for Excellence in Developmental Disabilities ($36,769,000),* 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 ($8,880,000),* which fund discretionary 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. This includes $1,000,000, first appropriated directly to ACL in FY 2014, to support transportation initiatives that demonstrate the inclusion of people with disabilities and seniors in the development and planning of community transportation systems.

- *Help America Vote Act (HAVA) grants ($4,963,000),* 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.

- *Youth Transitions Initiative ($5,000,000),* to invest in initiatives that coordinate services to address the comprehensive needs of youth with intellectual and developmental disabilities as they transition from adolescence into young adult life across all domains – health, education, employment, human services, and community living.

Aging and Disability Programs

The FY 2015 budget request also continues to fund the State Health Insurance Assistance Program (SHIPs) and the Paralysis Resource Center (PRC), both of which were transferred to ACL in FY 2014. 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. The 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. ACL is also requesting $20,000,000 in mandatory funding for the Aging and Disability Resource Centers program (existing mandatory funding for which expires in FY 2014), which has shown great promise and is ready to be taken to nationwide scale. In addition, ACL is requesting $1,000,000 to re-establish the National Clearinghouse on Long-Term Care, an outreach effort to help individuals plan for their future long-term care needs.

Finally, ACL's request includes a single budget line for Program Administration of $30,035,000, the same as the FY 2014 enacted level, which would support an estimated 143 FTE.

ACL looks forward to continuing a dialogue about how the Administration and HHS's broader resources can be leveraged to contribute and enhance community living and full participation for all Americans. 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 admission, hospital readmission, and emergency room visits.

Overview of Performance

The Administration for Community Living (ACL) is focused on the unique needs of individual groups, such as persons with developmental disabilities or frail seniors, and their caregivers 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. The agency's mission is to maximize the independence, well-being, and health of older adults, people with disabilities and their families and caregivers. ACL accomplishes this by advancing effective policies, services, and supports. Below, an overview of performance is provided for Administration on Aging (AoA) and Administration on Intellectual and Developmental Disabilities (AIDD).

AoA Overview of Performance

AoA program activities have a fundamental common purpose which reflects the legislative intent of the Older Americans Act (OAA): 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 (OAA Section 301).

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 performance 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 client outcome measure includes indicators focusing on consumer assessment of service quality, 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 ACL's goals and objectives and in turn measure success in accomplishing ACL's mission.

Performance Highlights

An analysis of AoA's performance trends shows that through FY 2012 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 and federal budgets, and the expanding needs of both the elderly and their caregivers. Below are some examples of these successes:

- OAA programs help older Americans 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 entry. 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 2005, one-third of home-delivered nutrition clients (313,362) lived with three or more ADL impairments and by FY 2012 the proportion of clients with three or more impairments grew to 43.5% or 369,914 clients, a 30% increase. Another approach to measuring AoA's success is the nursing home predictor score. The components of this composite score are predictive of nursing home entry based on scientific literature and AoA's Performance Outcomes Measures Project (POMP) which developed and tested 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, meaning AoA is reaching those most in need of help. In 2003, the nursing home predictor score was 46.57 and data show it has increased to 63.0 in FY 2012.

- 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 2012 The National Aging Services Network served 9,206 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 509 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 2012, over 93 percent of transportation clients and caregivers rated services good to excellent. To help ensure the continuation of these trends, AoA uses 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 2015

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 2015 as enacted in FY 2014, 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. Regardless of the historic nature of state and local support for these programs, AoA expects declining leveraged funds, as state, local, and private budgets face economic hardships. This will adversely impact performance through FY 2015.

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 ACL's goals and objectives and most strongly contributing to the HHS Strategic Plan goals of advancing the health, safety and well-being of the American people and ensuring efficiency, transparency, accountability and effectiveness of HHS programs. Below is a summary of each measure, its indicators and their relationship to ACL's goals and the HHS Strategic Plan.

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. For FY 2015, there are two efficiency indicators for AoA program activities, both consistently meet or exceed targets. 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.

Improvements in program efficiency support ACL's mission and HHS's strategic plan objective 4.A to strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud and integrating financial, performance, and risk management. 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.

Measure 2: Improve Client Outcomes

While improving efficiency, AoA is committed to maintaining quality and improving client outcomes. The FY 2015 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 indicators 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 indicators for the national Long-Term Care Ombudsman Program (LTCOP) focus on the core purpose of this program: advocacy on behalf of older adults. While some indicators experience year-to-year variation, all indicators have trended in the desired direction and the vast majority meet or exceed targets annually.

This measure supports ACL's overall mission and Goal 4 of its strategic plan; enable people with disability and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports to family caregivers. 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 and social well-being for individuals, families, and communities; 3.C improve the accessibility and quality of supportive services for people with disabilities and older adults; and 3.D promote prevention and wellness across the lifespan.

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. AoA's four indicators for effective targeting capture success with regards to increasing services to family caregivers; providing services to those most at risk for

institutionalization; insuring that older adults living in rural areas are receiving long-term services and supports; and addressing the needs of the economically vulnerable. While some indicators that are more budget sensitive have experienced yearly fluctuations, the overall performance since FY 2006 has increased.

Effective targeting of OAA services supports ACL'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 for individuals, families, and communities; 3.C improve the accessibility and quality of supportive services for people with disabilities and older adults; and 3.D promote prevention and wellness across the lifespan.

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). 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.

The AIDD performance measurement strategy focuses on four measures that address outcomes related to the AIDD mission and purpose of the DD Act: to assist people with intellectual and developmental disabilities to become independent and integrated into their community, protect their legal and human rights, and improve the quality of services and supports. These measures support HHS Strategic Plan Goal 3. Advance the Health, Safety and Well-Being of the American People and specifically Objectives 3.B promote economic & social well-being for individuals, families, and communities; and 3.C improve the accessibility and quality of supportive services for people with disabilities and older adults. The following highlights the AIDD Network's accomplishments in these three focus areas plus efforts to improve program efficiency.

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 engage in a variety of activities that promote systems change and capacity building. A key activity for many State Councils is leadership training to individuals with developmental disabilities and their family members to enhance civic engagement for creating more effective policy solutions.

An independent evaluation[8] found that State Councils fulfill their role in fostering leaders and self-advocacy and achieving systems change. Participants in leadership and self-advocacy training reported overwhelming satisfaction with the usefulness of the program. Many participants go on to leadership positions on State Councils and other disability-focused organizations and engage in systems change efforts. AIDD performance measure 8A (long-term objective 8.1) examines the success of these activities in terms of the percent of people reached by State Councils who are independent, self-sufficient and integrated into the community. The results have consistently trended up and have met or exceeded performance targets since FY 2008. This measure demonstrates progress toward Council objectives across multiple systems including that adults have jobs of their choice; students have the education and support they need to reach their educational goals; and individuals have homes and live with others of their choosing.

Given limited resources and economic pressures that create barriers to systems change and capacity building, the efficient use of federal funds is paramount. AIDD illustrates the Networks efficiency tied to outcomes through measure 8E, i.e. the number of individuals reached who are independent, self-sufficient and integrated into the community per $1,000 of federal funding. This measure has shown an increasing trend since FY 2008. Targets have been reached or exceeded for four out of the previous five years.

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. 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

[8] Westat, Inc. National Independent Study of the Administration on Developmental Disabilities Programs: Final Report. Volume 1. Prepared for HHS Administration for Children and Families, Administration for Developmental Disabilities. Accessed May 28, 2013 at http://www.acf.hhs.gov/sites/default/files/add/national_independent_study_vi_final.pdf

training and technical assistance to leadership and staff of the P&A system to improve their performance. Examples of PADD success include:

- PADD grantees are highly successful at meeting the needs of complainants: The annual performance 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 demonstrates the rate of successful benefits accruing from the P&A program to individuals with developmental disabilities. The rate of success has been consistently over 90 percent. Overall the measure trends upward but experiences year to year fluctuations which are to be expected given the overall high success rate.

- PADD grantees are efficient and responsive: An independent evaluation[9] found that among the sampled grantees over 90 percent of calls are responded to within the maximum response time (e.g. 48 hours).

In addition to individual advocacy, PADDs have demonstrated considerable success achieving system advocacy outcomes: closing residential facilities, influencing seclusion and restraint practices and issues related to access to services.

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. Highlights of UCEDD performance include:

- UCEDDS have been successful at highly leveraging the funds received from AIDD: The University Center grants are expected to function as a catalyst to support infrastructure and maximize the leveraging of additional funds to implement their core activities of interdisciplinary training, community service, research, and information dissemination.

[9] Ibid

The evaluation[10] found the average ratio of total UCEDD funding to AIDD grant funds was about 14 to 1. All UCEDDS in the sample had ratios above 4 to 1.

- UCEDD trained professionals are serving the disability community: Pre-service training is a mechanism through which UCEDDs advance practice, scholarship and policy that impact the lives of people with developmental disabilities and their families. UCEDDs performance in this area is measured as 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 2012 met the target at 37.7 percent. Since FY 2009 this measure has steadily increased.

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.

ACL's Commitment to Transparency, Accountability and Evaluation

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

- Supported increased access to program data and performance information. AoA continues to enhance the data portal (www.agid.acl.gov) which provides data visualization tools, downloadable data files, and data analysis tools which enables the development of benchmarks and trend analyses at the national and at the state level. AoA also supports efforts to facilitate developer use of federal data sets through http://www.data.gov/ and http://www.healthdata.gov/. A recent application was created using AoA's Elder Care Locator data.

- Enhanced support of efforts to measure Long-Term Services and Supports including service quality. AIDD has partnered with the Department of Education's National Institute on Disability and Rehabilitation Research and others to advance data collection efforts to measure state progress with regards to competitive employment, housing choice, self-determination and service quality.

[10] Ibid.

- Further analyzed the results from the AoA's National Survey of Older Americans Act Participants to help inform decision makers. Results show that: 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 in comparison to the overall US population 60 and older, the OAA programs are serving older people who are less healthy and have more limitations in function 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. This model is currently being further tested and refined with data from four additional States through ACL's System's Integration Program.

- Applied results of an independent evaluation conducted by Westat[11] to inform efforts to improve performance measurement across AIDD programs. AIDD continues to work with ACL performance staff and DD Network stakeholders to enhance the use of performance information in combination with external, national data collection efforts.

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

    - 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 covers a large array of topics; a costs study that measures the actual cost of providing a meal by cost category; 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, ACL/AoA and Centers for Medicare & 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 collection for the process study is scheduled to begin in early 2014.

[11] Ibid

- The evaluation of the Title III-E National Family Caregiver Support Program (NFCSP) 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. The evaluation seeks to assess the impact of the program at the individual, program, and long-term care (LTC) policy/home and community-based service (HCBS) system levels. The evaluation will also examine how the program meets its goals and whether the program has contributed to long-term care system efficiency. The first process evaluation phase of the study is scheduled to begin in the summer of 2014. The second outcome evaluation phase, is expected to begin later this year, will gather information from a sample of caregivers receiving NFCSP services and from a comparable group of caregivers not receiving NFCSP services.

- AoA is currently evaluating its Aging and Disability Resource Centers (ADRC). Process data collection was completed during the fall of 2013, and consumer-level data collection started during the summer of 2013 and is expected to conclude in March 2014. 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 was completed in June of 2013 and examined 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 relied on existing program data such as consumer and site level data submitted by grantees and grantee progress reports. The final process evaluation report is available on the AoA website at: http://www.aoa.gov/AoARoot/Program_Results/Program_Evaluation.aspx. In addition to the process evaluation, 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. The final report was completed during the fall of 2013.

- 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 design considered 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 and is available at: http://www.aoa.gov/AoARoot/Program_Results/docs/LTCOP%20Evaluation%20Study%20Design_01312013.pdf.

- The Administration on Intellectual and Developmental Disabilities awarded a six-year contract in 2011 to evaluate the eight Partnerships in Employment Systems Change projects. The evaluation of the eight employment projects will inform AIDD and its partners how to best work to support competitive, integrated employment systems for individuals with intellectual and developmental disabilities.

- AoA awarded a contract in the fall of 2012 to complete an organizational analysis on the Senior Medicare Patrol (SMP) program. This analysis was 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 was submitted in June 2013 and the To-Be report is scheduled for completion in January 2014.

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 to reflect the success of the DD Network under the purposes of the DD Act.

AoA provides formula grants to states or tribes and there is a great deal of flexibility in 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.
- 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.

In FY 2014, ACL is initiating a formula grant monitoring framework for Older Americans Act (OAA) Title III and VII state formula grants. The framework combines assessments of grantee's progress toward program goals and objectives with identification of risk or instances of fraud, waste and abuse. An integrated team from AoA's program staff, ACL regional offices, Office of Performance and Evaluation and Office of Grants Management will develop monitoring tools, evaluate monitoring efforts and provide staff training on the process. The monitoring approach will involve the review of a wide variety of program performance data and information such as state plans, financial reports and annual program data and corresponding performance measures. Feedback and follow-up are essential to performance improvement and enhanced program integrity. ACL's framework includes state specific monitoring reports that include findings, recommendations and recommended corrective actions; corresponding grantee response with timelines for corrective actions; and grant conditions when necessary. The new framework will be pilot tested with five to seven states in FY 2014. Based on the success with OAA Title III and VII, ACL will develop customized monitoring frameworks for AIDD State Grant Programs, OAA Title VI (Tribal Formula Grants), and ACL discretionary grants.

In addition to the new grant monitoring framework, ACL senior management is directly engaged in developing performance management 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 funding levels to propose to the Department and OMB.

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.

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All Purpose Table

Administration for Community Living
(dollars in thousands)

Program	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Health and Independence				
Home & Community-Based Supportive Services	347,724	347,724	347,724	--
Congregate Nutrition Services	416,104	438,191	438,191	--
Home-Delivered Nutrition Services	205,489	216,397	216,397	--
Nutrition Services Incentive Program	146,718	160,069	160,069	--
Preventive Health Services	19,849	19,848	19,848	--
Chronic Disease Self-Management Education [PPHF]	*7,086*	*8,000*	*8,000*	--
Falls Prevention [PPHF]	--	*5,000*	*5,000*	--
Senior Community Service Employment Program	424,805	434,371	380,000	(54,371)
Native American Nutrition & Supportive Services	26,157	26,158	26,158	--
Aging Network Support Activities	7,432	7,461	7,461	--
Subtotal, Health and Independence	1,601,364	1,663,219	1,608,848	(54,371)
Caregiver Services				
Family Caregiver Support Services	145,586	145,586	145,586	--
Native American Caregiver Support Services	6,031	6,031	6,031	--
Alzheimer's Disease Supportive Services Program 5/	3,786	3,800	3,800	--
Alzheimer's Disease Initiative -- Services [PPHF]	--	*10,500*	*10,500*	--
Lifespan Respite Care 5/	2,351	2,360	2,360	--
Subtotal, Caregiver Services	157,754	168,277	168,277	--
Protection of Vulnerable Adults				
Elder Justice Initiative/APS	*2,000*	--	25,000	25,000
Long-Term Care Ombudsman Program	15,885	15,885	15,885	--
Prevention of Elder Abuse & Neglect	4,773	4,773	4,773	--
Senior Medicare Patrol Program	8,875	8,910	8,910	--
Health Care Fraud and Abuse Control [HCFAC] 1/	*10,847*	*6,590*	*10,710*	*4,120*
Elder Rights Support Activities	3,859	3,874	3,874	--
Subtotal, Vulnerable Adults	46,239	40,032	69,152	29,120

Developmental Disabilities Programs				
State Councils on Developmental Disabilities	70,555	70,876	70,876	--
Protection and Advocacy	38,559	38,734	38,734	--
University Centers for Excellence in Developmental Disabilities	36,602	36,769	36,769	--
Projects of National Significance 3/	8,828	8,880	8,880	--
Youth Transitions Initiative	--	--	5,000	5,000
Subtotal, Developmental Disabilities	154,544	155,259	160,259	5,000
Consumer Information, Access & Outreach				
Aging and Disability Resource Centers [Discretionary]	6,095	6,119	--	(6,119)
Aging and Disability Resource Centers [Mandatory] 2/	*9,490*	*9,280*	*20,000*	*10,720*
Voting Access for People with Disabilities (HAVA)	4,961	4,963	4,963	--
Alzheimer's Disease Initiative--Communications Campaign [PPHF]	*150*	*4,200*	*4,200*	--
State Health Insurance Assistance Program	46,040	52,115	52,115	--
National Clearinghouse for Long-Term Care Information 3/	*86*	--	1,000	1,000
Medicare Improvements for Patients and Providers Act [TRA/BBA] 4/	*23,725*	*12,500*	--	*(12,500)*
Paralysis Resource Center 5/	6,352	6,700	6,700	--
Subtotal, Consumer Information, Access & Outreach	96,899	95,877	88,978	(6,899)
White House Conference on Aging	--	--	3,000	3,000
Holocaust Survivor Assistance Fund	--	--	5,000	5,000
Program Administration	28,064	30,035	30,035	--
Subtotal, Program Level	**2,084,864**	**2,152,699**	**2,133,549**	**(19,150)**
Less: Funds From Mandatory Sources				
HCFAC Wedge Funds 1/	*(10,847)*	*(6,590)*	*(10,710)*	*(4,120)*
ACA Direct Appropriations	*(9,576)*	*(9,280)*	--	*9,280*
ADRC Mandatory Funding	--	--	*(20,000)*	*(20,000)*
Prevention & Public Health Fund (ACA)	*(9,236)*	*(27,700)*	*(27,700)*	--
Taxpayer Relief Act/Bipartisan Budget Act 4/	*(23,725)*	*(12,500)*	--	*12,500*
PHS Evaluation Fund 5/	--	--	*(12,860)*	*(12,860)*
Total, Discretionary Budget Authority	**2,031,480**	**2,096,629**	**2,062,279**	**(34,350)**

1/ $10,710,000 is a placeholder amount for FY 2015. The Secretary and Attorney General will determine the final amount.

2/ Mandatory funding for ADRCs was provided by the Affordable Care Act in FY 2013 and FY 2014. The FY 2015 request is for new mandatory funding.

3/ Funding for this program was provided by the Affordable Care Act in FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act (save for obligations through January 3, 2013). The FY 2015 request is for discretionary funding.

4/ Includes funding for SHIPs, ADRCs, AAAs, and the National Center for Benefits Outreach Enrollment

5/ For FY 2015, these funds are requested from amounts under section 241 of the Public Health Service Act

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*")*, 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*, 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, **[$1,610,143,000]***$2,010,164,000*, together with $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 Reconciliation Act of 1990: *Provided, That, in addition to amounts provided herein, $12,860,000 shall be available from amounts available under section 241 of the PHS Act to supplement funds otherwise available for carrying out titles III and XXIX of such Act:* Provided *further*, 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, $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, 2016, and may be recaptured and reobligated in accordance with section 517(c) of the OAA: Provided further, That $3,000,000 shall be available until September 30, 2016 for the White House Conference on Aging.*

Appropriations Language Analysis

Administration for Community Living

Language Provision	Explanation
…section 6021(d) of the Deficit Reduction Act of 2005…	Provides authorization for the National Clearinghouse for Long-Term Care Information
Provided, That, in addition to amounts provided herein, $12,860,000 shall be available from amounts available under section 241 of the PHS Act to supplement funds otherwise available for carrying out titles III and XXIX of such Act	Provides funding from amounts provided under section 241 of the Public Health Service Act for 3 programs: Alzheimer's Disease Supportive Services Program, Lifespan Respite Care, and the Paralysis Resource Center
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:	Authorizes ACL to set-aside up to 1% of funding provided under Title III of the OAA to evaluate OAA programs and disseminate the results throughout the Aging Services Network
Provided further, That, of the amounts provided under this heading, $380,000,000 shall be available for carrying out title V of the OAA:	Authorizes ACL to administer the Senior Community Service Employment Program
Provided further, That with respect to the previous proviso, such funds shall be available through June 30, 2016, and may be recaptured and reobligated in accordance with section 517(c) of the OAA:	Ensures that SCSEP funding is available in accordance with its current Program Year funding schedule, rather than a standard Fiscal Year schedule
Provided further, That $3,000,000 shall be available until September 30, 2016 for the White House Conference on Aging.	Ensures that funding for the White House Conference on Aging is available through the end of FY 2016 in order to hold the conference and resolve any expenses incurred after September 30, 2015

Amounts Available for Obligation

Administration for Community Living

	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)	1,470,917,701	1,610,143,000	2,010,164,000
Subtotal, Appropriation (L/HHS, Ag, or Interior)	1,470,917,701	1,610,143,000	2,010,164,000
Rescission (Section 3004)	-2,941,835	--	--
Sequestration	-73,995,986	--	--
Secretary's transfer	-5,496,008	--	--
Subtotal, adjusted appropriation	1,388,483,872	1,610,143,000	2,010,164,000
Transfer of funds to Department of Agriculture	-2,542,042	-2,391,605	--
Comparable transfer from Department of Labor	424,804,974	434,371,000	--
Comparable transfer from Centers for Disease Control	6,352,000	--	--
Comparable transfer from General Departmental Management	1,197,616	--	--
Comparable transfer from Administration for Children and Families	163,418,541	--	--
Total, Discretionary Appropriation	1,981,714,961	2,042,122,395	2,010,164,000
Mandatory Appropriation:			
Appropriation (PPACA) ADRCs	9,490,000	9,280,000	--
Appropriation (Requested) ADRCs	--	--	20,000,000
Appropriation (PPACA) National Long-Term Care Clearinghouse	85,523	--	--
Appropriation (PPACA) Prevention Funds	9,236,000	27,700,000	27,700,000
Appropriation (Taxpayer Relief Act) MIPPA	23,725,000	12,500,000	--
Subtotal, adjusted mandatory. appropriation	42,536,523	49,480,000	47,700,000
Offsetting collections from:			
Trust Funds: HCFAC	9,575,523	6,590,000	10,710,000
Trust Funds: SHIPs HI/SMI	46,040,000	52,115,000	52,115,000
PHS Evaluation Funds	--	--	12,860,000
Subtotal, spending authority from offsetting collections	55,615,523	58,705,000	75,685,000
Unobligated balance, lapsing	-499,654	--	--
Total obligations	2,079,367,353	2,150,307,395	2,133,549,000

Summary of Changes

Administration for Community Living
(Dollars in thousands)

2014
Total estimated budget authority 2,096,629

2015
Total estimated budget authority 2,062,279

Net Change ..... -34,350

	FY 2015 PB FTE	FY 2015 PB BA	FY 2015 +/- FY 2014 FTE	FY 2015 +/- FY 2014 BA
Increases:				
A. Program:				
1. Elder Justice Initiative/APS	4	25,000	4	25,000
2. Youth Transitions Initiative	0	5,000	0	5,000
3. National Clearinghouse for Long-Term Care Information	0	1,000	0	1,000
4. White House Conference on Aging	0	3,000	0	3,000
5. Holocaust Survivor Fund	0	5,000	0	5,000
Subtotal, Program Increases		39,000		39,000
Total Increases				39,000
Decreases:				
A. Built-In:				
1. Shifts to PHS Funding	0	-12,860	0	-12,860
Subtotal, Program Decreases		-12,860		-12,860
A. Program:				
1. Senior Community Service Program	10	380,000	0	-54,371
2. Aging and Disability Resource Centers (Discretionary)	0	0	0	-6,119
Subtotal, Program Decreases		380,000		-60,490
Total Decreases				-73,350
Net Change				-34,350

Budget Authority by Activity

Administration for Community Living

	FY 2013 Actual	FY 2014 Enacted	FY 2015 President's Budget
Health and Independence			
Home & Community-Based Supportive Services	347,724	347,724	347,724
Congregate Nutrition Services	416,104	438,191	438,191
Home-Delivered Nutrition Services	205,489	216,397	216,397
Nutrition Services Incentive Program	146,718	160,069	160,069
Preventive Health Services	19,849	19,848	19,848
Senior Community Service Employment Program	424,805	434,371	380,000
Native American Nutrition & Supportive Services	26,157	26,158	26,158
Aging Network Support Activities	7,432	7,461	7,461
Subtotal, Health and Independence	1,594,278	1,650,219	1,595,848
Caregiver Services			
Family Caregiver Support Services	145,586	145,586	145,586
Native American Caregiver Support Services	6,031	6,031	6,031
Alzheimer's Disease Supportive Services Program 4/	3,786	3,800	--
Lifespan Respite Care 4/	2,351	2,360	--
Subtotal, Caregiver Services	157,754	157,777	151,617
Protection of Vulnerable Adults			
Elder Justice Initiative/APS	--	--	25,000
Long-Term Care Ombudsman Program	15,885	15,885	15,885
Prevention of Elder Abuse & Neglect	4,773	4,773	4,773
Senior Medicare Patrol Program	8,875	8,910	8,910
Elder Rights Support Activities	3,859	3,874	3,874
Subtotal, Vulnerable Adults	33,392	33,442	58,442
Developmental Disabilities Programs			
State Councils on Developmental Disabilities	70,555	70,876	70,876
Protection and Advocacy	38,559	38,734	38,734
University Centers for Excellence in Developmental Disabilities	36,602	36,769	36,769
Projects of National Significance 3/	8,828	8,880	8,880
Youth Transitions Initiative	--	--	5,000
Subtotal, Developmental Disabilities	154,544	155,259	160,259

Consumer Information, Access & Outreach			
Aging and Disability Resource Centers [Discretionary]	6,095	6,119	--
Voting Access for People with Disabilities (HAVA)	4,961	4,963	4,963
State Health Insurance Assistance Program	46,040	52,115	52,115
National Clearinghouse for Long-Term Care Information 3/	--	--	1,000
Paralysis Resource Center 4/	6,352	6,700	--
Subtotal, Consumer Information, Access & Outreach	63,448	69,897	58,078
White House Conference on Aging	--	--	3,000
Holocaust Survivor Assistance Fund	--	--	5,000
Program Administration	28,064	30,035	30,035
Total, Discretionary Budget Authority	2,031,480	2,096,629	2,062,279
HCFAC Wedge Funds 1/	10,847	6,590	10,710
ACA Direct Appropriations	9,576	9,280	--
ADRC Mandatory Funding (ACA) {Non-Add}	*9,490*	*9,280*	--
National Clearinghouse for Long-Term Care Information {Non-Add}	*86*	--	--
ADRC Mandatory Funding (Non-ACA) 2/	--	--	20,000
Prevention & Public Health Fund (ACA)	9,236	27,700	27,700
Chronic Disease Self-Management Education {Non-Add}	*7,086*	*8,000*	*8,000*
Falls Prevention {Non-Add}	--	*5,000*	*5,000*
Alzheimer's Disease Initiative - Services {Non-Add}	--	*10,500*	*10,500*
Alzheimer's Disease Initiative - Communications {Non-Add}	*150*	*4,200*	*4,200*
Adult Protective Services {Non-Add}	*2,000*	--	--
Taxpayer Relief Act/Bipartisan Budget Act	23,725	12,500	--
State Health Insurance Assistance Programs {Non-Add}	*7,118*	*3,750*	--
Aging and Disability Resource Centers {Non-Add}	*4,745*	*2,500*	--
Area Agencies on Aging {Non-Add}	*7,118*	*3,750*	--
National Center for Benefits Outreach & Enrollment {Non-Add}	*4,745*	*2,500*	--
PHS Evaluation Fund 4/	--	--	12,860
Alzheimer's Disease Supportive Services Program {Non-Add}	--	--	*3,800*
Lifespan Respite Care {Non-Add}	--	--	*2,360*
Paralysis Resource Center {Non-Add}	--	--	*6,700*
Total, Program Level	**2,084,864**	**2,152,699**	**2,133,549**

1/ $10,710,000 is a placeholder amount for FY 2015. The Secretary and Attorney General will determine the final amount.

2/ Mandatory funding for ADRCs was provided by the Affordable Care Act in FY 2013 and FY 2014. The FY 2015 request is for new mandatory funding.

3/ Funding for this program was provided by the Affordable Care Act in FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act (save for obligations through January 3, 2013). The FY 2015 request is for discretionary funding.

4/ For FY 2015, these funds are requested from amounts under section 241 of the Public Health Service Act

Authorizing Legislation

Administration for Community Living

	FY 2014 Amount Authorized	FY 2014 Appropriations Act	FY 2015 Amount Authorized	FY 2015 President's Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Expired	347,724,000	Expired	347,724,000
2) Nutrition Services Services: OAA Sections 331 and 336	Expired	654,588,000	Expired	654,588,000
3) Nutrition Services Incentive Program: OAA Section 311 1/	Expired	160,069,000	Expired	160,069,000
4) Preventive Health Services: OAA Section 502	Expired	19,848,000	Expired	19,848,000
5) National Family Caregiver Support Program: OAA Section 371	Expired	145,586,000	Expired	145,586,000
6) Community Service Employment for Older Americans Title V OAA Section 502	Expired	434,371,000	Expired	380,000,000
7) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Expired	26,158,000	Expired	26,158,000
8) Native American Caregiver Support Program: OAA Section 631	Expired	6,031,000	Expired	6,031,000
9) Long-Term Care Ombudsman Program: OAA Section 712	Expired	15,885,000	Expired	15,885,000
10) Prevention of Elder Abuse and Neglect: OAA Section 721	Expired	4,773,000	Expired	4,773,000
11) Senior Medicare Patrol Program OAA Sections 201 and 202, as amended	Expired	8,910,000	Expired	8,910,000
12) Elder Rights Support Activities OAA Sections 201, 202, and 411, as amended	Expired	3,874,000	Expired	3,874,000
13) Aging Network Support Activities: OAA Sections 202, 215 and 411	Expired	7,461,000	Expired	7,461,000
14) Alzheimer's Disease Demonstration Grants 1/ PHSA Section 398	Expired	3,800,000	Expired	0

15) Lifespan Respite Care 1/				
Lifespan Respite Care Act of 2006	Expired	2,360,000	Expired	0
Title XXIX of the Public Health Service Act				
16) Program Administration:				
OAA Section 205	Expired	30,035,000	Expired	30,035,000
17) Aging and Disability Resource Centers				
OAA Section 202b	Expired	6,119,000	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	Expired	25,000,000
& OAA Sections 751 and 752				
20) State Councils on Developmental Disabilities				
DD Act Section 129(a)	Expired	70,876,000	Expired	70,876,000
21) Protection and Advocacy				
DD Act Section 145	Expired	38,734,000	Expired	38,734,000
22) University Centers for Excellence in Developmental Disabilities				
DD Act Section 156	Expired	36,769,000	Expired	36,769,000
23) Projects of National Significance				
DD Act Section 163	Expired	8,880,000	Expired	8,880,000
24) Voting Assistance for People with Disabilities				
Help America Vote Act Section 291	Expired	4,963,000	Expired	4,963,000
25) Paralysis Resource Center 1/				
PHSA Sections 311 and 317(k)(2)	N/A	6,700,000	N/A	0
25) National Clearinghouse on Long-Term Care Information				
Deficit Reduction Act of 2005 Section 6021(d)	Expired	0	Expired	1,000,000
26) Youth Transitions Initiative				
DD Act Section 163	Expired	0	Expired	5,000,000
27) White House Conference on Aging				
OAA Sections 202 and 205	Expired	0	Expired	3,000,000
28) Holocaust Survivor Fund				
OAA Section 411	Expired	0	Expired	5,000,000
Total Request Level		$2,096,629,000		$2,062,279,000

Unfunded Authorizations:

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

Appropriations History Table

Administration for Community Living

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
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 /1	1,335,146,000	1,417,189,000	1,451,585,000	1,438,567,000
FY 2008 Rescission	--	--	--	-25,131,765
FY 2009 /2	1,381,384,000	1,492,741,000	1,478,156,000	1,491,343,000
FY 2009 ARRA /4	--	--	--	100,000,000
FY 2010 /3	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 Rescission				-3,000,646
FY 2012 /5	2,237,944,000	1,471,324,000	1,534,701,000	1,473,703,000
FY 2012 Rescission				-2,785,299
FY 2013	1,978,336,000	N/A	1,708,105,000	1,645,291,724
FY 2013 Rescission	--	--	--	-3,290,583
FY 2013 Sequestration	--	--	--	-82,768,046
FY 2013 Transfer	--	--	--	-6,133,066
FY 2014	2,094,755,000	N/A	1,716,664,000	1,662,258,000
FY 2015	2,062,279,000			

1/ 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.
2/ 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.
3/ American Recovery and Reinvestment Act of 2009, Public Law 111-5.
4/ 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.
5/ 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.

Appropriations Not Authorized by Law

Administration for Community Living

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2014
Alzheimer's Disease Suppoertive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$3,800,000
Older Americans Act	FY 2011	Such Sums	$1,927,486,000	$1,452,421,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,495,000	$2,360,000
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	$155,259,000
National Clearinghouse for Long-Term Care: Deficit Reduction Act of 2005 section 6021(d)	FY 2010	$1,000,000	$3,000,000	$0
Social Security Act, Title XX-B	FY 2014	$129,000,000	$0	$0

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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.[12] 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.[13] Health and Independence Programs are vital to helping seniors remain in their homes and communities for as long as possible. For example, 68 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, 57 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.[14]

The FY 2015 funding request for Health and Independence services is $1,608,848,000; a reduction of -$54,371,000 from the comparable FY 2014 enacted level. For FY 2015, specific program requests include:

- $347,724,000 for Home and Community-Based Supportive Services (HCBSS), the same as the FY 2014 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

[12] 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 09 February 2014.

[13] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 09 February 2014.

[14] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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.

- $814,657,000 for three Nutrition Services programs (Congregate Nutrition Services, Home-Delivered Nutrition Services and the Nutrition Services Incentives Program), the same as the FY 2014 enacted level. Nutrition Services help over 2.3 million older adults receive the meals they need to stay healthy and decrease their risk of disability. In FY 2015, these funds will support an estimated 208.7 million meals.

- $19,848,000 for Preventive Health Services, the same as the FY 2014 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.

- $8,000,000 for Chronic Disease Self-Management Education (CDSME), requested again for FY 2015 from the Prevention and Public Health Fund (PPHF) appropriated under the Affordable Care Act. This would continue funding at the FY 2014 enacted level. CDSME programs have proven effective in helping people to better self-manage their chronic conditions and reduce their need for more costly medical interventions.

- $5,000,000 for Falls Prevention Programs, requested again for FY 2015 from the PPHF. This funding would be used to fund a national resource center and competitive grants to States, Tribes, and other applicants who have experience in evidence-based falls prevention programs.

- $380,000,000 for the Senior Community Service Employment Program (SCSEP); a reduction of -$54,371,000 from the FY 2014 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 and FY 2014 budget requests, the FY 2015 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.

- $26,158,000 for Native American Nutrition and Supportive Services, the same as the FY 2014 enacted level. These funds will provide approximately 4.7 million meals and 775,000 rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

- $7,461,000 for Aging Network Support Activities, the same as the FY 2014 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 in carrying out their mission to help older people remain independent and live in their own homes and communities.

Outcome Table:

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.10: Increase the likelihood that the most vulnerable people receiving Older Americans Act Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. (Outcome)	FY 2012: 63% Target: 62% (Target Exceeded)	62%	62.5%	+0.5%
3.3: The % of OAA clients served who live in rural areas is at least 15% greater than the percent of all US elders who live in rural areas. (Outcome)	FY 2012: 36.87% Target: 24.3% (Target Exceeded)	24.3%	26.2%	+1.9%
3.4: Increase the number of States that serve more elderly living below the poverty level than the prior year.	FY 2012: 28 Target: 28 (Target Met)	Discontinued	Discontinued	N/A
3.6: The % of OAA clients served who live in poverty is at least 150% greater than the percent of all US elders who live below poverty.	FY 2012: 29.96% (Baseline)	24.85%	24.85%	Maintain

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Home and Community-Based Supportive Services

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Home and Community-Based Supportive Services	$347,724,000	$347,724,000	$347,724,000	--

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

FY 2015 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 that, when tailored to the needs of the individual, ensures that 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, 59 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 90 percent of seniors have at least one chronic condition and 75 percent have at least two.[15] Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain

[15] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 2.5a, 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 25 July,2013.

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 2012, the most recent available data, include:

- *Transportation Services* provided 24.5 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 nearly 29 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 nearly 4 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:

- 69 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;

- 13 percent have had a stroke;

- 5 percent have epilepsy; and

- 3 percent have Parkinson's disease.

Of the transportation participants, 95 percent take daily medications, with over 15 percent taking 10 to 20 medications daily.[16] Data from AoA's National Surveys of OAA Participants show that services such as transportation are providing these seniors with the assistance and information they need 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 over 85 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.[17] 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.[18]

Funding History:

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

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 .....$347,724,000
FY 2014 .....$347,724,000

Budget Request:

The FY 2015 request for Home and Community-Based Supportive Services is $347,724,000, the same as the FY 2014 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

[16] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[17] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[18] 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.

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 children. The overall budget request will support 8 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 26.9 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 1.8 million seniors who live in institutional settings.[19] Nationally, 25 percent of individuals 60 and older live alone[20], and in FY 2015 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.[21]

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 2015 compared to FY 2012, 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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[19] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 1.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 25 July,2013.

[20] Administration on Aging, agid.acl.gov. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2011), accessed August, 15, 2013.

[21] 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
2.9b: Maintain at 90% or higher the percentage of transportation clients who rate services good to excellent *(Outcome)*	FY 2012: 98.5% Target: 90% (Target Exceeded)	90%	90%	Maintain
2.11: Increase the percentage of transportation clients who live alone. *(Outcome)*	FY 2012: 70% Target: 70% (Target Met)	67%	67%	Maintain

Indicator	Most Recent Result	FY 2014 Projection	FY 2015 Projection	FY 2015 +/- FY 2014
Output C: Transportation Services units *(Output)*	FY 2012: 24.5 M	22 M	21.5 M	- 0.5 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2012: 28.94 M	27.3 M	26.9 M	- 0.4 M
Output E: Adult Day Care/Day Health units *(Output)*	FY 2012: 8.0 M	8.0 M	8.0 M	--
Output F: Case Management Services units *(Output)*	FY 2012: 3.98 M	4.0 M	4.0 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$6,172,606	$6,147,264	$6,147,264
Range of Awards	$216,042 - $34,222,255	$215,155 - $34,081,746	$215,155 - $34,081,746

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	5,347,830	5,325,874	5,325,874	--
Alaska	1,728,330	1,721,234	1,721,234	--
Arizona	6,506,240	6,478,530	6,478,530	--
Arkansas	3,464,888	3,450,663	3,450,663	--
California	34,222,255	34,081,746	34,081,746	--
Colorado	4,111,937	4,095,054	4,095,054	--
Connecticut	4,358,913	4,341,017	4,341,017	--
Delaware	1,728,330	1,721,234	1,721,234	--
District of Columbia	1,728,330	1,721,234	1,721,234	--
Florida	25,001,310	24,898,663	24,898,663	--
Georgia	7,827,657	7,795,519	7,795,519	--
Hawaii	1,728,330	1,721,234	1,721,234	--
Idaho	1,728,330	1,721,234	1,721,234	--
Illinois	14,375,088	14,316,068	14,316,068	--
Indiana	6,855,949	6,827,801	6,827,801	--
Iowa	4,216,933	4,199,620	4,199,620	--
Kansas	3,397,503	3,383,554	3,383,554	--
Kentucky	4,692,372	4,673,107	4,673,107	--
Louisiana	4,746,436	4,726,948	4,726,948	--
Maine	1,728,330	1,721,234	1,721,234	--
Maryland	5,797,027	5,773,227	5,773,227	--
Massachusetts	8,124,430	8,091,074	8,091,074	--
Michigan	11,139,629	11,093,893	11,093,893	--
Minnesota	5,442,946	5,420,599	5,420,599	--
Mississippi	3,238,958	3,225,660	3,225,660	--
Missouri	7,045,013	7,016,089	7,016,089	--
Montana	1,728,330	1,721,234	1,721,234	--
Nebraska	2,271,269	2,261,944	2,261,944	--
Nevada	2,436,001	2,426,000	2,426,000	--
New Hampshire	1,728,330	1,721,234	1,721,234	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	10,157,125	10,115,423	10,115,423	--
New Mexico	2,044,878	2,036,483	2,036,483	--
New York	24,032,984	23,934,312	23,934,312	--
North Carolina	9,272,300	9,234,231	9,234,231	--
North Dakota	1,728,330	1,721,234	1,721,234	--
Ohio	13,674,310	13,618,168	13,618,168	--
Oklahoma	4,234,162	4,216,778	4,216,778	--
Oregon	4,091,730	4,074,931	4,074,931	--
Pennsylvania	17,695,572	17,622,920	17,622,920	--
Rhode Island	1,728,330	1,721,234	1,721,234	--
South Carolina	4,742,125	4,722,656	4,722,656	--
South Dakota	1,728,330	1,721,234	1,721,234	--
Tennessee	6,690,497	6,663,028	6,663,028	--
Texas	20,116,440	20,033,849	20,033,849	--
Utah	1,847,519	1,839,934	1,839,934	--
Vermont	1,728,330	1,721,234	1,721,234	--
Virginia	7,738,845	7,751,887	7,751,887	--
Washington	6,383,529	6,357,321	6,357,321	--
West Virginia	2,744,933	2,733,663	2,733,663	--
Wisconsin	6,324,483	6,298,516	6,298,516	--
Wyoming	1,728,330	1,721,234	1,721,234	--
Subtotal, States	338,924,306	337,532,792	337,532,792	--
American Samoa	467,446	465,527	465,527	--
Guam	864,165	860,617	860,617	--
Northern Mariana Islands	216,042	215,155	215,155	--
Puerto Rico	4,329,829	4,312,052	4,312,052	--
Virgin Islands	864,165	860,617	860,617	--
Subtotal, States and Territories	345,665,953	344,246,760	344,246,760	--
Undistributed 22/	2,058,047	3,477,240	3,477,240	--
TOTAL	**347,724,000**	**347,724,000**	**347,724,000**	**--**

[22] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Congregate Nutrition…….	$416,104,000	$438,191,000	$438,191,000	--
Home-Delivered Nutrition	$205,489,000	$216,397,000	$216,397,000	--
Nutrition Services Incentive Program……..	$146,718,000	$160,069,000	$160,069,000	--
Total……...	$768,311,000	$814,657,000	$814,657,000	--

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

FY 2015 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 to the older Americans who congregate for social engagement and meaningful volunteer roles, which contributes to their 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 who themselves receive meals, 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 purchase food 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 five Tribes elected to spend nearly $2.4 million on commodities, including $141,939 assessed by USDA as administrative expenses, in FY 2014.

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.[23] 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, including 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.

Multiple chronic diseases and conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals' health, and contribute to increased hospitalizations and health care costs.[24] Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to

[23] Hung et al. Recent trends in chronic disease, impairment and disability among older adults in the United States. BMC Geriatrics. 2011. 11:47.

[24] Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions among Medicare Beneficiaries, United States, 2010. Prev Chronic Dis 2013; 10:120137. DOI http://dix.doi.org/10.5888/pcd10.12037

nutrition as a primary prevention, risk reduction, or treatment modality. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, the two-thirds of Medicare beneficiaries with 2 or more chronic conditions account for 93 percent of Medicare spending, and the one-third of Medicare beneficiaries with 4 or more chronic conditions account for almost three-fourths of Medicare spending.[25]

Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered program participants than for the general Medicare population, the provision of healthy meals, access to lifestyle modification programs, and evidence-based advice such as nutrition education and counseling are important. Overall, 75 percent of Medicare beneficiaries had 2 or more chronic conditions[26] and over 36 percent had 4 or more chronic conditions.[27] Data from AoA's National Survey of OAA Participants indicate that about 44 percent of congregate and 63 percent of home-delivered participants have 6 to 15 illnesses and conditions. About 30 percent of congregate and 52 percent of home-delivered participants take over 6 medications per day and some take as many as 30 medications.[28] The congregate and home-delivered program participants are significantly less healthy than the general Medicare population and access to healthy meals is essential to their well-being.

Prevalence for malnutrition or risk for malnutrition across the community- and facility-based care settings has varied based on factors used to determine malnutrition. A study applying similar criteria found the lowest prevalence (38 percent) among older adults in the community, compared to 91 percent in rehabilitation facilities, 86 percent in hospitals, and 67 percent in nursing homes.[29] Data from AoA's National Survey of OAA Participants indicate that about 18 percent of congregate and 39 percent of home-delivered program participants stayed overnight in the hospital or a nursing home in the past year and thus might be at risk of malnutrition.[30] Individuals transitioning between or among facility-based care settings and their homes are likely to be in poorer health and at higher risk for poor nutrition, and have an increased need for healthy home-delivered and congregate meals as well as nutrition education and counseling to aid recovery and decrease the risk of readmission.

Even if an older adult has not been hospitalized in the past year, the older adult participants served in the congregate and home-delivered nutrition programs demonstrate a greater need for healthy prepared meals, rather than simply access to food. Data from AoA's National Survey of

[25] *Id.*

[26] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html Accessed 25 July, 2013.

[27] *Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions among Medicare Beneficiaries, United States, 2010. Prev Chronic Dis 2013; 10:120137. DOI http://dix.doi.org/10.5888/pcd10.12037.*

[28] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[29] Kaiser et al. JAGS 2010; 58: 1734-1738

[30] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

OAA Participants indicate that about 17 percent of congregate and 59 percent of home-delivered participants indicate that they have 3 or more impairments in instrumental activities of daily living (IADLs), meaning that they are unable to shop for groceries and prepare meals for themselves. The data also indicate that about 51 percent of congregate and 81 percent of home-delivered participants need help in getting outside the house, thus limiting their ability to shop for food themselves.[31] Although many of these older adults may rely on family and friends for assistance, about 49 percent of congregate and 54 percent of home-delivered participants live alone.[32] Living alone is a risk factor for social isolation, poorer health, and nursing home placement.

Data from AoA's National Survey of OAA Participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 75 percent of congregate and 83 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 68 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[33] The extra support provided by these programs can help older adults avoid more costly institutional care. Using State Program Report data, made available on ACL's data portal (www.agid.acl.gov), independent research has found that states that invest more in delivering meals (both Federal, state, and all other sources of funding) to older adults' homes have lower rates of "low-care" seniors in nursing homes who have the functional capacity to live in a less care-intensive environment, after adjusting for several other factors.[34] For every $25 per year per older adult that states spend on home-delivered meals, they reduce their percentage of low-care nursing home residents compared to the national average by 1 percent.[35]

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. Eighty-eight percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the percentage of home-delivered meal recipients with severe disabilities (3+ ADL) was 43.5 percent in 2012 (Outcome 3.5). 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, in combination with state and local funding for nutrition, are helping seniors remain healthy and independent in their homes include:

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[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] Thomas, K & Mor, V. The relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract
[35] *Id.*

- *Home-Delivered Nutrition Services* provided 137.4 million meals to over 850,000 individuals in FY 2012 (Output G).

- *Congregate Nutrition Services* provided over 86.3 million meals to over 1.6 million seniors in a variety of community settings in FY 2012 (Output H).

Funding History:

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

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 .....$768,311,000
FY 2014 .....$814,657,000

Budget Request:

The FY 2015 request for Nutrition Services is $814,657,000, the same as the FY 2014 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 71 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 359,000 home-delivered meal recipients with severe disabilities who are projected to be served in FY 2015. 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 2012, State and local funding comprised approximately 64 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 2015 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 Federal funds are reduced or do not keep up with inflation and 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 9,206 Target: 8,600 (Target Exceeded)	8,600	9,250	+ 650
2.9a: Maintain at 90% or higher the percentage of home-delivered meal clients who rate services good to excellent. *(Outcome)*	FY 2012: 88% Target: 90% (Target Not Met)	90%	90%	Maintain
3.5: Increase the percentage of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	FY 2012: 43.5% Target: Baseline	44.3%	44.8%	+ 0.5%
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output G: Number of Home-Delivered meals served *(Output)*	FY 2012: 137.4 M	130.9 M	128.4 M	-2.5 M
Output H: Number of Congregate meals served *(Output)*	FY 2012: 86.3 M	82.3 M	80.3 M	-2.0 M
Outputs G& H: Total Number of Meals *(Outputs)*	FY 2012: 223.7 M	213.2 M	208.7 M	-4.5 M

Note: 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.

Grant Awards Tables:

Congregate Nutrition Programs Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$7,386,438	$7,746,591	$7,746,591
Range of Awards	$258,525 - $39,623,562	$271,131 - $43,228,051	$271,131 - $43,228,051

Home-Delivered Nutrition Programs Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$3,647,723	$3,825,590	$3,825,590
Range of Awards	$127,670 - $20,927,250	$133,896 - $22,048,734	$133,896 - $22,048,734

Nutrition Services Incentive Program Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	309	309	309
Average Award[36]	$474,816	$518,023	$518,023
Range of Awards	$462 - $14,534,734	$462 - $15,449,628	$462 - $15,449,628

[36] If the 254 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,546,417 in FY 2013 and $2,755,553 in FY 2014 and FY 2015.

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	6,068,408	6,511,955	6,511,955	--
Alaska	2,068,203	2,169,045	2,169,045	--
Arizona	8,135,056	8,895,789	8,895,789	--
Arkansas	4,163,564	4,163,564	4,163,564	--
California	39,623,562	43,228,051	43,228,051	--
Colorado	5,410,449	5,978,941	5,978,941	--
Connecticut	5,241,452	5,241,452	5,241,452	--
Delaware	2,068,203	2,169,045	2,169,045	--
District of Columbia	2,068,203	2,169,045	2,169,045	--
Florida	28,468,480	30,962,559	30,962,559	--
Georgia	10,014,735	10,973,199	10,973,199	--
Hawaii	2,068,203	2,169,045	2,169,045	--
Idaho	2,068,203	2,169,045	2,169,045	--
Illinois	17,286,541	17,286,541	17,286,541	--
Indiana	8,105,861	8,320,826	8,320,826	--
Iowa	5,081,501	5,081,501	5,081,501	--
Kansas	4,089,903	4,089,903	4,089,903	--
Kentucky	5,570,252	5,791,780	5,791,780	--
Louisiana	5,645,998	5,645,998	5,645,998	--
Maine	2,068,203	2,169,045	2,169,045	--
Maryland	6,666,347	7,244,786	7,244,786	--
Massachusetts	9,780,267	9,780,267	9,780,267	--
Michigan	12,926,499	13,524,083	13,524,083	--
Minnesota	6,398,439	6,834,789	6,834,789	--
Mississippi	3,891,114	3,891,114	3,891,114	--
Missouri	8,467,047	8,467,047	8,467,047	--
Montana	2,068,203	2,169,045	2,169,045	--
Nebraska	2,738,802	2,738,802	2,738,802	--
Nevada	3,109,985	3,420,814	3,420,814	--
New Hampshire	2,068,203	2,169,045	2,169,045	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	12,190,488	12,190,488	12,190,488	--
New Mexico	2,511,415	2,727,494	2,727,494	--
New York	28,963,855	28,963,855	28,963,855	--
North Carolina	11,542,567	12,616,135	12,616,135	--
North Dakota	2,068,203	2,169,045	2,169,045	--
Ohio	16,393,785	16,393,785	16,393,785	--
Oklahoma	5,080,736	5,080,736	5,080,736	--
Oregon	5,034,431	5,508,448	5,508,448	--
Pennsylvania	21,279,716	21,279,716	21,279,716	--
Rhode Island	2,068,203	2,169,045	2,169,045	--
South Carolina	5,968,512	6,522,158	6,522,158	--
South Dakota	2,068,203	2,169,045	2,169,045	--
Tennessee	7,942,564	8,608,241	8,608,241	--
Texas	24,742,235	27,060,605	27,060,605	--
Utah	2,332,537	2,556,342	2,556,342	--
Vermont	2,068,203	2,169,045	2,169,045	--
Virginia	9,237,708	10,058,787	10,058,787	--
Washington	7,951,293	8,686,777	8,686,777	--
West Virginia	3,305,947	3,305,947	3,305,947	--
Wisconsin	7,586,993	7,687,478	7,687,478	--
Wyoming	2,068,203	2,169,045	2,169,045	--
Subtotal, States	405,835,683	425,518,338	425,518,338	--
American Samoa	594,843	594,843	594,843	--
Guam	1,034,101	1,084,523	1,084,523	--
Northern Mariana Islands	258,525	271,131	271,131	--
Puerto Rico	4,883,248	5,255,732	5,255,732	--
Virgin Islands	1,034,101	1,084,523	1,084,523	--
Subtotal, States and Territories	413,640,501	433,809,090	433,809,090	--
Undistributed 37/	2,463,499	4,381,910	4,381,910	--
TOTAL	**416,104,000**	**438,191,000**	**438,191,000**	**--**

[37] 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
ADMINISTRATION FOR COMMUNITY LIVING
ADMINISTRATION ON AGING

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	3,177,759	3,321,462	3,321,462	--
Alaska	1,021,362	1,071,165	1,071,165	--
Arizona	4,296,544	4,537,352	4,537,352	--
Arkansas	1,995,550	2,068,715	2,068,715	--
California	20,927,250	22,048,734	22,048,734	--
Colorado	2,857,538	3,049,595	3,049,595	--
Connecticut	2,402,675	2,498,252	2,498,252	--
Delaware	1,021,362	1,071,165	1,071,165	--
District of Columbia	1,021,362	1,071,165	1,071,165	--
Florida	15,035,675	15,792,643	15,792,643	--
Georgia	5,289,299	5,596,948	5,596,948	--
Hawaii	1,021,362	1,071,165	1,071,165	--
Idaho	1,021,362	1,071,165	1,071,165	--
Illinois	7,751,933	8,082,580	8,082,580	--
Indiana	4,062,628	4,244,089	4,244,089	--
Iowa	2,105,057	2,193,513	2,193,513	--
Kansas	1,788,240	1,863,836	1,863,836	--
Kentucky	2,830,077	2,954,133	2,954,133	--
Louisiana	2,744,355	2,872,528	2,872,528	--
Maine	1,028,376	1,081,160	1,081,160	--
Maryland	3,520,842	3,695,248	3,695,248	--
Massachusetts	4,339,413	4,540,013	4,540,013	--
Michigan	6,584,877	6,898,042	6,898,042	--
Minnesota	3,309,491	3,486,126	3,486,126	--
Mississippi	1,841,271	1,925,602	1,925,602	--
Missouri	3,986,638	4,155,738	4,155,738	--
Montana	1,021,362	1,071,165	1,071,165	--
Nebraska	1,165,501	1,217,228	1,217,228	--
Nevada	1,642,544	1,744,807	1,744,807	--
New Hampshire	1,021,362	1,071,165	1,071,165	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	5,650,333	5,884,229	5,884,229	--
New Mexico	1,326,408	1,391,175	1,391,175	--
New York	12,498,399	13,027,753	13,027,753	--
North Carolina	6,096,226	6,434,937	6,434,937	--
North Dakota	1,021,362	1,071,165	1,071,165	--
Ohio	7,783,568	8,110,984	8,110,984	--
Oklahoma	2,418,704	2,514,252	2,514,252	--
Oregon	2,658,943	2,809,618	2,809,618	--
Pennsylvania	9,152,573	9,517,980	9,517,980	--
Rhode Island	1,021,362	1,071,165	1,071,165	--
South Carolina	3,152,280	3,326,667	3,326,667	--
South Dakota	1,021,362	1,071,165	1,071,165	--
Tennessee	4,194,879	4,390,687	4,390,687	--
Texas	13,067,653	13,802,428	13,802,428	--
Utah	1,231,933	1,303,878	1,303,878	--
Vermont	1,021,362	1,071,165	1,071,165	--
Virginia	4,878,911	5,130,546	5,130,546	--
Washington	4,199,488	4,430,744	4,430,744	--
West Virginia	1,431,503	1,491,504	1,491,504	--
Wisconsin	3,726,193	3,921,045	3,921,045	--
Wyoming	1,021,362	1,071,165	1,071,165	--
Subtotal, States	200,407,871	210,210,751	210,210,751	--
American Samoa	136,498	136,498	136,498	--
Guam	510,681	535,583	535,583	--
Northern Mariana Islands	127,670	133,896	133,896	--
Puerto Rico	2,579,096	2,680,719	2,680,719	--
Virgin Islands	510,681	535,583	535,583	--
Subtotal, States and Territories	204,272,497	214,233,030	214,233,030	--
Undistributed 38/	1,216,503	2,163,970	2,163,970	--
TOTAL	**205,489,000**	**216,397,000**	**216,397,000**	--

[38] 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.

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	2,717,066	2,888,092	2,888,092	--
Alaska	361,153	383,886	383,886	--
Arizona	1,852,626	1,969,240	1,969,240	--
Arkansas	2,469,995	2,625,469	2,625,469	--
California	11,778,198	12,519,580	12,519,580	--
Colorado	1,257,978	1,337,162	1,337,162	--
Connecticut	1,353,616	1,439,662	1,439,662	--
Delaware	636,764	690,524	690,524	--
District of Columbia	448,777	477,025	477,025	--
Florida	6,247,984	6,641,265	6,641,265	--
Georgia	2,584,490	2,747,171	2,747,171	--
Hawaii	449,797	478,109	478,109	--
Idaho	686,740	731,746	731,746	--
Illinois	6,040,150	6,420,348	6,420,348	--
Indiana	1,713,783	1,821,658	1,821,658	--
Iowa	1,853,368	1,970,028	1,970,028	--
Kansas	2,096,178	2,245,929	2,245,929	--
Kentucky	1,613,303	1,714,852	1,714,852	--
Louisiana	3,037,339	3,228,525	3,228,525	--
Maine	562,507	597,914	597,914	--
Maryland	1,507,170	1,602,040	1,602,040	--
Massachusetts	5,582,108	6,038,694	6,038,694	--
Michigan	6,758,859	7,184,297	7,184,297	--
Minnesota	1,723,958	1,832,473	1,832,473	--
Mississippi	1,385,842	1,473,074	1,473,074	--
Missouri	3,926,098	4,173,227	4,173,227	--
Montana	1,113,135	1,204,909	1,204,909	--
Nebraska	1,111,943	1,181,935	1,181,935	--
Nevada	993,966	1,061,830	1,061,830	--
New Hampshire	1,075,409	1,143,101	1,143,101	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	3,470,661	3,689,123	3,689,123	--
New Mexico	1,878,920	1,997,189	1,997,189	--
New York	14,534,734	15,449,628	15,449,628	--
North Carolina	3,147,453	3,345,570	3,345,570	--
North Dakota	756,288	803,892	803,892	--
Ohio	5,179,861	5,505,909	5,505,909	--
Oklahoma	2,130,135	2,264,217	2,264,217	--
Oregon	1,665,493	1,770,327	1,770,327	--
Pennsylvania	5,452,243	5,795,436	5,795,436	--
Rhode Island	411,542	437,447	437,447	--
South Carolina	1,518,521	1,614,105	1,614,105	--
South Dakota	851,097	904,670	904,670	--
Tennessee	1,521,882	1,617,677	1,617,677	--
Texas	10,766,639	11,444,347	11,444,347	--
Utah	1,254,473	1,333,436	1,333,436	--
Vermont	749,547	796,727	796,727	--
Virginia	2,062,772	2,192,614	2,192,614	--
Washington	1,973,427	2,097,645	2,097,645	--
West Virginia	1,562,065	1,660,389	1,660,389	--
Wisconsin	2,550,472	2,711,012	2,711,012	--
Wyoming	766,328	814,564	814,564	--
Subtotal, States	138,783,700	148,069,689	148,069,689	--
American Samoa	--	--	--	--
Guam	309,967	329,478	329,478	--
Northern Mariana Islands	43,406	46,139	46,139	--
Puerto Rico	2,747,118	2,920,036	2,920,036	--
Virgin Islands	178,800	190,054	190,054	--
Subtotal, States and Territories	142,062,991	151,555,396	151,555,396	--
Tribal Organizations	3,283,410	3,505,490	3,505,490	--
Undistributed 39/	1,371,599	1,603,890	1,603,890	--
TOTAL	**146,718,000**	**160,069,000**	**160,069,000**	--

[39] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Preventive Health Services	$19,849,000	$19,848,000	$19,848,000	--

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

FY 2015 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. These funds 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 funding gives States and Territories flexibility to allocate resources among preventive health activities to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of their 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 over 78 years today. On average, an American turning age 65 today can expect to live an additional 19.1 years.[40] The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, totaling 5.9 million in 2012 and projected to reach 8.9 million by the year 2030.[41] 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.

[40] National Centers for Health Statistics, Health U.S., 2012: With Special Feature on Emergency Care. Table 18. Hyattsville, MD 2013.

[41] 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.

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 was included in the FY 2014 appropriation and is also proposed for FY 2015. 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 Supportive 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. Examples of evidence-based interventions include:

- *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.

- *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 cardiovascular problems and unnecessary duplication of prescriptions. These programs have also been shown to improve medication usage rates and decrease medication errors among older adults.

Funding History:

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

FY 2010 .....$21,026,000
FY 2011 .....$20,984,000
FY 2012 .....$20,944,000
FY 2013 .....$19,849,000
FY 2014 .....$19,848,000

Budget Request:

The FY 2015 budget request for Preventive Health Services is $19,848,000, the same as the FY 2014 enacted level. AoA continues to request appropriations language that was included by Congress for FY 2012, and again for FY 2014, 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, ACL has invested in an Aging and Disability Evidence-Based Program and Practices (ADEPP) review process that consists of a rigorous review of evidence-based interventions involving two panels of independent expert reviewers. One set of reviewers assess and rate the quality of research; the other reviewers rate the program on readiness for dissemination. Intervention summaries are made available on ACL's website at (http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx) and a link to the page is one resource on the Title IIID webpage. ADEPP is one way that ACL is working to improve access to information on evaluated interventions and reduce the lag time between the creation of scientific knowledge and its practical application in the field.

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.[42] Grantees can use the Title IIID Highest-Tier Criteria Evidence-Based Disease Prevention and Health Promotion Programs Cost Chart[43] on the site to search the 45+ highest-level criteria programs listed.

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

[43] http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/Title-IIID-Highest-Tier-Evidence-FINAL.pdf

Underscoring the need for these programs, the 2013 National Survey of Older Americans Act Participants found that between 72 and 90 percent of clients across OAA services take three or more different prescription medications every day. In addition, between 17 and 38 percent of clients across OAA services reported having stayed 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.[44]

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 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 2014 Projection	FY 2015 Projection	FY 2015 +/- FY 2014
Output AB: The number of people served with health and disease prevention programs *(Output)*	N/A (baseline set in FY 2013)	N/A	N/A	TBD

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$352,345	$350,884	$350,884
Range of Awards	$12,332 - $2,000,744	$12,281 - $1,992,449	$12,281 - $1,992,449

[44] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	312,653	311,357	311,357	--
Alaska	98,657	98,248	98,248	--
Arizona	380,319	378,742	378,742	--
Arkansas	198,557	197,733	197,733	--
California	2,000,744	1,992,449	1,992,449	--
Colorado	240,398	239,401	239,401	--
Connecticut	245,092	244,076	244,076	--
Delaware	98,657	98,248	98,248	--
District of Columbia	98,657	98,248	98,248	--
Florida	1,461,664	1,455,604	1,455,604	--
Georgia	457,632	455,734	455,734	--
Hawaii	98,657	98,248	98,248	--
Idaho	98,657	98,248	98,248	--
Illinois	789,367	786,094	786,094	--
Indiana	400,823	399,161	399,161	--
Iowa	217,951	217,047	217,047	--
Kansas	179,893	179,147	179,147	--
Kentucky	274,333	273,195	273,195	--
Louisiana	277,493	276,343	276,343	--
Maine	98,847	98,437	98,437	--
Maryland	338,915	337,509	337,509	--
Massachusetts	436,805	434,993	434,993	--
Michigan	651,262	648,562	648,562	--
Minnesota	318,214	316,895	316,895	--
Mississippi	184,167	183,404	183,404	--
Missouri	397,190	395,543	395,543	--
Montana	98,657	98,248	98,248	--
Nebraska	117,210	116,724	116,724	--
Nevada	142,417	141,827	141,827	--
New Hampshire	98,657	98,248	98,248	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	582,711	580,295	580,295	--
New Mexico	119,550	119,055	119,055	--
New York	1,291,839	1,286,483	1,286,483	--
North Carolina	542,091	539,844	539,844	--
North Dakota	98,657	98,248	98,248	--
Ohio	784,410	781,158	781,158	--
Oklahoma	241,578	240,576	240,576	--
Oregon	239,217	238,225	238,225	--
Pennsylvania	955,835	951,872	951,872	--
Rhode Island	98,657	98,248	98,248	--
South Carolina	277,242	276,092	276,092	--
South Dakota	98,657	98,248	98,248	--
Tennessee	391,150	389,528	389,528	--
Texas	1,176,078	1,171,202	1,171,202	--
Utah	108,013	107,565	107,565	--
Vermont	98,657	98,248	98,248	--
Virginia	455,071	453,184	453,184	--
Washington	373,204	371,656	371,656	--
West Virginia	143,708	143,112	143,112	--
Wisconsin	367,345	365,822	365,822	--
Wyoming	98,657	98,248	98,248	--
Subtotal, States	19,354,872	19,274,622	19,274,622	--
American Samoa	12,332	12,281	12,281	--
Guam	49,328	49,124	49,124	--
Northern Mariana Islands	12,332	12,281	12,281	--
Puerto Rico	253,137	252,088	252,088	--
Virgin Islands	49,328	49,124	49,124	--
Subtotal, States and Territories	19,731,329	19,649,520	19,649,520	--
Undistributed[45]	117,671	198,480	198,480	--
TOTAL	19,849,000	19,848,000	19,848,000	--

[45] The undistributed line reflects the amount reserved from the Preventive Health 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.

Chronic Disease Self-Management Education

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
CDSME……..	$7,086,000	$8,000,000	$8,000,000	--

Note: Funding in FY 2013 and FY 2014 was provided from the Prevention and Public Health Fund, and FY 2015 funding is requested again from that source.

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 2015 Public Health Service Act Authorization.....Expired

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

Program Description and Accomplishments:

Chronic Disease Self-Management Education (CDSME) programs, such as the Stanford University Chronic Disease Self-Management Program (CDSMP), are low-cost, evidence-based prevention models that use state-of-the-art techniques to help those with chronic conditions address issues related to the management and treatment of their condition, build self-confidence, improve their health status, and reduce their need for more costly medical care. In addition to the CDSMP, which is appropriate for any type of chronic condition, there are other proven CDSME programs, including the Spanish CDSMP, the Diabetes Self-Management Program (DSMP), Spanish DSMP, Chronic Pain Self-Management Program, Positive Self-Management Program for HIV, Arthritis Self-Management Program, and online versions of the CDSMP and DSMP.

In the United States, over 75 percent of older adults have multiple (2 or more) chronic conditions,[46] placing them at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement. [47] Chronic

[46] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data tables 1.1]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html Accessed 25 July, 2013.

[47] Vogeli C, Shields AE, Lee TA, Gibson TB, Marder WD, Weiss KB, Blumenthal D. Multiple chronic conditions: prevalence, health consequences, and implications for quality, care management, and costs. J Gen Intern Med 2007;22(Suppl 3):391–395. http://www. ncbi.nlm.nih. gov/pmc/ articles/PMC2150598/;

conditions also impact health care costs: 93 percent of Medicare expenditures are for beneficiaries with chronic conditions. [48]

CDSME programs have been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations), to be effective at helping participants adopt healthy behaviors, and improve their psychological and physical health status. [49] Some evidence suggests that CDSME programs may also significantly reduce the use of hospital care and physician services and reduce health care costs.[50]

CDSMEs emphasize an individual's role in managing his/her illness. The in-person programs consist of a series of workshops that are conducted once a week for two and a half hours over six to seven weeks in health care and community settings such as hospitals, 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 trained leaders. One or both of the leaders are non-health professionals or lay people with chronic diseases themselves. Core topics covered include: techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with health professionals; and 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 up to three years. In FY 2010, AoA funded 47 state grants for CDSME programs for a two year project period, using funding provided under the Recovery Act. AoA also funded a Resource Center through a grant to the National Council on Aging. Competitive grants and contracts are also used to support evaluation and related activities.

The Recovery Act grants concluded in March 2013. As of April 2013, over 101,000 people had completed CDSME courses across the country, well exceeding the programmatic goal to reach 50,000 completers within two years from the award date.

A new round of grants, funded in FY 2012 through the Prevention and Public Health Fund (PPHF), provided grants to 22 states to continue these activities. These three-year grants will allow states to provide CDSME programs to approximately 80,000 adults to help them better

[48] Nawrocki J. CMS Provides Data on Care for Chronic Conditions to Find Better Care Models. NetNews. April 2, 2013 http://health.wolterskluwerlb.com/2013/04/cms-provides-data-on-care-for-chronic-conditions-to-help-find-better-care-models/

[49] Brady TJ, Murphy L, O'Colmain BJ, Beauchesne D, Daniels B, Greenberg M, et al. A Meta-Analysis of Health Status, Health Behaviors, and Health Care Utilization Outcomes of the Chronic Disease Self-Management Program. Prev Chronic Dis 2013;10:120112. http://dx.doi.org/10.5888/pcd10.120112

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

manage chronic conditions. The funding is not only increasing access to CDSME programs but also fostering the development of comprehensive, integrated delivery systems to embed and sustain these programs within the long-term supports and services and health care systems.

Funding History:

FY 2010 .....[51]
FY 2011 .....$0
FY 2012 .....$10,000,000
FY 2013 .....$7,086,000
FY 2014 .....$8,000,000

Budget Request:

AoA requests FY 2015 funding totaling $8,000,000 for CDSME from the Prevention and Public Health Fund, the same as the FY 2014 enacted level. The Prevention and Public Health Fund (ACA 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 programs, by emphasizing an individual's role in managing his/her illness, help participants to reduce their pain and depression, improve mobility and exercise, increase energy, and boost confidence in their ability to manage their conditions. [52] A recent national study indicated that the program can also help participants achieve better care, better health, and lower health care costs. Participants reported significant improvements in aspects of their care (communication with their physicians, medication compliance, and health literacy), better health outcomes (self-assessed health, depression and quality of life), and reduced health care utilization (lower emergency room visits and hospitalizations), resulting in estimated potential cost savings.[53] 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.

[51] 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.

[52] Brady, TJ, Murphy, L: Sorting through the Evidence: Executive Summary of Arthritis Self-Management Program and the Chronic Disease Self-Management Program Meta-Analyses, May 2011, Centers for Disease Control and Prevention. http://www.cdc.gov/arthritis/docs/ASMP-executive-summary.pdf

[53] Whitelaw, N., Lorig, K., Smith, M. L., & Ory, M. G. (March 19, 2013). National Study of Chronic Disease Self-Management Programs (CDSMP). Retrieved May 3, 2013 from http://www.ncoa.org/improve-health/center-for-healthy-aging/content-library/CDSMP_Grantee_Webinar_03_19_2013_ALL_FINAL.pdf

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. For example, nearly 11 million adults over the age of 65 have diabetes.[54] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. CDSME programs are having a significant reach and impact on these populations. In FY 2012 alone, 22,809 individuals with chronic conditions completed the CDSME program through AoA's network (Output CD1). Nearly 61 percent of participants reporting relevant data indicate having multiple chronic conditions, with the most common conditions being hypertension (43.7 percent), arthritis (41.1 percent), and diabetes (31.2 percent). Over one-third of the participants are minority elders, including 23 percent African-Americans and over 16 percent Hispanics.

CDSME programs are also 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. At the community level, aging services provider organizations work in collaboration with public 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 Resource Centers.

Continued funds will support competitive grants to States, as well as related technical assistance and evaluation activities such as a contract for an online database quality assurance system and technical assistance on building the business acumen of states and local agencies to help them sustain their CDSME programs and continued funding for a National Resource Center on Chronic Disease Self-Management Education 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.

[54]Centers for Disease Control and Prevention. National Diabetes Fact Sheet. http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf,Accessed May 4, 2013.

Grant Awards Table:

Chronic Disease Self-Management Education Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	23	23	23
Average Award	$297,102	$325,425	$325,425
Range of Awards	$140,000 - $790,000	$140,000 - $1,000,000	$140,000 - $1,000,000

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
CD2: Increase the percentage of individuals who complete the CDSME program *(Outcome)*	FY 2012: 74% (Target: Baseline)	74%	75%	+ 1%
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output CD1: Total number of individuals with chronic conditions completing the CDSME program *(Output)*	FY 2012: 22,809	20,000	20,000	Maintain

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 the fall of 2011 for 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 was completed during the summer of 2013 and the final report is available on the AoA website at: http://www.aoa.gov/AoARoot/Program_Results/Program_Evaluation.aspx. The results of the work with CMS are expected to be completed during the fall of 2013.

Resource and Program Data:

Chronic Disease Self-Management Education
(Dollars in Thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	1	790	--	--	22	6,485
Continuations	22	6,043	23	7,485	1	1,000
Contracts	1	100	1	310	1	310
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		153		205		205
Total Resources		7,086		8,000		8,000

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

Falls Prevention

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Falls Prevention……..	--	$5,000,000	$5,000,000	--

Note: Funding in FY 2014 was provided from the Prevention and Public Health Fund, and FY 2015 funding is requested again from that source.

Authorizing Legislation: Section 411 of the Older Americans Act of 1965, as amended, and the Patient Protection and Affordable Care Act (ACA), Section 4002 [42 U.S.C. 300u-11]

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

Program Description and Accomplishments:

Falls are the leading cause of both fatal and nonfatal injuries for those 65 and over. [55] One in three adults aged 65 and older falls each year. [56] In 2010, fall-related injuries resulted in 2.3 million emergency room visits, over 660,000 hospitalizations, about 21,700 deaths, and an estimated $30 billion in direct medical costs. [57] Of those who fall, 20 to 30 percent will experience serious injuries, such as brain trauma, broken bones, or hip fractures. [58] The average hospital stay for a hip fracture is one week and about one-third of those with hip fractures stay in a nursing home for a year or more. [59] 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. [60] Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[61] The importance of preventing falls is underscored by the inclusion of falls prevention screening in the annual Medicare wellness visit.

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[55] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web–based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed August 15, 2013.

56 Tromp AM, Pluijm SMF, Smit JH, et al. Fall-risk screening test: a prospective study on predictors for falls in community-dwelling elderly. J Clin Epidemiol 2001;54(8):837–844.

[57] Centers for Disease Control and Prevention, Falls Among Older Adults: An Overview. Retrieved on February 5, 2014 from http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html

[58] Stevens JA. Fatalities and injuries from falls among older adults – United States, 1993–2003 and 2001–2005. MMWR 2006b;55.45:1222–24.

[59] Centers for Disease Control and Prevention, Hip Fractures Among Older Adults: An Overview. Retrieved on February 5, 2014 from http://www.cdc.gov/HomeandRecreationalSafety/Falls/adulthipfx.html

[60] Bell AJ, Talbot-Stern JK, Hennessy A. Characteristics and outcomes of older patients presenting to the emergency department after a fall: a retrospective analysis. Medical Journal of Australia 2000;173(4):176–7.

61 Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of falling and restriction of mobility in elderly fallers. Age and Ageing 1997;26:189–193.

Falls can result in significant loss of independence and often trigger the onset of a series of growing needs. For those over age 75, fallers are more than four times more likely to be admitted to a skilled nursing facility[62]. And falls, even without a major injury, can cause an older adult to become fearful or depressed, making it difficult for them to stay active, which in turn increases the need for assistance.

Falls prevention programs help participants to achieve improved strength, balance, and mobility and provide education on how to avoid falls and reduce fall risk factors. These programs may also 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. Since 2006, more than 27,000 older adults in 38 states have been served via AoA-supported Falls Prevention/Management programs, including A Matter of Balance, Stepping On, and Tai Chi: Moving for Better Balance.

Randomized controlled trials of several community-based Falls Prevention/Management programs have clearly demonstrated a reduction in falls. When compared with control groups, the risk of falling for participants in the Tai Chi: Moving for Better Balance intervention was decreased 55 percent;[63] and the Stepping On program reduction was 31 percent.[64] Matter of Balance is an evidence-based program designed to reduce the fear of falling and increase activity levels among older adults. Research has shown significant improvements for participants regarding their level of falls management (the degree of confidence participants perceive concerning their ability to manage the risk of falls and of actual falls); falls control (the degree to which participants perceive their ability to prevent falls); level of exercise; and social limitations with regard to concern about falling.[65] Matter of Balance participation has been associated with total medical cost savings, and cost savings in the unplanned inpatient, skilled nursing facility, and home health settings. Participation was associated with a $938 decrease in total medical costs per year. This finding was driven by a $517 reduction in unplanned hospitalization costs, a $234 reduction in skilled nursing facility costs, and an $81 reduction in home health costs.[66]

[62] Donald IP, Bulpitt CJ. The prognosis of falls in elderly people living at home. Age and Ageing 1999;28:121–5

[63] Fuzhong L, Harmer P, Fisher JK, Mcauley E. Tai Chi: Improving Functional Balance and Predicting Subsequent Falls in Older Persons. Med Sci Sports Exerc. (2004) 36 (12): 2046-2052.

[64] Clemson L, Cumming RG, Kendig H, Swann M, Heard R, Taylor K. The Effectiveness of a Community-Based Program for Reducing the Incidence of Falls in the Elderly: A Randomized Trial. J Am Geriatr Soc. (Sept 2004) 52 (9): 1487–1494.

[65] Healy, T.C., Peng, C., Haynes, P., McMahon, E., Botler, J., & Gross, L. (2008). The feasibility and effectiveness of translating A Matter of Balance into a volunteer lay leader model. Journal of Applied Gerontology, 27(1): 34-51.

[66] http://innovation.cms.gov/Files/reports/CommunityWellnessRTC.pdf

Funding History:

FY 2010 .....$0
FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$5,000,000

Budget Request:

ACL is requesting $5,000,000 from the Prevention and Public Health Fund in FY 2015, the same as the FY 2014 enacted level. Since FY 2014 was the first year of funding and the funding opportunity announcement has not yet been issued at the time of this writing, programmatic decisions have not been finalized. However, we anticipate that the funds may be used to fund a national resource center and competitive grants to States, Tribes, and/or other applicants to implement evidence-based falls prevention programs through ACL's network of community-based provider organizations.

State and/or tribal grants might be used to:

- Promote and disseminate fall prevention tools to support patient assessment and referral, and the use of evidence-based community programs;

- Better integrate health care and state/local health department activities in the delivery of fall prevention services in collaboration with the aging services network;

- Provide, expand and sustain evidence-based community-based programs and community change strategies that reduce falls and falls risks;

- Utilize and expand the local evidence-based program infrastructure for falls prevention/management programs started in the AoA Evidence-Based Disease and Disability Prevention Program;

- Promote Community Integrated Health Care Systems and capitalize on opportunities within the Affordable Care Act, including Care Transitions programs to reduce hospital readmissions due to falls, and the annual Medicare wellness visits that include screening for falls prevention and referrals to community-based interventions to address modifiable risk factors;

Grantees may be expected to implement at least one evidence-based falls prevention/management program; establish partnerships/coalitions with Falls Prevention coalitions, healthcare providers, public health officials, and ADRCs; and cooperate with federal research efforts. Funds may also be used to fund a falls prevention resource center which will promote best practices for development, implementation, and sustainability of falls prevention/management programs.

Grant Awards Table:

Falls Prevention Program Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	--	16	16
Average Award	--	$297,563	$297,563
Range of Awards	--	$200,000 - $450,000	$200,000 - $450,000

Resource and Program Data:

Falls Prevention
(Dollars in Thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	16	4,761	15	4,361
Continuations	--	--	--	--	1	400
Contracts	--	--	1	197	1	197
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		42		42
Total Resources		--		5,000		5,000

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

Senior Community Service Employment Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014 PB
SCSEP..……..	$424,805,000	$434,371,000	$380,000,000	-$54,371,000
FTE…….	10	10	10	--

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

FY 2015 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 is below 125 percent 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 (DOL) but is proposed for transfer to ACL in FY 2015.

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 that 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 also reserved for 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 provided input and suggestions related to priorities and targeting.

In general, 75 percent of Federal funds for 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 2010 .....$825,425,000[67]
FY 2011 .....$449,100,000
FY 2012 .....$448,251,000
FY 2013 .....$424,805,000
FY 2014 .....$434,371,000

Budget Request

The FY 2015 request for SCSEP is $380,000,000, a reduction of -$54,371,000 from the FY 2014 enacted level. 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 of its top 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.

In order to continue operations at this reduced level, ACL proposes to re-structure SCSEP solely as a community service program. In years past, SCSEP has been administered alongside the programs associated with the 1998 Workforce Investment Act (WIA), which provides the framework for a national workforce preparation and employment system designed to meet both the needs of the nation's businesses and the needs of job seekers and those who want to further their careers. SCSEP has not fit well within this context, as older workers involved in the program were typically not looking to advance their career but rather to simply supplement their income during their retirement years. The older SCSEP worker is not looking to build a resume but rather to increase his or her income and contribute to the community.

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

Under ACL administration, emphasis would shift to integration with other OAA services, providing additional benefits to older people as well creating opportunities for them to become contributing members to local communities, aging services programs and the Aging Services Network as a whole. For example, seniors hired through the SCSEP program to provide assistance to older adults residing in public housing could also take part in Title IIIC nutrition programs or IIID exercise programs at their job site in addition to their supportive employment. In addition, new opportunities for seniors to assist other seniors are likely to arise when SCSEP is aligned with the Aging Services Network infrastructure and support system. The Department of Labor reports that currently nearly 1/3 of SCSEP employees are housed with public agencies with many of these in public libraries. Many others are in non-profit organizations serving as receptionists, security personnel and custodians.

In line with OAA requirements, Aging Network entities administering the SCSEP program would have the opportunity to directly target those in greatest need, both as SCSEP employees as well as through SCSEP placements in programs serving minorities or other underserved populations. ACL would also make improving program performance a priority. This would include targeting SCSEP to people with the greatest need. In this way, the program's eligibility, income and other requirements could become better aligned with those of other HHS income maintenance programs. Additionally, ACL anticipates taking a close look at the balance of funding between state and national SCSEP grantees and targeting these limited funds to the areas where performance data indicate the potential for the largest impact.

ACL does not propose to undertake this reduction in SCSEP funding lightly. The proposed transfer of SCSEP to ACL provides a rare opportunity to assess the underlying structure of a program and to make changes that will not only improve program performance, but that will also improve targeting while making unfortunate but necessary funding reductions in light of the extremely tight budget environment.

Outcome Table

Measure	Most Recent Result	PY 2014 Projection	PY 2015 Projection	FY 2015 +/- FY 2014
Output 1.1: Average earnings in the second and third quarters after exit (Outcome)	PY 2012: $7,181	$7,564	TBD	TBD
Output 1.3: Percent of participants employed in the first quarter after exit (Outcome)	PY 2012: 41.7%	43.9%	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 2012: 73.3%	73.4%	TBD	TBD

Note: 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.

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Native American Nutrition and Supportive Services

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Native American Nutrition & Supportive Services…..	$26,157,000	$26,158,000	$26,158,000	--

Authorizing Legislation: Sections 201, 613, and 623 of the Older Americans Act of 1965, as amended

FY 2015 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 2011 American Community Survey, approximately 301,000 persons age 60 and over identified themselves as Native Americans or Alaskan Natives, and another 242,000 persons age 60 and over identified themselves as Native American or Alaskan Native 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 2012, the most recent year for which data are available, include:

- *Transportation Services*, which provided 712,509 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities (Output L).

- *Home-Delivered Nutrition Services*, under which 2.65 million meals were provided to 22,287 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 nearly 2.38 million meals to 49,511 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 917,810 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 2010 .....$27,704,000
FY 2011 .....$27,653,000
FY 2012 .....$27,601,000
FY 2013 .....$26,157,000
FY 2014 .....$26,158,000

Budget Request:

The FY 2015 request for Native American Nutrition and Supportive Services is $26,158,000, the same as the FY 2014 enacted level.

Native American Nutrition and Supportive Services, like the same services that Home and Community-Based Supportive Services 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 2015 request level, these services will provide 774,500 rides (Output L), 2.4 million meals at home (Output M), and 2.3 million meals at congregate sites (Output N) to approximately 77,600 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 2015 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 297 Target: 300 (Target Not Met)	300	300	Maintain
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output L: Transportation Services units *(Output)*	FY 2012: 712,509	784,000	774,500	-9,500
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2012: 2.65 M	2.4 M	2.4 M	--
Output N: Congregate Nutrition meals *(Output)*	FY 2012: 2.38 M	2.26 M	2.265 M	+5,000
Output O: Information, Referral and Outreach units *(Output)*	FY 2012: 917,810	900,000	900,000	--

Grant Awards Table:

Native American Nutrition & Supportive Services Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	256	256	256
Average Award	$100,686	$100,016	$100,016
Range of Awards	$72,220 - $1,505,000	$73,650 - $1,505,000	$73,650 - $1,505,000

Resource and Program Data:

Native American Nutrition and Supportive Services
(Dollars in Thousands)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	256	25,776	256	25,604	256	25,604
New Discretionary	--	--	1	150	--	--
Continuations	--	--	--	--	1	150
Contracts	1	366	1	366	1	366
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		15		38		38
Total Resources		26,157		26,158		26,158

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

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Aging Network Support Activities

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014 PB
Aging Network Support Activities	$7,432,000	$7,461,000	$7,461,000	--

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

FY 2015 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 five 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 738,234 individuals in FY 2013.

ACL also continues to support civic engagement efforts that help connect older adults with volunteer opportunities in their communities. In FY 2011, AoA launched the *Aging Network's Volunteer Collaborative,* which will help the aging network more effectively use and expand the number of volunteers. The Collaborative is a partnership of a number of aging organizations and the Corporation for National and Community Service. It has assessed needs and barriers to volunteering; offers technical assistance through workshops and webinars; developed a robust website; and awarded small incentive grants. It also developed a partnership with LexisNexis to reduce the cost for volunteer background checks.

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, 2013, the National Alzheimer's Call Center handled over 294,000 calls through its national and local partners, and its on-line message board community recorded over 5.2 million page views. 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 recovered over $175 million in client benefits, representing a return of more than eight dollars for every Federal dollar invested in the program.

- Projects have directly served over 50,000 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 provides women with access to a one-stop gateway that integrates financial information and resources on retirement planning for health and long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including 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 published in hard copy and Web-based formats. Since its establishment 1998, the Center has conducted approximately 200 workshops per year on strategies to access financial and retirement planning information for women. It has developed and published over 175 Fact Sheets tailored to the specific needs of hard-to-reach women and maintains an interactive web site.

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.

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, a referral database of Chronic Disease Self-Management (CDSME) workshops, and culturally appropriate caregiver manual/toolkit for American Indian and Alaskan Native caregivers caring for elders with dementia.

LGBT elders also 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 2015, 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 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 2010 .....$8,198,000
FY 2011 .....$8,184,000
FY 2012 .....$7,873,000
FY 2013 .....$7,432,000
FY 2014 .....$7,461,000

Budget Request:

The FY 2015 request for Aging Network Support Activities is $7,461,000, the same as the FY 2014 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Aging Network Support Activities:			
National Eldercare Locator and Engagement	$2,030	$2,038	$2,038
National Alzheimer's Call Center	942	945	945
National Education & Resource Center on Women & Retirement	234	235	235
Pension Information and Counseling Program	1,617	1,623	1,623
National Resource Centers on Native Americans	652	655	655
National Minority Aging Organizations	1,161	1,165	1,165
Program Performance and Technical Assistance	796	799	799
Total, Aging Network Support Activities	**$7,432**	**$7,461**	**$7,461**

Grant Awards Table:

Aging Network Support Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	24	25	25
Average Award	$303,542	$274,731	$285,720
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)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	18	5,329	7	1,046	7	1,603
Continuations	6	1,956	19	6,097	18	5,540
Contracts	--	--	1	25	1	25
Interagency Agreements	1	10	2	47	2	47
Program Support 1/		137		246		246
Total Resources		7,432		7,461		7,461

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

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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.[68] 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).[69]

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.[70] 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.[71]

At the same time, ACL recognizes that it must also address the growing need for more caregivers every day. By 2020, it is projected that there will be 16.2 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of four million seniors (or a 35 percent

[68] *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

[69] *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

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

[71] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

between 2011 and 2020) needing caregiver assistance.[72] To address these caregiver-related needs, ACL requests a total of $168,277,000, the same as the FY 2014 enacted level. The request includes:

- $145,586,000 for Family Caregiver Support Services, the same as the FY 2014 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.

- $6,031,000 for Native American Caregiver Support Services, the same as the FY 2014 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.

- $3,800,000 for Alzheimer's Disease Supportive Services, the same as the FY 2014 enacted level. This program focuses 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. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act.

- $10,500,000 for services to individuals with Alzheimer's Disease (AD) and their families under the President's Alzheimer's Initiative, funded from the Prevention and Public Health Fund. The same amount is available from the Prevention Fund in FY 2014. 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.

[72] 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 and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population (2011) [data table 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2011CharAndPerc.html . Accessed 25 July,2013.

- $2,360,000 for Lifespan Respite Care, the same as the FY 2014 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. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act.

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Family Caregiver Support Services	$145,586,000	$145,586,000	$145,586,000	--

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

FY 2015 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 to provide a coordinated set of supports which caregivers can access on behalf of seniors. 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 1.1 million contacts to caregivers assisting them in locating services from a variety of public and private agencies (Output I).

- *Counseling and Training Services* provided 138,427 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 69,000 caregivers with 6.3 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).[73] 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 2013 National Survey of OAA Participants, 19 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-seven percent describe their own health as fair to poor.[74] 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.[75]

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 78 percent of caregivers of program clients reported in 2013 that services enabled them to provide care longer than otherwise would have been possible.[76] 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-one 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).

[73] *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
[74] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.
[75] *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.
[76] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

(based on responses from care recipients unable to live independently) [77]

Funding History:

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

FY 2010 .....$154,197,000
FY 2011 .....$153,912,000
FY 2012 .....$153,621,000
FY 2013 .....$145,586,000
FY 2014 .....$145,586,000

[77] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

Budget Request:

The FY 2015 request for Family Caregiver Support Services is $145,586,000, the same as the FY 2014 enacted level. With this proposed funding, 790,000 caregivers (Outcome 3.1) will be provided with supportive services, including respite care or temporary relief from their caregiving responsibilities. 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 78 percent of caregivers report these supportive services enable them to provide care longer.

In FY 2015, AoA expects the aging services network to meet or exceed the target of only 27 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 2012 that rate had been reduced by nearly 60 percent to 26 percent of caregivers reporting difficulty getting services.

For FY 2015, 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 2015 compared to FY 2012. 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Outcome 2.6: Reduce the percent of caregivers who participate in the National Family Caregiver Support Program who report difficulty in getting services. *(Outcome)*	FY 2012: 26% Target: 28% (Target Exceeded)	28%	27%	- 1.0%
Outcome 2.9c: Maintain at 90% or higher the percentage of National Family Caregiver Support Program clients who rate services good to excellent. *(Outcome)*	FY 2012: 93.8% Target: 90% (Target Exceeded)	90%	90%	Maintain
Outcome 3.1: Increase the number of caregivers served through the National Family Caregiver Support Program. *(Outcome)*	FY 2012: 867,546 Target: 792,000 (Target Exceeded)	790,000	790,000	Maintain
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output I: Caregivers access assistance units of service. *(Output)*	FY 2012: 1,131,781	1.05 M	1.04 M	- 10,000
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2012: 138,427	121,000	118,000	- 3,000
Output K: Caregivers receiving respite care services. *(Output)*	FY 2012: 68,995	65,900	66,100	+ 200

Note: 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$2,584,357	$2,573,753	$2,573,753
Range of Awards	$90,453 - $14,711,105	$90,081 - $14,702,604	$90,081 - $14,702,604

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	2,220,390	2,206,505	2,206,505	--
Alaska	723,620	720,651	720,651	--
Arizona	3,063,358	3,103,554	3,103,554	--
Arkansas	1,423,632	1,408,847	1,408,847	--
California	14,711,105	14,702,604	14,702,604	--
Colorado	1,856,698	1,878,721	1,878,721	--
Connecticut	1,749,484	1,721,520	1,721,520	--
Delaware	723,620	720,651	720,651	--
District of Columbia	723,620	720,651	720,651	--
Florida	11,527,293	11,546,017	11,546,017	--
Georgia	3,418,391	3,455,065	3,455,065	--
Hawaii	723,620	720,651	720,651	--
Idaho	723,620	720,651	720,651	--
Illinois	5,540,545	5,472,900	5,472,900	--
Indiana	2,878,077	2,849,523	2,849,523	--
Iowa	1,607,487	1,577,341	1,577,341	--
Kansas	1,320,014	1,295,632	1,295,632	--
Kentucky	1,950,378	1,935,102	1,935,102	--
Louisiana	1,887,778	1,874,587	1,874,587	--
Maine	723,620	720,651	720,651	--
Maryland	2,398,426	2,396,329	2,396,329	--
Massachusetts	3,135,868	3,099,001	3,099,001	--
Michigan	4,652,840	4,618,195	4,618,195	--
Minnesota	2,390,107	2,374,116	2,374,116	--
Mississippi	1,286,333	1,281,036	1,281,036	--
Missouri	2,877,048	2,850,250	2,850,250	--
Montana	723,620	720,651	720,651	--
Nebraska	871,922	855,735	855,735	--
Nevada	1,064,959	1,087,045	1,087,045	--
New Hampshire	723,620	720,651	720,651	--

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	4,097,131	4,044,765	4,044,765	--
New Mexico	909,221	908,751	908,751	--
New York	9,063,268	8,956,618	8,956,618	--
North Carolina	4,166,899	4,195,336	4,195,336	--
North Dakota	723,620	720,651	720,651	--
Ohio	5,629,924	5,551,309	5,551,309	--
Oklahoma	1,722,263	1,703,328	1,703,328	--
Oregon	1,820,218	1,820,805	1,820,805	--
Pennsylvania	6,876,661	6,751,748	6,751,748	--
Rhode Island	723,620	720,651	720,651	--
South Carolina	2,104,546	2,125,724	2,125,724	--
South Dakota	723,620	720,651	720,651	--
Tennessee	2,866,541	2,863,391	2,863,391	--
Texas	8,808,631	8,842,879	8,842,879	--
Utah	852,599	853,564	853,564	--
Vermont	723,620	720,651	720,651	--
Virginia	3,290,920	3,301,214	3,301,214	--
Washington	2,807,974	2,808,735	2,808,735	--
West Virginia	1,008,212	997,669	997,669	--
Wisconsin	2,709,247	2,688,849	2,688,849	--
Wyoming	723,620	720,651	720,651	--
Subtotal, States	141,973,448	141,372,773	141,372,773	--
American Samoa	90,453	90,081	90,081	--
Guam	361,810	360,325	360,325	--
Northern Marianas Islands	90,453	90,081	90,081	--
Puerto Rico	1,846,036	1,856,555	1,856,555	--
Virgin Islands	361,810	360,325	360,325	--
Subtotal, States and Territories	144,724,010	144,130,140	144,130,140	--
Undistributed[78]	861,990	1,455,860	1,455,860	--
TOTAL	**145,586,000**	**145,586,000**	**145,586,000**	--

[78] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Native American Caregiver Support Services…….....	$6,031,000	$6,031,000	$6,031,000	--

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

FY 2015 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 the Native American Nutrition and Supportive Services program 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 Native American Caregiver Support Services during the past five years is as follows:

FY 2010 .....$6,388,000
FY 2011 .....$6,376,000
FY 2012 .....$6,364,000
FY 2013 .....$6,031,000
FY 2014 .....$6,031,000

Budget Request:

The FY 2015 request for Native American Caregiver Support Services is $6,031,000, the same as the FY 2014 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 2015 are expected to decline due to the economic downturn impacting Tribal government budgets.

In FY 2015 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 2015 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Outcome 3.1: Increase the number of caregivers served through the National Family Caregiver Support Program. *(Outcome)*	FY 2012: 867,546 Target: 792,000 (Target Exceeded)	790,000	790,000	Maintain

Grant Awards Table: Native American Caregivers Supportive Services Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	218	218	218
Average Award	$27,663	$27,663	$27,663
Range of Awards	$13,360 - $54,689	$13,360 - $54,740	$13,360 - $54,740

Resource and Program Data: Native American Caregiver Support Services (Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	218	6,031	218	6,031	218	6,031
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		--
Total Resources		6,031		6,031		6,031

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
ADSSP……..	$3,786,000	$3,800,000	$3,800,000	--

Note: For FY 2015, these funds are requested from amounts under section 241 of the Public Health Service Act

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

FY 2015 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. The statute governing the ADSSP requires that States "expend not less than 50 percent of the federal grant funds for the provision of (direct) services" to individuals with Alzheimer's disease or related dementias, their families and their caregivers.

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 (LTSS) system.

AoA presently supports 18 state grantees through this program. Eleven States continue to translate eight evidence-based interventions into practice and 4 States are offering innovative programming for caregivers and their loved ones with dementia. Additionally, nine states are funded to design systems to ensure access to dementia capable home and community based services.

One example of an evidence-based intervention 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.[79] 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' LTSS systems 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 2010 .....$11,462,000
FY 2011 .....$11,441,000
FY 2012 .....$4,010,000
FY 2013 .....$3,786,000
FY 2014 .....$3.800,000

Budget Request:

The FY 2015 request for the Alzheimer's Disease Supportive Services Program is $3,800,000, the same as the FY 2014 enacted level. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act. 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 unable to undertake subsequent translations of research funded by National Institute on Aging, Centers for Disease Control and Prevention, and other science agencies. The need for cutting

[79] 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.

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 about 5 million individuals have this disease. [80]

The FY 2015 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.

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. [81]

By the end of the first quarter of FY 2014, 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 projects that it will have an analysis of the evaluations 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.

[80] 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

[81] 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Outcome ALZ2. Increase number of individuals served with evidence-based interventions – cumulative[82] *(Outcome)*	FY 2012: 14,600 Target: 8,800 (Target Exceeded)	19,000	21,500	+ 2,500
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output AC: Number of individuals served – cumulative[83] *(Output)*	FY 2012: 32,377	42,000	44,000	+ 2,000
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	FY 2012: 25%	21%	21%	--

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	5	10	10
Average Award	$619,700	$285,100	$285,100
Range of Awards	$480,379 - $748,660	$250,000- $450,000	$250,000- $450,000

[82] Cumulative count began in 2008.
[83] Cumulative count began in 2008.

Resource and Program Data:

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

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	5	3,099	10	2,851	10	2,851
Continuations	--	--	--	--	--	--
Contracts	1	604	1	791	1	791
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		83		158		158
Total Resources		3,786		3,800		3,800

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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alzheimer's Disease Initiative – Services (Prevention Fund)	--	$10,500,000	$10,500,000	--

Note: Funding in FY 2014 was provided from the Prevention and Public Health Fund, and FY 2015 funding is requested again from that source.

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 2015 Public Health Service Act Authorization.....Expired

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

Program Description and Accomplishments:

On February 7, 2012, the President announced a new effort to fight Alzheimer's Disease. About 5 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 require significant amounts of health care and intensive long-term services and supports (LTSS) – including 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.[84] 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.[85] 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.

[84] 2013 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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

Caregivers of persons with Alzheimer's disease are at an even greater risk of stress and ill health than other caregivers. Measured by duration of care, dementia caregivers provide care on average one to four years more than caregivers caring for someone with an illness other than Alzheimer's disease (43 percent vs. 33 percent). They are also more likely to be providing care for five years or longer (32 percent vs. 28 percent).[86] In another study, 44 percent of caregivers of people with dementia indicated depressive symptoms, compared with 27 percent of caregivers of people who had cognitive impairment but no dementia.[87] Data from the 2010 BRFSS caregiver survey found that 7 percent of dementia caregivers say the greatest difficulty of caregiving is that it creates or aggravates their own health problems compared with 2 percent of other caregivers.[88]

Developing more dementia capable LTSS systems designed to meet the needs of caregivers of individuals with Alzheimer's Disease and related dementias is critical to helping these individuals continue to provide care. Through this initiative, AoA will work with lead agencies across State, local, and tribal governments and with the Aging Network to identify and address the needs of persons with Alzheimer's disease and their caregivers when they seek assistance.

Funding History:

FY 2010 .....$0
FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$10,500,000

Budget Request:

The FY 2015 budget includes $10,500,000 from the Prevention and Public Health Fund for Alzheimer's disease services as part of the President's efforts to fight Alzheimer's disease. The same amount was available in FY 2014.

ACL will use the $10.5 million it is requesting in FY 2015 to expand one particular approach to improving care for those with Alzheimer's disease and their caregivers, which focuses on building and strengthening the dementia capability of a handful of States, tribal entities, or large

[86] Alzheimer's Association, 2011 Alzheimer's Disease Facts and Figures, Alzheimer's and Dementia , Vol.7, Issue 2.
[87] Fisher GG, Franks MM, Plassman BL, Brown SL, Potter GG, Llewellyn D, et al. Caring for individuals with dementia and cognitive impairment, not dementia: Findings from The Aging, Demographics, and Memory Study. J Am Ger Soc 2011;59(3):488–94.

[88] Bouldin ED, Andresen E. Caregiving Across the United States. Caregivers of persons with Alzheimer's disease or dementia in Connecticut, New Hampshire, New Jersey, New York, and Tennessee. Data from the 2010 Behavioral Risk Factor Surveillance System. Seattle, Wash.: University of Washington Department of Epidemiology; 2010.

localities. A “dementia capable” LTSS system is able to identify those with dementia and their caregivers, understand their unique circumstances, communicate appropriately with them, 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; and
- 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; and
- 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.

Resource and Program Data:

Alzheimer's Disease Initiative – Services
(Dollars in thousands)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	11	9,982	11	9,982
Continuations	--	--	--	--	--	--
Contracts	--	--	1	500	1	500
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		18		18
Total Resources		--		10,500		10,500

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

Lifespan Respite Care

	FY 2013 Final	FY 2014 Enacted	FY 2015 Final	FY 2015 +/- FY 2014
Lifespan Respite Care..	$2,351,000	$2,360,000	$2,360,000	--

Note: For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act.

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

FY 2015 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 percent) caring for someone over age 18 have medium or high levels of burden and 31 percent of all family caregivers indicated they experienced high levels of stress.[89]

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[90] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers.[91] 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 percent of family caregivers receive no respite at all.[92]

[89] 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

[90] 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

[91] National Alliance for Caregiving and AARP, 2009

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

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 developmental disabilities, and for caregivers of veterans and individuals with Alzheimer's disease, spinal cord injuries, autism, and serious emotional disorders. [93]

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 test-bed 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, the Lifespan Respite Care Program has made grants to eligible state agencies and for the funding of a National Technical Assistance Resource Center as follows:

- Grants to new states each year have allowed for the initial development of Lifespan Respite Programs. To date, 31 states and the District of Columbia have received initial three-year grants.

- In FY 2011 and FY 2012, a total of ten states (eight in 2011 and two in 2012) were awarded competitive expansion supplements to focus specifically on providing respite services to meet demand and fill gaps in service where identified;
- Integration and Sustainability grants in FY 2012 and FY 2013 have been awarded to a total of fifteen states (seven in 2012 and eight in 2013) enabling them to more fully embed the concept of respite and family support into statewide home and community-based services across the age and disability spectrum; and

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

- Two Technical Assistance Resource Center cooperative agreements (the first awarded in FY 2009 and the second in FY 2012), have afforded the opportunity to provide basic and advanced technical assistance to grantees on a range of topics pertaining to general program development and implementation; population-specific respite information and training; program sustainability; the collection, synthesis and dissemination of available respite research information; and the development and maintenance of a National Registry of respite services.

Examples of grantee accomplishments to date include:

- Creation and adoption of statewide respite plans and/or policies to guide further development of respite and caregiver support programs;

- 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," dedicated websites and statewide respite registries 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;

- Development of data collection methodologies to track service provision and programmatic outcomes;

- 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. Special emphasis is placed on implementing or enhancing lifespan respite care statewide and 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 2010 .....$2,500,000
FY 2011 .....$2,495,000
FY 2012 .....$2,490,000
FY 2013 .....$2,351,000
FY 2014 .....$2,360,000

Budget Request:

The FY 2015 request for Lifespan Respite is $2,360,000, the same as the FY 2014 enacted level. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act. 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 percent of family caregivers of care recipients age 18 and older, and 81 percent 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.[94]

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

The resources requested for FY 2015 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.

Output Table:

Lifespan Respite Care Output

Indicator	Most Recent Result	FY 2014 Projection	FY 2015 Projection	FY 2015 +/- FY 2014
Output AE: Increase the number of people served as a result of Lifespan Respite Care *(Output)*	N/A (Baseline in FY 2013)	TBD	TBD	N/A

Grant Awards Table:

Lifespan Respite Care Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	10	26	26
Average Award	$230,199	$88,153	$88,153
Range of Awards	$115,968 - $267,654	$50,000 - $100,000	$50,000 - $100,000

Resource and Program Data:

Lifespan Respite Care Program
(Dollars in thousands)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	9	2,034	25	2,042	3	600
Continuations	1	268	1	249	23	1,691
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		49		69		69
Total Resources		2,351		2,360		2,360

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

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.[95] 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.[96] 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.[97]

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.[98] 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.[99] Protection of Vulnerable Adults

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[95] 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

[96] 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

[97] 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

[98] 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.

[99] 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 issues of elder abuse, neglect, and exploitation affect millions of Americans. ACL's FY 2015 Elder Justice Initiative proposes +$25,000,000 to begin funding the Elder Justice Act. These funds will be used to fund Adult Protective Services, research, and evaluation activities.

The total FY 2015 request for Protection of Vulnerable Adults is $69,152,000; an increase of +$25,000,000 over the FY 2014 enacted level. For FY 2015, specific program requests include:

- $25,000,000 in discretionary funding for the Adult Protective Services (APS) program authorized by the Elder Justice Act of 2009 (included in Subtitle H of the Affordable Care Act) as part of ACL's Elder Justice Initiative. APS funding will be used to develop program standards and data collection efforts. Funds will also be used to support the implementation of a nationwide APS data system, research to translate promising interventions from other violence prevention areas to elder abuse, and evaluations of the effectiveness of the intervention.

- $15,885,000 for the Long-Term Care Ombudsman Program, the same as the FY 2014 enacted level. This consumer advocacy program improves the quality of care for the residents of long-term care facilities in all States.

- $4,773,000 for Prevention of Elder Abuse and Neglect, the same as the FY 2014 enacted level. This program provides formula grants to states to train, educate, and promote public awareness of elder abuse prevention efforts.

- $8,910,000 for the Senior Medicare Patrol Program, the same as the FY 2014 enacted level. SMP funds competitive grants to support a volunteer-based network that helps to educate consumers on how to prevent healthcare fraud and abuse and helps to preserve the financial integrity of Medicare and Medicaid. This program is also supported by Health Care Fraud and Abuse Control (HCFAC) "wedge" funding, the level for which is determined annually as a result of negotiations between the Attorney General and the Secretary of HHS. HCFAC funds pay for infrastructure that supports States' Senior Medicare Patrols, as well as expansion grants to SMPs targeted to high-fraud states.

- $3,874,000 for Elder Rights Support Activities, the same as the FY 2014 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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Elder Justice Initiative

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Elder Justice/APS	$2,000,000	--	$25,000,000	+$25,000,000
FTE……....	0	0	4	+4

1/ Funding for this activity was provided from the Prevention and Public Health Fund in FY 2013. The FY 2015 request is for discretionary funding.

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; Sections 411 and 751 of the Older Americans Act, as amended

Program Description:

Combating the rising scourge of elder abuse, neglect, and exploitation in America remains one of ACL's top priorities. A 2004 national survey showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[100] Data is limited, but according to a 1998 national incidence study, 84 percent of all elder abuse incidents go unreported, meaning that for every reported case of abuse there are over five that go unreported.[101]

The negative effects of abuse, neglect, and exploitation on the health and independence of seniors are 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.[102] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress.

The issues of elder abuse, neglect, and exploitation affect millions of Americans. Enactment of the Affordable Care Act included enactment of the Elder Justice Act. ACL's FY 2015 Elder Justice Initiative proposes $25,000,000 to fund Elder Justice Act activities. These funds will be used to fund Adult Protective Services, research, and evaluation activities.

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[100] 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

[101] 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

[102] 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.

Adult Protective Services

Unlike Child Protective Services, there is currently no federal infrastructure for Adult Protective Services. Adult Protective Services (APS) programs are the principal state and local agencies responsible for receiving and responding to reports of abuse, neglect, and exploitation of vulnerable adults, including elders and people with disabilities. These current State and local APS programs provide a range of services designed to ensure the safety and well-being of adults 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 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.

APS programs exist in all states, and APS is a state-established, -administered, and primarily state-funded, program. There is currently no Federal infrastructure to support basic programmatic standards. State and local governments have created varied APS programs whose interventions reflect the unique parameters of their state authorizing legislation. The increasing complexity of elder and other adult abuse cases, the rising older population, difficult State and local budget conditions, and the absence or inadequacy of consistent data systems and uniform reporting requirements have presented challenges to State, local, and Tribal APS programs, particularly when it comes to developing the most promising and effective interventions possible to prevent adult abuse, neglect, and exploitation. These conditions also have prevented APS programs from evaluating their services or conducting 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 National Adult Protective Services (NAPS) program, to be funded by this initiative, will support a multifaceted approach to improving state APS systems and addressing these challenges. It would provide for the development of a national APS data system; provide competitive grants to States to test and evaluate innovative approaches to preventing adult abuse, neglect, and exploitation; and establish ACL as a Federal resource for APS. This funding 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 abuse prevention interventions.

Research and Evaluation

The Elder Justice Act of 2009 established the Elder Justice Coordinating Council (EJCC) to coordinate activities related to elder abuse, neglect, and exploitation across the Federal government. As Chair of the EJCC, the Secretary of HHS has lead responsibility for identifying and proposing solutions to the problems surrounding elder abuse. The Secretary has assigned responsibility for implementing the EJCC to the Administration for Community Living. As part of that role, ACL has led the staff-level interagency Elder Justice Working Group (EJWG) efforts to review all Federal elder justice activities, consider insights and recommendations from experts in the field, and refine proposals for the key priority areas for Federal action to address elder abuse for consideration by the EJCC.

The findings of the EJCC indicate that research in the area of elder abuse, neglect, and exploitation is still in its early stages, with limited knowledge of risk and protective factors related to either victims or perpetrators, nor about effective and evidence-based prevention, intervention, and remediation practices. Many of these same challenges have limited efforts to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. Our understanding of the phenomena of elder abuse is decades behind our understanding of either child abuse or domestic violence. We know that elder abuse, neglect, and exploitation can have devastating consequences, including increased mortality, increases in occurrence and severity of chronic diseases, and the loss of savings and even homes. Additionally, we know that people with disabilities, including older adults, are 4 to 10 times more likely to be victims of violence, abuse or neglect.[103] Research indicates that 11.5 percent of adults with a disability have been victims of sexual assault, versus 3.9 percent of adults without disabilities.[104]

However, we do not know the best way to effectively screen for elder and other adult abuse, neglect, and exploitation; what the best programs and practices are to address it; nor how to effectively prevent it from occurring, or reoccurring.

Moreover, there is no comprehensive system designed to serve as a coordinated and seamless response for helping adult victims of abuse, nor to preventing abuse before it happens. Through this Elder Justice Initiative proposal, ACL seeks to provide federal leadership, in coordination

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[103] Petersilia JR. Crime victims with developmental disabilities: a review essay. *Criminal Justice & Behavior* 2001;28(6):655–94.

Sobsey D, Mansell S. An international perspective on patterns of sexual assault and abuse of people with disabilities. *International Journal of Adolescent Medicine & Health* 1994;7(2):153–78.

Centers for Disease Control and Prevention (CDC). *Behavioral Risk Factor Surveillance System Survey Data*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2006.

[104] *Id.*

with the Elder Justice Coordinating Council, on this issue. A critical step in this process is building a base of evidence and evaluation in order to construct a strong base for future leadership.

Funding History:

FY 2010 .....$0
FY 2011 .....$0
FY 2012 .....$6,000,000
FY 2013 .....$2,000,000
FY 2014 .....$0

Note: Funding in FY 2012 and FY 2013 was provided from the Prevention and Public Health Fund. The FY 2015 request is for discretionary funding.

Budget Request:

The FY 2015 request for the Elder Justice Initiative is $25,000,000 in first-time discretionary funding.

It is well documented that APS programs and administrators lack reliable information and guidance on best practice and standards for conducting case investigations and for staffing and managing APS programs. In addition, although all states currently have APS programs, these programs are chronically underfunded nationwide. State APS agencies are facing unprecedented budget reductions and APS caseloads are increasing. The economic downturn has impacted each of these trends, all of which lead to a system that is less equipped to respond in an effective and timely way to reports of elder abuse, neglect and exploitation.

Funding to support APS program work nationally is a top ACL priority. Funding under this proposal will support:

- APS National Data System Development and Technical Assistance: Funds will be used to implement a national APS data system, which is currently under development; and to provide technical assistance to states on using and interfacing with this system.

- APS Demonstration Grants: Funds will be used to award competitive grants to states to test and demonstrate how to interface with the national data collection pilot project and to develop APS program standards to help states improve the quality and consistency of APS programs

- APS Evaluation: Funds will be used to design an exploratory study to understand the current state of APS systems across the country and the range of services provided and characteristics of adults addressed by each agency

Funding will also be used to advance a coordinated Federal research strategy to fill the gaps in knowledge and fund initial research on high priority areas. Such research is essential in order to develop evidence-based interventions to prevent, identify and report, and respond to elder abuse, neglect and exploitation. Grant funding would be used to increase the evidence-base on screening for elder abuse, neglect, and exploitation. Preliminary priority areas include:

- Build the evidence-base for screening of elder abuse, neglect, and exploitation.
- Research to identify perpetrator characteristics, including why they abuse and how to develop preventive interventions.
- Characteristics of victims and risk factors for experiencing abuse.
- Research into the consequences of elder abuse, neglect, and financial exploitation, such as potential declines in health and increased risk for co-occurring types of elder abuse.

Output Table:

Adult Protective Services Output

Indicator	Most Recent Result	FY 2014 Projection	FY 2015 Projection	FY 2015 +/- FY 2014
Output AP.1: Design Adult Protective Service evaluation to develop and test appropriate methods of addressing elder abuse, neglect and exploitation.	Contract Awarded	Ongoing	Ongoing	N/A

Resource and Program Data:

Elder Justice Initiative/Adult Protective Services
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	1	503	--	--	5-10	5,000
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	TBD	5,000
Interagency Agreements	1	1,455	--	--	TBD	14,250
Program Support 1/		42		--		750
Total Resources		2,000		--		25,000

1/ Program Support -- Includes funds for salaries and benefits, contract fees, grant systems, and review costs

Long-Term Care Ombudsman Program

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Long-Term Care Ombudsman Program	$15,885,000	$15,885,000	$15,885,000	--

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

FY 2015 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 life and quality of care for the estimated 2.9 million individuals who reside in 69,508 long-term care facilities.[105] 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 with and on behalf of these residents, advocate for systemic improvement of long-term care systems, 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.[106] 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

[105] National Ombudsman Reporting System (NORS) – Federal Fiscal 2011.
[106] 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 24,643 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 3,320 volunteers support these paid staff and certified volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 193,650 complaints (Output Q).

- Ombudsmen provided over 420,776 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 2010 .....$16,825,000
FY 2011 .....$16,793,000
FY 2012 .....$16,761,000
FY 2013 .....$15,885,000
FY 2014 .....$15,885,000

Budget Request:

The FY 2015 request for the Long-Term Care Ombudsman program is $15,885,000, the same as the FY 2014 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,[107] 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. Outcome 2.14 targets a decrease in complaints that the program was unable to resolve to the satisfaction of the resident.

The FY 2015 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 frequently support individuals who choose to transition out of nursing home facilities into more integrated settings. They also 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 and assisted living 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.

[107] 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
Outcome 2.12: Decrease the average number of complaints per LTC facility *(Outcome)*	FY 2012: 2.73 Target: 3.9 (Target Exceeded)	3.0	2.8	- 0.2*
Outcome 2.14 : Decrease the number of complaints not resolved to the satisfaction of the resident *(Outcome)*	FY 2012: 9,705 Target: 11,300	10,700	9,700	- 1,000*
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output Q: Decrease the Number of Complaints *(Output)*	FY 2012: 193,650	190,000	190,000	Maintain *
Output R: Number of Ombudsman Consultations *(Output)*	FY 2012: 420,776	425,000	437,000	+ 12,000
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2012: 24,643	26,000	27,600	+ 1,000

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

Grant Awards Table:

Long-Term Care Ombudsman Program Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$283,392	$280,824	$280,824
Range of Awards	$9,919 - $1,625,913	$9,829 - $1,618,546	$9,829 - $1,618,546

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	246,892	243,821	243,821	--
Alaska	79,350	78,631	78,631	--
Arizona	333,813	333,076	333,076	--
Arkansas	155,042	151,860	151,860	--
California	1,625,913	1,618,546	1,618,546	--
Colorado	222,012	223,864	223,864	--
Connecticut	186,673	183,391	183,391	--
Delaware	79,350	78,631	78,631	--
District of Columbia	79,350	78,631	78,631	--
Florida	1,168,176	1,159,301	1,159,301	--
Georgia	410,945	410,859	410,859	--
Hawaii	79,350	78,631	78,631	--
Idaho	79,350	78,631	78,631	--
Illinois	602,276	593,323	593,323	--
Indiana	315,640	311,549	311,549	--
Iowa	163,550	161,021	161,021	--
Kansas	138,935	136,820	136,820	--
Kentucky	219,879	216,856	216,856	--
Louisiana	213,219	210,866	210,866	--
Maine	79,898	79,365	79,365	--
Maryland	273,547	271,260	271,260	--
Massachusetts	337,145	333,272	333,272	--
Michigan	511,603	506,369	506,369	--
Minnesota	257,126	255,908	255,908	--
Mississippi	143,055	141,354	141,354	--
Missouri	309,736	305,063	305,063	--
Montana	79,350	78,631	78,631	--
Nebraska	90,552	89,354	89,354	--
Nevada	127,615	128,082	128,082	--
New Hampshire	79,350	78,631	78,631	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2014 +/- FY 2012
New Jersey	438,995	431,948	431,948	--
New Mexico	103,054	102,123	102,123	--
New York	971,046	956,337	956,337	--
North Carolina	473,638	472,374	472,374	--
North Dakota	79,350	78,631	78,631	--
Ohio	604,734	595,409	595,409	--
Oklahoma	187,918	184,565	184,565	--
Oregon	206,583	206,248	206,248	--
Pennsylvania	711,097	698,693	698,693	--
Rhode Island	79,350	78,631	78,631	--
South Carolina	244,912	244,203	244,203	--
South Dakota	79,350	78,631	78,631	--
Tennessee	325,915	322,310	322,310	--
Texas	1,015,273	1,013,204	1,013,204	--
Utah	95,714	95,715	95,715	--
Vermont	79,350	78,631	78,631	--
Virginia	379,060	376,622	376,622	--
Washington	326,273	325,251	325,251	--
West Virginia	111,219	109,488	109,488	--
Wisconsin	289,501	287,835	287,835	--
Wyoming	79,350	78,631	78,631	--
Subtotal, States	15,570,374	15,431,077	15,431,077	--
American Samoa	9,919	9,829	9,829	--
Guam	39,675	39,315	39,315	--
Northern Mariana Islands	9,919	9,829	9,829	--
Puerto Rico	200,379	196,785	196,785	--
Virgin Islands	39,675	39,315	39,315	--
Subtotal, States and Territories	15,869,941	15,726,150	15,726,150	--
Undistributed[108]	15,059	158,850	158,850	--
TOTAL	**15,885,000**	**15,885,000**	**15,885,000**	--

[108] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Prevention of Elder Abuse & Neglect…..	$4,773,000	$4,773,000	$4,773,000	--

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

FY 2015 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 2012 over $28 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of approximately $7 ($6.85) 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 2010 .....$5,055,000
FY 2011 .....$5,046,000
FY 2012 .....$5,036,000
FY 2013 .....$4,773,000
FY 2014 .....$4,773,000

Budget Request and Anticipated Accomplishments:

The FY 2015 request for the Prevention of Elder Abuse and Neglect program is $4,773,000, the same as the FY 2014 enacted level. The FY 2015 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 2015 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. Past examples of these efforts undertaken by states include creation of informational cards for law enforcement officers to provide crucial resource information to victims of elder

abuse, training to first responders, and community-based multidisciplinary teams that serve in a technical advisory role to elder abuse prevention agencies throughout a state.

Output Table:

Prevention of Elder Abuse and Neglect Output

Indicator	Most Recent Result	FY 2014 Projection	FY 2015 Projection	FY 2015 +/- FY 2014
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, dollars in thousands)*	FY 2012: $28,638	$28,300	$28,100	-$200

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$85,154	$84,500	$84,500
Range of Awards	$2,980 - $471,073	$2,958 - $471,073	$2,958 - $471,073

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	76,215	76,215	76,215	--
Alaska	23,843	23,660	23,660	--
Arizona	89,944	81,500	81,500	--
Arkansas	48,157	48,157	48,157	--
California	471,073	471,073	471,073	--
Colorado	59,819	56,082	56,082	--
Connecticut	59,907	59,907	59,907	--
Delaware	23,843	23,660	23,660	--
District of Columbia	23,843	23,660	23,660	--
Florida	344,252	344,252	344,252	--
Georgia	110,726	103,321	103,321	--
Hawaii	23,843	23,660	23,660	--
Idaho	23,843	23,660	23,660	--
Illinois	197,384	197,384	197,384	--
Indiana	98,224	98,224	98,224	--
Iowa	55,927	55,927	55,927	--
Kansas	45,843	45,843	45,843	--
Kentucky	66,595	66,595	66,595	--
Louisiana	68,518	68,518	68,518	--
Maine	23,843	23,660	23,660	--
Maryland	78,087	78,087	78,087	--
Massachusetts	109,606	109,606	109,606	--
Michigan	160,862	160,862	160,862	--
Minnesota	76,347	76,347	76,347	--
Mississippi	45,198	45,198	45,198	--
Missouri	97,643	97,643	97,643	--
Montana	23,843	23,660	23,660	--
Nebraska	29,770	29,770	29,770	--
Nevada	34,385	27,629	27,629	--
New Hampshire	23,843	23,660	23,660	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	143,950	143,950	143,950	--
New Mexico	27,766	26,393	26,393	--
New York	318,066	318,066	318,066	--
North Carolina	127,617	126,782	126,782	--
North Dakota	23,843	23,660	23,660	--
Ohio	197,185	197,185	197,185	--
Oklahoma	60,208	60,208	60,208	--
Oregon	56,795	56,795	56,795	--
Pennsylvania	242,944	242,944	242,944	--
Rhode Island	23,843	23,660	23,660	--
South Carolina	65,989	63,080	63,080	--
South Dakota	23,843	23,660	23,660	--
Tennessee	91,810	91,810	91,810	--
Texas	274,281	274,281	274,281	--
Utah	25,789	24,837	24,837	--
Vermont	23,843	23,660	23,660	--
Virginia	102,820	102,820	102,820	--
Washington	87,911	86,291	86,291	--
West Virginia	36,736	36,736	36,736	--
Wisconsin	90,309	90,309	90,309	--
Wyoming	23,843	23,660	23,660	--
Subtotal, States	4,684,617	4,648,207	4,648,207	--
American Samoa	2,980	2,958	2,958	--
Guam	11,922	11,830	11,830	--
Northern Mariana Islands	2,980	2,958	2,958	--
Puerto Rico	54,217	54,217	54,217	--
Virgin Islands	11,922	11,830	11,830	--
Subtotal, States and Territories	4,768,638	4,732,000	4,732,000	--
Undistributed 109/	4,362	41,000	41,000	--
TOTAL	**4,773,000**	**4,773,000**	**4,773,000**	--

[109] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Senior Medicare Patrol Program…..	$8,875,000	$8,910,000	$8,910,000	--

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

FY 2015 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 network of volunteers whose purpose is to educate Medicare beneficiaries on preventing and identifying healthcare fraud and abuse. Projects use the skills of 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 (CMS), 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 and published in the annual OIG report for calendar year 2011 shows that SMP projects:

- Maintained 5,671 active volunteers who worked over 88,169 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;
- Educated 431,128 beneficiaries in 11,109 group education sessions and held 66,303 one-on-one counseling sessions with or on behalf of beneficiaries;
- Conducted 8,800 community outreach education events; and
- Resolved 76,224 inquiries for information or assistance from beneficiaries.

In addition, the SMARTFACTS data show that since the program's inception 16 years ago, SMP projects have educated over 3.5 million beneficiaries in 94,077 group education sessions and 1,179,190 one-on-one counseling sessions, and conducted 83,862 community outreach education events.

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 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 ACL's National Consumer Protection Technical Resource Center (Center).

In the past four years, the critically important role of the SMP program has continued to be recognized by partners in Medicare fraud prevention in the private and public sectors. In FY 2010 and FY 2011, 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 SMP projects fight Medicare fraud in high fraud areas and expand the capacity of the program to reach more beneficiaries. In FY 2012 and FY 2013, ACL received 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 2010 .....$9,438,000
FY 2011 .....$9,420,000
FY 2012 .....$9,402,000
FY 2013 .....$8,875,000
FY 2014 PB.....$8,910,000

Budget Request:

The FY 2015 request for the Senior Medicare Patrol (SMP) program is $8,910,000, the same as the FY 2014 enacted level. This amount will enable ACL to continue the proven fraud prevention activities of the SMP program.

Since the program's inception, SMP projects have educated over 3.5 million beneficiaries and received nearly 30,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. While SMPs make numerous referrals of potential fraud to CMS and the OIG, 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 process 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 Outputs

Indicator	Most Recent Result	CY 2014 Projection	CY 2015 Projection	FY 2015 +/- FY 2014
Output W: Beneficiaries Educated and Served *(Output)*	CY 2012: 649,297	675,000	630,000	- 45,000

Grant Awards Table:

Senior Medicare Patrol Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	54	54	54
Average Award	$152,925	$165,000	$165,000
Range of Awards	$30,000-$640,000	$75,000-$177,927	$75,000-$177,927

Resource and Program Data:

Senior Medicare Patrols
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	26	4,380	54	8,910
Continuations	54	8,875	28	4,530	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		--
Total Resources		8,875		8,910		8,910

Elder Rights Support Activities

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Elder Rights Support Activities	$3,859,000	$3,874,000	$3,874,000	--

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

FY 2015 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 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. Recently, Model Approaches – Phase II grants were developed that promote legal service delivery systems that are optimally responsive to complex legal issues emerging from cases of elder abuse, neglect, and financial exploitation.

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/disability services networks. These grants provide funding for the National Legal Resource Center (NLRC), which supports the leadership, knowledge, and systems capacity of legal and aging provider organizations. The NLRC works to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. ACL is funding four projects as partners under the NLRC 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 creating and managing 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 reaching 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 point 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 2010 .....$4,103,000
FY 2011 .....$4,096,000
FY 2012 .....$4,088,000
FY 2013 .....$3,859,000
FY 2014 .....$3,874,000

Budget Request:

The FY 2015 request for Elder Rights Support Activities is $3,874,000, the same as the FY 2014 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Elder Rights Support Activities:			
Model Approaches to Statewide Legal Assistance	$1,881	$1,888	$1,888
National Legal Assistance and Support Projects	702	705	705
National Center on Elder Abuse	762	765	765
National Long-Term Care Ombudsman Resource Center	514	516	516
Total, Elder Rights Support Activities	**$3,859**	**$3,874**	**$3,874**

Grant Awards Table:

Elder Rights Support Activities Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	22	19	19
Average Award	$171,318	$197,421	$197,421
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 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	13	1,666	8	2,102	--	--
Continuations	9	2,103	11	1,649	19	3,751
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		90	--	123		123
Total Resources		3,859		3,874		3,874

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

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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 2015 request for Programs for People with Developmental Disabilities authorized under the Developmental Disabilities Assistance and Bill of Rights Act is $165,259,000, an increase of +$5,000,000 over the FY 2014 enacted level. For FY 2015, specific program requests include:

- $70,876,000 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.

- $38,734,000 to continue funding for State Protection and Advocacy systems in each State and Territory that 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.

- $36,769,000 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.

- $8,880,000 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. This program also includes $1,000,000 for grants to communities with models that best demonstrate the inclusion of people with disabilities and seniors in the development and planning of community transportation systems.

- $5,000,000 in new funding for a Youth Transitions initiative, to invest in supports currently being developed to address the comprehensive needs of youth with intellectual and developmental disabilities as they transition from adolescence into young adult life across all systems – health, education, employment, human services, and community living.

State Councils on Developmental Disabilities

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
State DD Councils	$70,555,000	$70,876,000	$70,876,000	--

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

FY 2015 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method.....Formula Grant

Program Description and Accomplishments:

State Councils on Developmental Disabilities (DD Councils) 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. DD Councils 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 DD Council 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 DD 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.

DD 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 DD Council 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 startup 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.

Funding History:

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

FY 2010 .....$75,066,000
FY 2011 .....$74,916,000
FY 2012 .....$74,774,000
FY 2013 .....$70,555,000
FY 2014 .....$70,876,000

Budget Request:

The FY 2015 budget request for State Councils is $70,876,000, the same as the FY 2014 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 2015, 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 systems change efforts aimed at turning fragmented approaches into innovative and cost-effective strategies that create opportunities for people with developmental disabilities and their families.

Advances in self-advocacy would be greatly impacted if funding were no longer available for State Councils. All 56 Councils work to build leadership skills by providing individuals with developmental disabilities and their family members a variety of opportunities including

opportunities to educate policymakers and participate in the design and redesign of systems impacting their lives.

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 14.33% Target: 13.79% (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. (Outcome)	FY 2012: 9.52 Target: 9.17 (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 2012: 706,588 (Actual)	N/A	N/A	N/A
8ii: Number of all individuals trained by the Councils. (Output)	FY 2012: 256,865 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

State Councils on Developmental Disabilities Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$1,259,907	$1,262,357	$1,262,357
Range of Awards	$235,156 - $6,496,150	$235,613 - $6,508,782	$235,613 - $6,508,782

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	1,280,763	1,283,254	1,283,254	--
Alaska	451,553	452,431	452,431	--
Arizona	1,392,777	1,395,485	1,395,485	--
Arkansas	752,346	753,809	753,809	--
California	6,496,150	6,508,782	6,508,782	--
Colorado	859,459	861,131	861,131	--
Connecticut	681,469	682,794	682,794	--
Delaware	451,553	452,431	452,431	--
District of Columbia	451,553	452,431	452,431	--
Florida	3,499,415	3,506,220	3,506,220	--
Georgia	2,041,448	2,045,418	2,045,418	--
Hawaii	451,553	452,431	452,431	--
Idaho	451,553	452,431	452,431	--
Illinois	2,477,331	2,482,149	2,482,149	--
Indiana	1,409,080	1,411,820	1,411,820	--
Iowa	730,126	731,546	731,546	--
Kansas	579,619	580,746	580,746	--
Kentucky	1,195,739	1,198,064	1,198,064	--
Louisiana	1,328,158	1,330,740	1,330,740	--
Maine	451,553	452,431	452,431	--
Maryland	950,796	952,645	952,645	--
Massachusetts	1,320,431	1,322,999	1,322,999	--
Michigan	2,439,721	2,444,467	2,444,467	--
Minnesota	966,956	968,836	968,836	--
Mississippi	906,239	908,001	908,001	--
Missouri	1,294,246	1,296,762	1,296,762	--
Montana	451,553	452,431	452,431	--
Nebraska	451,553	452,431	452,431	--
Nevada	469,007	469,919	469,919	--
New Hampshire	451,553	452,431	452,431	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	1,492,899	1,495,803	1,495,803	--
New Mexico	479,397	480,330	480,330	--
New York	4,107,730	4,115,718	4,115,718	--
North Carolina	1,998,086	2,001,972	2,001,972	--
North Dakota	451,553	452,431	452,431	--
Ohio	2,695,852	2,701,094	,701,094	--
Oklahoma	846,197	847,842	847,842	--
Oregon	781,744	783,264	783,264	--
Pennsylvania	2,958,678	2,964,431	2,964,431	--
Rhode Island	451,553	452,431	452,431	--
South Carolina	1,073,121	1,075,207	1,075,207	--
South Dakota	451,553	452,431	452,431	--
Tennessee	1,426,128	1,428,901	1,428,901	--
Texas	4,794,740	4,804,064	4,804,064	--
Utah	637,622	638,862	638,862	--
Vermont	451,553	452,431	452,431	--
Virginia	1,416,470	1,419,224	1,419,224	--
Washington	1,183,050	1,185,351	1,185,351	--
West Virginia	740,372	741,812	741,812	--
Wisconsin	1,224,785	1,227,167	1,227,167	--
Wyoming	451,553	452,431	452,431	--
Subtotal, States	67,249,889	67,380,663	67,380,663	--
American Samoa	235,156	235,613	235,613	--
Guam	235,156	235,613	235,613	--
Northern Mariana Islands	235,156	235,613	235,613	--
Puerto Rico	2,364,288	2,368,885	2,368,885	--
Virgin Islands	235,156	235,613	235,613	--
Subtotal, States and Territories	**70,554,801**	**70,692,000**	**70,692,000**	--
TOTAL	**$70,554,801**	**$70,692,000**	**$70,692,000**	**--**

Developmental Disabilities – Protection and Advocacy

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
DD – Protection & Advocacy……..	$38,559,000	$38,734,000	$38,734,000	--

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

FY 2015 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. The program also funds a Native American Consortium to protect the legal and human rights of Native Americans 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 of concerns 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 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. In the first case of its kind, the Oregon P&A and co-counsels from other law firms filed suit on behalf of eight individuals with intellectual or developmental disabilities who are able and would prefer to work in an integrated employment setting, but instead are segregated in sheltered workshops. The case claims that the integration mandate under Title II of the Americans with Disabilities Act (ADA) applies to the provision of employment-related services. The U.S. Department of Justice supports the Plaintiffs' case, making clear that it interprets the Title II integration mandate of the ADA to prohibit the unnecessary provision of employment-related services to persons with disabilities in segregated sheltered workshops, in which persons with disabilities have little to no opportunity to interact with non-disabled persons.

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 2010 .....$41,024,000
FY 2011 .....$40,942,000
FY 2012 .....$40,865,000
FY 2013 .....$38,559,000
FY 2014 .....$38,734,000

Budget Request:

The FY 2015 budget request for PADD is $38,734,000, the same as the FY 2014 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, including children, are at an increased risk to experience abuse and neglect.[110] A 2009 report from the Government 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 which involved children with disabilities.[111] 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 percent were resolved using short-term assistance strategies;
- 22 percent were addressed through technical assistance in self-advocacy;
- 15 percent involved investigation and monitoring; and
- 12 percent 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 2015, the program expects to further increase the result by one half of one percent over the previous year.

[110] 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

[111] 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 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 85.2% Target: 83.4% (Target Exceeded)	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 2012: 18,189 (Actual)	N/A	N/A	N/A
8iv: Number of people receiving information and referral from the Protection and Advocacy program. (Output)	FY 2012: 45,069 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

Developmental Disabilities – Protection and Advocacy Grant Awards[112]

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	56	56	56
Average Award	$671,308	$672,628	$672,628
Range of Awards	$194,139 - $3,255,484	$194,139 - $3,297,166	$194,139 - $3,297,166

[112] Excludes grants to tribal organizations.

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alabama	617,829	619,708	619,708	--
Alaska	362,881	362,881	362,881	--
Arizona	652,541	659,935	659,935	--
Arkansas	380,743	382,159	382,159	--
California	3,255,484	3,297,166	3,297,166	--
Colorado	441,150	447,027	447,027	--
Connecticut	374,341	373,697	373,697	--
Delaware	362,881	362,881	362,881	--
District of Columbia	362,881	362,881	362,881	--
Florida	1,826,878	1,864,950	1,864,950	--
Georgia	1,037,180	1,045,869	1,045,869	--
Hawaii	362,881	362,881	362,881	--
Idaho	362,881	362,881	362,881	--
Illinois	1,264,649	1,265,728	1,265,728	--
Indiana	765,273	764,876	764,876	--
Iowa	371,678	372,163	372,163	--
Kansas	362,881	362,881	362,881	--
Kentucky	580,510	577,204	577,204	--
Louisiana	563,103	566,770	566,770	--
Maine	362,881	362,881	362,881	--
Maryland	469,144	466,854	466,854	--
Massachusetts	601,556	604,505	604,505	--
Michigan	1,240,187	1,239,838	1,239,838	--
Minnesota	510,645	512,759	512,759	--
Mississippi	424,774	424,574	424,574	--
Missouri	685,591	687,561	687,561	--
Montana	362,881	362,881	362,881	--
Nebraska	362,881	362,881	362,881	--
Nevada	362,881	362,881	362,881	--
New Hampshire	362,881	362,881	362,881	--

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

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
New Jersey	743,286	743,327	743,327	--
New Mexico	362,881	362,881	362,881	--
New York	1,847,809	1,829,821	1,829,821	--
North Carolina	1,080,862	1,089,450	1,089,450	--
North Dakota	362,881	362,881	362,881	--
Ohio	1,345,518	1,332,036	1,332,036	--
Oklahoma	420,110	418,336	418,336	--
Oregon	404,997	407,305	407,305	--
Pennsylvania	1,385,181	1,370,712	1,370,712	--
Rhode Island	362,881	362,881	362,881	--
South Carolina	570,582	573,680	573,680	--
South Dakota	362,881	362,881	362,881	--
Tennessee	747,696	748,866	748,866	--
Texas	2,405,074	2,432,653	2,432,653	--
Utah	362,881	362,881	362,881	--
Vermont	362,881	362,881	362,881	--
Virginia	727,507	729,693	729,693	--
Washington	608,571	618,587	618,587	--
West Virginia	366,505	365,960	365,960	--
Wisconsin	642,636	637,929	637,929	--
Wyoming	362,881	362,881	362,881	--
Subtotal, States	35,891,448	36,003,556	36,003,556	--
American Samoa	194,139	194,139	194,139	--
Guam	194,139	194,139	194,139	--
Northern Mariana Islands	194,139	194,139	194,139	--
Puerto Rico	925,263	887,069	887,069	--
Virgin Islands	194,139	194,139	194,139	--
Subtotal, States and Territories	37,787,406	37,861,320	37,861,320	--
Grants to Tribes	194,139	194,139	194,139	--
Training and Technical Assistance[113]	771,594	872,680	872,680	--
TOTAL	**$38,559,000**	**$38,734,000**	**$38,734,000**	**--**

[113] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
UCEDDs……....	$36,602,000	$36,769,000	$36,769,000	--

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

FY 2015 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, advise Federal, State, and community policymakers about, and promote 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 2013, the Administration on Intellectual and Developmental Disabilities (AIDD) awarded 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 2010 .....$38,943,000
FY 2011 .....$38,865,000
FY 2012 .....$38,792,000
FY 2013 .....$36,602,000
FY 2014 .....$36,769,000

Budget Request:

The FY 2015 request for UCEDDs is $36,769,000, the same as the FY 2014 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 percent are in leadership positions with:

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

It is estimated that over 36 percent 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, a growing body of research has documented that persons with developmental and other disabilities are more likely to experience health disparities compared to the general population. The University of New Hampshire UCEDD is conducting the Health and Health Care Disparities among Individuals with Disabilities project to determine what factors relate to or explain health outcomes and health care access among the diverse populations of individuals with disabilities. The goal of the Health Disparities Project is to generate new knowledge about health access and health outcomes among sub-groups of people with disabilities and translate and disseminate the findings for researchers, policy makers, and others.

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 University of Hawaii UCEDD's Asia-United States Partnership (AUSP). The goal of this partnership is to improve child health through cross-cultural exchanges in early childhood development with leaders in East Asia (Beijing, Shanghai, and Hong Kong SAR, Philippines, Singapore, and Thailand) and the United States.

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.

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
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 2012: 39.67% Target: 38.04% (Target Exceeded)	Prior Result +1%	Prior Result +1%	N/A
8viii: Number of professionals trained by UCEDDs. (Output)	FY 2012: 5,289 (Actual)	N/A	N/A	N/A
8ix: Number of people reached through UCEDD community training and technical assistance activities. (Output)	FY 2012: 852,603 (Actual)	N/A	N/A	N/A
8x: Number of people receiving direct or model demonstration services from UCEDDs. (Output)	FY 2012: 145,460 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

University Centers of Excellence in Developmental Disabilities Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	67	68	68
Average Award	$535,215	$535,215	$535,215
Range of Awards	$535,215	$535,215	$535,215

Resource and Program Data:

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

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	17	9,098	4	1,769	--	--
Continuations	50	26,761	64	34,254	68	36,023
Contracts	1	732	1	735	1	735
Interagency Agreements	--	--	--	--	--	--
Program Support /1		11		11		11
Total Resources		36,602		36,769		36,769

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

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Developmental Disabilities – Projects of National Significance

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
DD – Projects of National Significance 1/	$8,828,000	$8,880,000	$8,880,000	--

1/ For comparability purposes, funding displayed in FY 2013 includes amounts transferred to ACL for inclusive transportation. This funding was appropriated directly to ACL in FY 2014 and is reflected in the FY 2015 request.

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

FY 2015 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 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, PNS resources are expected to fund a new project related to gathering and disseminating information and providing technical assistance to people and entities interested in supported decision making as an alternative to guardianship.

In FY 2015, 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 longitudinal research studies of trends in residential services and supports, employment, community supports, family supports, and quality indicators related to publicly funded DD services and the supported decision making project.

Funding History:

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

FY 2010 .....$14,136,000
FY 2011 .....$14,134,000
FY 2012 .....$8,317,000
FY 2013 .....$8,828,000
FY 2014 .....$8,880,000

Budget Request:

The FY 2015 request for the Projects of National Significance program is $8,880,000, the same as the FY 2014 enacted level. The request will support continued funding for employment initiatives, technical assistance, longitudinal data collection and analysis, evaluation, and monitoring. In addition, AIDD will provide self-advocacy organizations with an opportunity to thrive and grow through a targeted technical assistance effort.

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.

Consistent with the purpose of the DD Act, including the promotion of self-determination, AIDD has worked collaboratively exploring supported decision-making and guardianship reform, to maximize the opportunity for people with intellectual and developmental disabilities and Older Americans to live independently and to exert control and choice in their own lives. AIDD proposes to continue funding a joint integrated training and technical assistance/resource center on supported decision making to advance work in this area.

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.

In FY 2015 ACL will also continue to issue grants totaling $1 million to communities with the models that best demonstrate the inclusion of people with disabilities, including intellectual and developmental and/or physical disabilities, and seniors in the development and planning of the community transportation systems. These funds were appropriated directly to ACL for the first time in FY 2014.

Grant Awards Tables:

Developmental Disabilities – Projects of National Significance Grant Awards

	FY 2013 Final	**FY 2014 Enacted**	**FY 2015 President's Budget**
Number of Awards	21	25	25
Average Award	$347,905	$289,000	$289,000
Range of Awards	$100,000 - $575,000	$100,000 - $575,000	$100,000 - $575,000

Resource and Program Data:

Developmental Disabilities – Projects of National Significance
(Dollars in thousands)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	4	300	6	790	19	6,435
Continuations	17	7,006	19	6,435	6	790
Contracts	6	1,305	7	1,377	7	1,377
Interagency Agreements	--	--	--	--	--	--
Program Support /1		217		278		278
Total Resources		8,828		8,880		8,880

1/ Program Support -- Includes funds for salaries and benefits, contract fees, and grant systems and review costs.

Youth Transitions Initiative

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Youth Transitions	--	--	$5,000,000	+$5,000,000

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

Program Description:

Currently, there are insufficient supports available to transitioning youth with disabilities, and furthermore, there is insufficient coordination across Federal agencies currently serving this population. The July 2012 GAO Report, Students with Disabilities: Better Federal Coordination Could Lessen Challenges in the Transition from High School strongly recommended development of an interagency approach across HHS, Education, Labor, and Social Security to work towards improving common outcomes for transitioning youth with disabilities and their families related to health, education, employment, support services and community living. HHS' response to this report acknowledged that "more must be done toward developing a coordinated, integrated transition strategy." The GAO report builds upon a long and demonstrated history of reports and data indicating the need to ensure that youth with disabilities are not exiting high school only to become dependent upon SSI, SSDI and Medicaid at a cost of tens of billions of federal dollars – and that the lack of coordination across systems is a major contributor to this trend.

Successful outcomes for youth with disabilities include engagement in productive activities, including paid employment, with quality health and functional status. In response to the GAO report, an interagency workgroup (Federal Partners in Transition, FPT) led by senior leadership from each of four agencies (Education, Labor, Social Security, and HHS) has been convened. Demonstration projects have shown promising employment results for youth with intellectual and developmental disabilities when Medicaid-funded LTSS, vocational rehabilitation, Social Security, and education systems collaborate. A prime example of the impact of Employment First policies can be seen from their implementation in Washington State. In 2005, King County in Washington State changed their approach to transitioning students with intellectual and developmental disabilities from school to employment by adopting a statewide Employment First policy coupled with supportive services. In just five years, the percent of youth with disabilities that are employed rose from six percent to 56 percent.

Models implemented under this initiative do not focus on the entire SSI population, but rather are targeted to transitioning youth with ID/DD, and would address ongoing needed supports. The models would be required to address transitioning across several systems for youth with ID/DD including pediatric to adult health care, education to post-secondary education and vocational systems to produce successful outcomes in competitive, integrated employment. Of specific interest is implementing approaches that provide ongoing long term services and supports which will provide meaningful assistance to these youth into adulthood through Medicaid or other funding streams. Family supports will be critical to successful models as well, with a holistic approach on providing family members supporting their youth with targeting, ongoing assistance. For example, a successful model may include implementing training curriculums on best practices within and outside of disability services for accessing and coordinating community supports, leadership development, and self-advocacy – and would be made available to youth, siblings, parents and other family supporting the transitioning youth with ID/DD.

Funding History:

FY 2010 .....$0
FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$0

Budget Request:

The FY 2015 request for the Youth Transitions Initiative is $5,000,000 in first-time funding. As the lead HHS entity in the Federal Partners in Transition effort, AIDD will invest in state initiatives, with the goal of generating results similar to the Washington state model, that bring together entities such as state Developmental Disabilities agency, Department of Education, Vocational Rehabilitation, Council on Developmental Disabilities, University Centers for Excellence in Developmental Disabilities and other agencies to address the comprehensive needs of youth with intellectual and developmental disabilities as they transition from adolescence into young adult life across all systems – health, education, employment, human services, and community living. These entities will identify federal, state, and local laws, regulations and policies that contribute as barriers to employment for youth with ID/DD, develop plans to deconstruct such barriers, and implement cross agency programs that that produce better outcomes for this population. AIDD will also fund an evaluation component for the initiative.

Through grants, cooperative agreements and coordinated interagency program implementation, activities are expected to:

- Promote innovative utilization of health and long-term supports in coordination with education, vocational rehabilitation, and employment services.

- Encourage integration of health and LTSS transition planning into secondary and post-secondary education programs.

- Provide technical assistance and training to ensure integration of health and long-term supports with education, vocational rehabilitation and employment services.

- Establish and implement a coordinated federal evaluation agenda to ensure that outcomes across systems are measured and reported.

Resource and Program Data:

Youth Transitions Initiative
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	TBD	4,500
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	1	500
Interagency Agreements	--	--	--	--	--	--
Program Support /1		--		--		--
Total Resources		--		--		5,000

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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 (ADRC) and the State Health Insurance Assistance Program (SHIP) 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 services and supports – 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 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. 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 each reach out to key populations to assist them in accessing services and in planning for future needs.

The FY 2015 request for these programs is $88,978,000, a decrease of -$6,899,000 from the FY 2014 enacted level. This request would provide:

- $20,000,000 in mandatory funding for ADRCs. No discretionary funding is requested in the FY 2015 President's Budget, therefore, this request represents the sole source of funding for ADRCs going forward. 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.

- $4,963,000 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) which 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, were transferred to ACL in FY 2014, and fit naturally within ACL's mission of promoting community living. In FY 2015, the SHIPS will continue to benefit from deeper connection to ACL's aging and disability services networks.

- $1,000,000 for the National Clearinghouse for Long-Term Care Information, an outreach effort that increases awareness of the need to plan ahead for long-term care. In FY 2014 ACL requested to shift funding for this program from mandatory funding under ACA to discretionary funding. This request is repeated in FY 2015.

- $6,700,000 for the Paralysis Resource Center (PRC), which provides comprehensive information and referral services for people living with paralysis and their families and caregivers. Transferred to ACL in FY 2014, the PRC will continue to benefit from extensive ties to ACL's disability networks. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act.

Aging and Disability Resource Centers

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Discretionary…….	$6,095,000	$6,119,000	--	-$6,119,000
Mandatory…….	$9,490,000	$9,280,000	$20,000,000	+$10,720,000
Total…….	$15,585,000	$15,399,000	$20,000,000	+$4,601,000
FTE……...	4	3	3	--

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.

FY 2015 Authorization .....Expired

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 consumer-friendly entry points into long-term care at the community-level. ADRCs grew out of best practice innovations in some states known as "No Wrong Door"[114] (NWD) and "Single Points of Entry" programs, where people of all ages may turn for objective information and one-on-one assistance on their long-term services and support options. Since 2003, the Administration on Aging, along with the Centers for Medicare & Medicaid Services (CMS), and most recently the Veterans Health Administration (VHA), have entered into cooperative agreements with States to develop the foundational infrastructure for delivering one-on-one person-centered counseling and streamlined access to public programs that make it easier for individuals to learn about and access their health and long-term services and support options. ACL, CMS, and the VHA are now working with 8 ADRC states to build on the lessons learned and best practices from prior ADRC investments to develop national standards for a "high-performing" No Wrong Door system that serves all populations and all payers.

NWD/ADRC systems help States make better use of taxpayer dollars by streamlining access to community services and supports (both publicly and privately funded) and diverting individuals

[114] 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).

from more costly forms of care, including institutional care and unnecessary hospital re-admissions. These systems are a key component in transforming States' long-term supports and services programs, work which is not only vital, but ongoing. Services provided by NWD/ADRC systems for all populations and all payers which highlight the need for continued funding include:

- Targeted discharge planning, care transition and nursing home 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" person-centered counseling to help consumers, families, and caregivers fully understand the options, including private pay, available to them;

- Streamlined access to publicly-supported long-term care services and support programs for individuals who appear to be eligible for such 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.

- ACL is currently evaluating this program and expects a final evaluation report by the end of calendar year 2014. The evaluation includes process and outcomes studies and is designed to produce generalizable outcomes about the degree to which ADRCs are meeting their goals of effectively integrating and streamlining access to LTSS. The evaluation will also inform program refinement and continuous quality management.

With FY 2012 funds, ADRCs responded to more than five million contacts to help individuals make better informed decisions about their health and long-term services and support options, with the vast majority of these decisions resulting in referrals for community-based services. High performing NWD/ADRC systems that serve all populations including Medicaid-eligible individuals satisfy one of three statewide system change requirements states must meet in order to qualify for enhanced Federal match under the CMS Medicaid Balancing Incentive Program.

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

Over 509 ADRC sites have been established across 50 states, two territories, and Washington, DC, increasing the coordination and capacity of existing infrastructure in the aging, disability and Medicaid networks. Together these ADRC sites can reach roughly 77 percent of the U.S. population.

- 32 States and Territories have achieved statewide coverage, and an additional 5 States have achieved 50 percent or more of statewide coverage.

- 41 states with ADRC programs sites currently conduct care transitions through formal interventions across 386 hospitals. To date, the cumulative number of persons who have completed a formal care transition program is 16,043.

- 42 states are actively partnering across ADRC and Money Follows the Person programs. The number of states where the ADRC is the Local Contact Agency is 30, with 274 ADRC program sites performing nursing facility transitions.

Funding History:

Comparable total funding for Aging and Disability Resource Centers is as follows:

FY 2010 .....$23,684,000
FY 2011 .....$16,469,000
FY 2012 .....$16,457,000
FY 2013 .....$15,585,000
FY 2014 PB.....$15,399,000

Note: Mandatory appropriations of $10 million for FY 2010 through FY 2014 for ADRCs were made under Section 2405 of P.L. 111-148, the Affordable Care Act of 2010.

Budget Request:

ACL's FY 2015 request for ADRCs is $20,000,000 each year for five years in new mandatory funding, as the first year of five years of funding at that level. Mandatory funding under the Affordable Care Act expires in FY 2014, so this request will be the only source of funding proposed for ADRC activities in FY 2015.

Over the next five years, ACL intends to fund approximately 35 new state grantees to finalize their development and operation of sustainable No Wrong Door systems based on the national standards established by ACL, CMS and the VHA. Funded states will replicate the national standards to develop person-centered, conflict-free access system for long-term services and

supports for all populations and all payers. In addition to the grants to states, funding would be used to support a technical assistance contract and salaries for ACL staff administering ADRC activities.

Activities in the 35 states funded by this proposal to develop sustainable No Wrong Door systems represent a substantial state-wide reform of access to long-term services and supports. Building on past ADRC activities, the transformation brought about by this funding will include:

- Funded state's program will meet national standards established by ACL/CMS and VHA for "No Wrong Door" Systems and be required to report on its progress and performance using federally prescribed efficiency and consumer outcome measures that align with the national standards;
- Governors of funded states will have to establish a multi-agency governance structure to oversee the development, financing and administration of its No Wrong Door System, and this structure must include the State Unit on Aging, the State Medicaid Agency, and the other state agencies responsible for serving the people with physical disabilities as well as those with intellectual and developmental disabilities;
- Funded states will commit to using Medicaid administrative funding to support the NWD infrastructure on an on-going basis; and
- Funded states will ensure that local NWD sites:
    - Include a full range of organizations that play a formal reimbursable role in carrying out the NWD functions they have been designated by the state to perform to ensure the state's NWD System can effectively serve all LTSS populations;
    - Use nationally certified person-centered counselors to provide one-on-one assistance to consumers; and
    - Conduct formal functional and financial assessments that are required to determine an individual's eligibility for the public LTSS programs that are administered by the state, including Medicaid.

Finally, funded states' NWD systems, including local sites, will use the federally prescribed reporting data to continually evaluate performance and make improvements in NWD systems at the state and local site level. Funded states will actively involve consumer stakeholders in this process.

Outcome and Outputs Table:

Aging and Disability Resource Centers Outcome and Outputs

Measure	Most Recent Result	FY 2014 Target	FY 2015 Target	FY 2015 +/- FY 2014
LTC.2: Percent of individuals who indicate ADRC information and counseling contribute to informed decision making *(Outcome)*	FY 2012: 91% (Baseline set in FY 2013)	83%	83%	Maintain
Indicator	**Most Recent Result**	**FY 2014 Projection**	**FY 2015 Projection**	**FY 2015 +/- FY 2014**
Output AF: Total number of ADRC contacts *(Output)*	FY 2012: 5.2M	3.6 M	4.0 M	+ 400,000
Output AG: Increase in the number of ADRC programs *(Output)*	FY 2012: 468	280	300	+ 20

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
(Dollars in thousands)

	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	10	6,698	15	5,634	TBD	11,202
Continuations	32	5,663	10	6,601	15	5,634
Contracts	2	2,367	1	2,530	1	2,530
Interagency Agreements	--	--	--	--	--	--
Program Support /1		857		634		634
Total Resources		15,585		15,399		20,000

1/ Program Support -- Includes funds for salaries, benefits, contract fees, grant systems, and review costs.

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Voting Access for Individuals with Disabilities

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Voting Access for People with Disabilities	$4,961,000	$4,963,000	$4,963,000	--

Authorizing Legislation: Section 291 of the Help America Vote Act

FY 2015 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 (P&A) 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 competitive one-year awards.

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.

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, identifying and implementing technologies to assist individuals with disabilities in voting, 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 2010 .....$17,410,000
FY 2011 .....$17,375,000
FY 2012 .....$5,235,000
FY 2013 .....$4,961,000
FY 2014 .....$4,963,000

Note: FY 2011 was the final year of funding for an additional HAVA formula grant to State Election Commissioners.

Budget Request:

The FY 2015 budget request for Voting Access for Individuals with Disabilities to the Protection and Advocacy Systems and related technical assistance is $4,963,000, the same as the FY 2014 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. 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.

Grant Awards Table:

Voting Access for Individuals with Disabilities Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	55	55	55
Average Award	$83,890	$83,920	$83,920
Range of Awards	$35,000 - $347,600	$35,000 - $348,401	$35,000 - $348,401

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

FY 2015 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Voting Access for Individuals with Disabilities (CFDA 93.618)

State/Territory	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
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	347,600	348,401	348,401	--
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	175,751	176,919	176,919	--
Georgia	90,517	90,851	90,851	--
Hawaii	70,000	70,000	70,000	--
Idaho	70,000	70,000	70,000	--
Illinois	118,682	117,917	117,917	---
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	70,000	70,000	--
Michigan	91,079	90,516	90,516	--
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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2014 +/- FY 2012
New Jersey	81,350	81,186	81,186	--
New Mexico	70,000	70,000	70,000	--
New York	179,511	179,233	179,233	--
North Carolina	89,053	89,314	89,314	--
North Dakota	70,000	70,000	70,000	--
Ohio	106,469	105,727	105,727	--
Oklahoma	70,000	70,000	70,000	--
Oregon	70,000	70,000	70,000	--
Pennsylvania	117,517	116,894	116,894	--
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	236,775	238,662	238,662	--
Utah	70,000	70,000	70,000	--
Vermont	70,000	70,000	70,000	--
Virginia	74,668	74,970	74,970	--
Washington	70,000	70,000	70,000	--
West Virginia	70,000	70,000	70,000	--
Wisconsin	70,000	70,000	70,000	--
Wyoming	70,000	70,000	70,000	--
Subtotal, States	4,438,972	4,440,590	4,440,590	--
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	4,613,972	4,615,590	4,615,590	--
Training and Technical Assistance[115]	347,028	347,410	347,410	--
TOTAL	**$4,961,000**	**$4,963,000**	**$4,963,000**	**--**

[115] 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 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Alzheimer's Disease Initiative – Outreach (Prevention Fund)	$150,000	$4,200,000	$4,200,000	--

Authorizing Legislation: Section 411 of the Older Americans Act of 1965, as amended

FY 2015 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 ACL received $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. During the first year of the Campaign, a new website (alzheimers.gov) was launched and a variety of outreach materials were developed. Going forward, AoA will continue to promote the new website to caregivers and associated organizations using materials already developed. Future efforts will feature Public Service Announcements instead of the paid media approach taken previously. Given the success of the television spot (awards from a health care and an advertising organization) this approach may reach a new and broader audience.

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 highlights the alzheimers.gov website and deploys 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.

Funding History:

FY 2010 .....$0
FY 2011 .....$0
FY 2012 .....$4,000,000
FY 2013 .....$150,000
FY 2014 PB.....$4,200,000

Budget Request:

The FY 2015 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, the same as the amount provided for this activity in FY 2014.

These funds will be used to continue to develop both the information available on the alzheimers.gov web site and the effectiveness of our outreach efforts. 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 2015 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.[116] This may require development of specific additional outreach materials and further analysis to determine if content and messaging are culturally competent.

[116] *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.

Resource and Program Data:

Alzheimer's Disease Initiative – Outreach Campaign
(Dollars in thousands)

Mechanism	FY 2013 Final		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	1	150	1	4,200	1	4,200
Interagency Agreements	--	--	--	--	--	--
Program Support /1		--		--		--
Total Resources		150		4,200		4,200

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State Health Insurance Assistance Programs

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
State Health Insurance Assistance Programs…..	$46,040,000	$52,115,000	$52,115,000	--
FTE…….	5	5	5	--

Authorizing Legislation: Section 4360 of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b-4).

FY 2015 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.

In FY 2014 the SHIP program was transferred from the Centers for Medicare & 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. ACL is working closely with CMS to ensure an orderly transition of the program.

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 2010 .....$46,960,000
FY 2011 .....$52,000,000
FY 2012 .....$52,115,000
FY 2013 .....$46,040,000
FY 2014 .....$52,115,000

In addition, the following legislative action has taken place since FY 2010 which provided additional mandatory funding for the SHIPs:

- 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.

- The Bipartisan Budget Act of 2013 provides an additional $3.75 million for SHIPs in FY 2014.

Budget Request:

The SHIP budget request for FY 2015 is $52,115,000, the same as the FY 2014 enacted level. This includes funding for 5 FTE and related administrative expenses to administer the program.

Funds will be used to continue SHIP grants and enable States to continue the personalized counseling that they have been providing while making 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.

Grant Awards Table:

State Health Insurance Assistance Programs Grant Awards

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget
Number of Awards	54	54	54
Average Award	$852,593	$903,921	$903,921
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 for Long-Term Care Information

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
National Clearinghouse on Long-Term Care Information……..	$85,523	--	$1,000,000	+$1,000,000

Note: Funding for this program was provided by the Affordable Care Act in FY 2013, but unobligated balances were rescinded by the Taxpayer Relief Act in FY 2013 (save for obligations through January 3, 2013). The FY 2015 request is for discretionary funding.

Authorizing Legislation: Section 6021(d) of the Deficit Reduction Act of 2005 (P.L. 106-224).
Mandatory Appropriation (FY 2013): Title VIII of the Affordable Care Act, P.L. 111-148

FY 2015 Authorization .....Expired

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, 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 an ongoing evaluation of both website content and outreach strategy and a more robust social media presence.

Funding History:

Funding for the past 5 years is as follows:

FY 2010 1/ $3,000,000
FY 2011 1/ $3,000,000
FY 2012 ..... $3,000,000
FY 2013 2/ $85,523
FY 2014 PB.....……..$0
1/ Prior to FY 2012 funding for this activity was administered by CMS.
2/ Reflects obligations prior to January 3, 2013 when funding was rescinded.

Budget Request:

The FY 2015 President's Budget request for the National Clearinghouse on Long-Term Care is $1,000,000, an increase of +$1,000,000 over the FY 2014 enacted level. This funding is requested in FY 2015 from discretionary funding, as mandatory funding previously appropriated by the Affordable Care Act for FY 2015 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. Approximately 70 percent of Americans over age 65 will require some type of long-term services and supports.[117] 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.[118] 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 of information can seem overwhelming. The web site now features a decision tool to provide streamlined calls to action and related information. Longtermcare.gov is now the first organic search result in a Google search on the term "long-term care." Continued funding will ensures that consumers will find objective information on how best to prepare for long-term care.

[117] http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/How_Much.aspx
[118] http://www.longtermcare.gov/LTC/Main_Site/Paying/Costs/Index.aspx

Resource and Program Data:

National Clearinghouse for Long-Term Care Information
(Dollars in thousands)

Mechanism	FY 2013 Final 2/		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	1	1,000
Interagency Agreements	--	--	--	--	--	--
Program Support /1		86		--		--
Total Resources		86		--		1,000

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 2013, but unobligated balances were rescinded by the Taxpayer Relief Act in FY 2013 (save for obligations through January 3, 2013). The FY 2015 request is for discretionary funding.

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Paralysis Resource Center

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Paralysis Resource Center	$6,352,000	$6,700,000	$6,700,000	--

Note: For comparability purposes, only the transferred amount of direct grant funding is displayed here. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act

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, in FY 2014 funding and administrative responsibilities for the PRC were transferred from the Centers for Disease Control

and Prevention to ACL. Under ACL, the PRC will benefit from extensive ties to ACL's disability networks and will provide a valuable source of information as ACL continues to strengthen its policy and advocacy efforts in the field of disabilities.

Funding History:

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

FY 2010 .....$6,610,000
FY 2011 .....$5,800,000
FY 2012 .....$6,700,000
FY 2013 .....$6,352,000
FY 2014 .....$6,700,000

Note: This program was funded at CDC through FY 2013 and was transferred to ACL in FY 2014. Funding at CDC included both grant and administrative funds. For comparability purposes, since ACL has been appropriated administrative funding for this program within its Program Administration line, only grant funding amounts are displayed.

Budget Request:

The FY 2015 President's Budget request is $6,700,000, the same as the FY 2014 enacted level. For FY 2015, these funds are requested from amounts provided under section 241 of the Public Health Service Act.

The work done by the PRC 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.[119] 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.

[119]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 2013 Final 2/		FY 2014 Enacted		FY 2015 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	1	6,533	--	--
Continuations	--	--	--	--	1	6,533
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		--		167		167
Total Resources		--		6,700		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 2013. It was transferred to ACL in FY 2014. Resource and program data is not available prior to the proposed transfer to ACL.

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White House Conference on Aging

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
White House Conference	--	--	$3,000,000	+$3,000,000

Authorizing Legislation: Sections 202 and 205 of the Older Americans Act of 1965, as amended

FY 2015 Older Americans Act Authorization.....Expired

Background:

This request is for funds to hold a White House Conference on Aging no later than December 31, 2015. This conference, held once a decade, was last convened in 2005. This would be the sixth such Conference in our nation's history.

White House Conferences on Aging have served as catalysts for developing aging policy for the past 40 years. Past White House Conferences on Aging have prompted the development of many of the programs that represent America's commitment to the elderly. The recommendations made at these conferences have resulted in improvements in the public policies which assist seniors and their families and led to better quality of life for older Americans.

Budget Request:

For FY 2015, $3,000,000 is requested, to remain available through FY 2016.

ACL, working with the White House, is committed to creating a conference with the goal of broad participation from older adults, family caregivers, aging services providers, policy makers and advocates at the federal, state and local level. We will work with stakeholders to develop the structure for such a conference, including a focus on regional participation. We will strive to employ current technologies to facilitate efficient and effective participation by individuals in local and national events. ACL will work with other agencies within HHS and across the federal government in creating and supporting this conference.

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Holocaust Survivor Assistance Fund

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Holocaust Survivor Assistance Fund	--	--	$5,000,000	+$5,000,000

Authorizing Legislation: Section 411 of the Older Americans Act of 1965, as amended

FY 2015 Older Americans Act Authorization.....Expired

Allocation Method.....Competitive Grants

Background:

The United States is home to an estimated 130,000 victims of Nazi persecution, approximately 25 percent of whom are living in poverty. Because of the experiences they endured at the beginning of their lives, Holocaust survivors ("survivors") are likely to have greater and more complex physical and mental health needs as they age. The nonprofit social service agencies that serve this population project that the need for supportive services will continue to grow and intensify over the next five to ten years, which will further widen existing funding and service gaps.

Funding Request:

For FY 2015, the President's Budget requests $5,000,000 in new funding to establish the Holocaust Survivor Assistance Fund ("Fund"). This would be amplified with additional matching dollars from the philanthropic sector. The Fund would target a leverage of 3:1 private to public dollars.

The Fund would help provide supportive services for survivors living in the United States, such as intensive case management services, legal assistance, and emergency assistance with survivors' immediate service needs. The requested funds would be administered in accordance with input received through an extensive community engagement process that the Special Envoy for U.S. Holocaust Survivor Services is conducting with survivors, their families, and the various organizations that serve this population.

The Fund will help bridge the funding and service gaps that this population is facing today. It will generate innovative approaches for the coordination of home- and community-based

services and will help this population age with dignity and support in their homes and communities.

Program Administration

	FY 2013 Final	FY 2014 Enacted	FY 2015 President's Budget	FY 2015 +/- FY 2014
Program Administration	$28,064,000	$30,035,000	$30,035,000	--
FTE[120]……....	135	143	143	--

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 (EJA).

FY 2015 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. The majority of these funds cover pay, rent and security and external services, all of which are relatively fixed in the short term.

In FY 2012, ACL was created by bringing together three existing entities: the Administration on Aging (AoA), an HHS operating division; the Administration on Developmental Disabilities (ADD), part of the Administration for Children and Families (ACF); and the Office of Disability (OD), part of the HHS Office of the Secretary (OS). Consistent with the FY 2014 appropriation, ACL's request reflects a single consolidated line item to fund program administration. In prior

[120] Overall comparable FTE for ACL are projected at 162 in FY 2013, 171 in FY 2014 and 178 in FY 2015. FTE numbers for Program Administration only reflect those FTE funded from the Program Administration budget line, comparably adjusted in FY 2013 to include FTE that came to ACL from the Office of Disability and the Administration on Developmental Disabilities. Program Administration FTE also include those 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 2013-FY 2015), SHIP funds (5 FTE in each of FY 2013-FY 2015) or with CMS CMMI funds (2 FTE in FY 2014 and 3 FTE in FY 2015); ADRC FTE supported with mandatory funds (4 in FY 2013, 3 in each of FY 2014-FY 2015); FTE related to transferred or new programs (SCSEP, Elder Justice, White House Conference on Aging-10 in FY 2013 and FY 2014 and 16 in FY 2015). These FTE are included in the appropriate narrative tables in other sections of this document.

years, funding was provided through a combination of direct appropriations to AoA and transfers of funding. [121]

Funding History:

Comparable funding for ACL Program Administration since the agency's creation in FY 2012 is as follows:

FY 2012	$29,558,000	145 FTE
FY 2013	$28,064,000	135 FTE
FY 2014	$30,035,000	143 FTE

Budget Request:

The FY 2015 request for Program Administration is $30,035,000, the same as the FY 2014 enacted level. This request will support 143 FTE, the same level of FTE usage currently projected for FY 2014. The request includes $158,605 to cover the cost of a 1% FY 2015 pay raise, which would be offset through reductions to contractual and other obligations.

ACL 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 until renovations to the Mary E. Switzer building are complete. ACL is working with the HHS Facilities and Logistics Service (FLS) to refine the schedule and milestones and to ensure that cost estimates are sufficient to cover all costs associated with the transition to Switzer, including build-out, moving, and rent. ACL's move is now estimated to occur in late 2014 or early 2015.

Performance Measures

Program Administration is not directly measured by ACL'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.

[121] Funding totals in FY 2013 included comparable transfers from ACF of $4,859,206 and of $1,197,616 from OS.

Budget Authority by Object Class

Object Classification - Direct
Administration for Community Living
(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	14,128	14,577	449
Other than full-time permanent (11.3)	1,795	1,871	76
Other personnel compensation (11.5)	141	142	1
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**16,064**	**16,590**	**526**
Civilian benefits (12.1)	4,480	4,636	156
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**20,544**	**21,226**	**682**
Travel and transportation of persons (21.0)	340	397	57
Transportation of things (22.0)	3	3	0
Rental payments to GSA (23.1)	2,359	2,503	144
Communication, utilities, and misc. charges (23.3)	466	475	9
Printing and reproduction (24.0)	15	15	0
Other Contractual Services:			
Advisory and assistance services (25.1)	23,240	36,489	13,249
Other services (25.2)	225	229	4
Purchase of goods and services from government accounts (25.3)	6,338	7,377	1,039
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	**29,804**	**44,096**	**14,292**
Supplies and materials (26.0)	57	68	11
Equipment (31.0)	13	20	8
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	1,990,914	1,941,359	(49,556)
Interest and dividends (43.0)	-	-	-
Refunds (44.0)	-	-	-
Total Non-Pay Costs	**2,023,970**	**1,988,935**	**(35,035)**
Total Budget Authority by Object Class	**2,044,514**	**2,010,161**	**(34,353)**

Salaries and Expenses

Administration for Community Living
(Dollars in Thousands)

	FY 2014 Enacted	FY 2015 Budget	FY 2015 +/- FY 2014
Personnel compensation:			
Full-time permanent (11.1)	14,128	14,577	449
Other than full-time permanent (11.3)	1,795	1,871	76
Other personnel compensation (11.5)	141	142	1
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**16,064**	**16,590**	**526**
Civilian benefits (12.1)	4,480	4,636	156
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**20,544**	**21,226**	**682**
Travel and transportation of persons (21.0)	340	397	57
Transportation of things (22.0)	3	3	0
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Communication, utilities, and misc. charges (23.3)	466	475	9
Printing and reproduction (24.0)	15	15	0
Other Contractual Services:			
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Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	-	-	-
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**29,804**	**44,096**	**14,292**
Supplies and materials (26.0)	57	68	11
Total Non-Pay Costs	**33,043**	**47,556**	**14,513**
Total Salary and Expense	**53,587**	**68,782**	**15,195**
Direct FTE	156	162	6

Detail of Full-Time Equivalent Employment (FTE)

Administration for Community Living

	2013 Actual Civilian 1/	2013 Actual Military	2013 Actual Total	2014 Est. Civilian	2014 Est. Military	2014 Est. Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total
Immediate Office of the Administrator									
Direct:	16		16	17		17	19		19
Reimbursable:	0		0	0		0	0		0
Total:	16	0	16	17	0	17	19	0	19
Administration on Aging									
Direct:	28		28	28		28	32		32
Reimbursable:	6		6	6		6	6		6
Total:	34	0	34	34	0	34	38	0	38
Administration on Intellectual & Developmental Disabilities									
Direct:	21		21	24		24	24		24
Reimbursable:	0		0	0		0	0		0
Total:	21	0	21	24	0	24	24	0	24
Center for Management and Budget									
Direct:	25		25	26		26	26		26
Reimbursable:	1		1	1		1	1		1
Total:	26	0	26	27	0	27	27	0	27
Center for Disability and Aging Policy									
Direct:	26		26	26		26	26		26
Reimbursable:	2		2	4		4	5		5
Total:	28	0	28	30	0	30	31	0	31
Office of Regional Operations									
Direct:	33		33	35		35	35		35
Reimbursable:	4		4	4		4	4		4
Total:	37	0	37	39	0	39	39	0	39
FTE Total	**162**	**0**	**162**	**171**	**0**	**171**	**178**	**0**	**178**

	Average GS Grade
FY 2011	12.8
FY 2012	12.8
FY 2013	12.9
FY 2014	12.8
FY 2015	12.8

1/ For FY 2013, accurate actual FTE data for SHIPs and SCSEP is not available, since staff working on these programs in CMS and the Dept. of Labor also work on other programs. As a result, FTE numbers for FY 2013 have been made comparable to the numbers included for these programs in FY 2014 and FY 2015.

Detail of Positions

Administration for Community Living

	2013 Actual	2014 Base	2015 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	$ 155,130	$ 155,577	$ 155,577
ES-6			
ES-5	2	2	2
ES-4	2	2	2
ES-3		1	1
ES-2			
ES-1			
Subtotal	4	5	5
Total - ES Salary	$ 673,813	$ 823,750	$ 829,928
GS-15	28	26	27
GS-14	27	25	28
GS-13	48	59	69
GS-12	20	24	25
GS-11	6	6	8
GS-10	2	2	2
GS-9	7	8	8
GS-8	1	1	1
GS-7	2	2	2
GS-6	1	1	1
GS-5	1	1	1
GS-4	0	0	0
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	143	155	172
Total - GS Salary	$ 14,975,626	$ 16,648,158	$ 17,673,416

	2013 Actual	2014 Base	2015 Budget
Average ES level	3.2	3	3
Average ES salary	$168,453	$164,750	$165,986
Average GS grade	12.9	12.8	12.8
Average GS salary	$104,725	$103,207	$102,752
Average GS salary & benefits	$134,048	$132,104	$131,523

FTE Funded by the Affordable Care Act

Administration for Community Living
(Dollars in thousands)

Program	Section(s)	FY 2011			FY 2012			FY 2013		
		$	FTEs	CEs	$	FTEs	CEs	$	FTEs	CEs
Pre-existing programs funded by ACA (Mandatory)										
National Clearinghouse for Long-Term Care Information 1/	Title VIII	$ 3,000	0	0	$ 3,000	1	0	$ 86	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$ -	0	0	$ 25,000	0	0
New programs authorized and funded by ACA (Mandatory)										
Aging and Disability Resource Centers 2/	Section 2405	$ 10,000	3	0	$ 10,000	4	0	$ 9,490	4	0
New programs funded from the PPHF under ACA (Discretionary)										
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ -	0	0	$ 6,000	0	0	$ 2,000	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$ -	0	0	$ 10,000	0	0	$ 7,086	1	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ -	0	0	$ -	0	0	$ -	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ -	0	0	$ 4,000	0	0	$ 150	0	0
Falls Prevention--(PPHF)	Section 4002	$ -	0	0	$ -	0	0	$ -	0	0
Programs authorized by ACA but funded by other sources (Discretionary)										
Elder Justice Initiative/Adult Protective Services	Subtitle H, Sections 6701-6703	$ -	0	0	$ -	0	0	$ -	0	0

Program	Section(s)	FY 2014			FY 2015		
		$	FTEs	CEs	$	FTEs	CEs
Pre-existing programs funded by ACA (Mandatory)							
National Clearinghouse for Long-Term Care Information 1/	Title VIII	$ -	0	0	$ -	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$ -	0	0
New programs authorized and funded by ACA (Mandatory)							
Aging and Disability Resource Centers 2/	Section 2405	$ 9,280	3	0	$ -	0	0
New programs funded from the PPHF under ACA (Discretionary)							
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ -	0	0	$ -	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$ 8,000	0	0	$ 8,000	0	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ 10,500	0	0	$ 10,500	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ 4,200	0	0	$ 4,200	0	0
Falls Prevention--(PPHF)	Section 4002	$ 5,000	0	0	$ 5,000	0	0
Programs authorized by ACA but funded by other sources (Discretionary)							
Elder Justice Initiative/Adult Protective Services	Subtitle H, Sections 6701-6703	$ -	0	0	$ 25,000	4	0

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Significant Items in Appropriations Committee Reports

Administration for Community Living

Community Living **-** The Committee encourages CMS and ACL to continue their joint expansion and support of home- and community-based services for individuals with disabilities through the Money Follows the Person program, the Community First Choice Option, and other programs. In support of this effort, the Committee encourages CMS and ACL to provide regulatory guidance and technical assistance to States and other interested parties regarding the various Federal tools that have been created to help them expand access to home- and community-based long-term services and supports. In addition, the Committee encourages CMS and ACL to create an interagency task force on implementing the Olmstead decision.

Actions Taken or To Be Taken - CMS and ACL will continue to collaborate on the joint expansion, financing and oversight of the full range of CMS and ACL initiatives that will help states develop consumer-centered systems of long-term services and supports. This past year, at the direction of the HHS Secretary, CMS and ACL co-convened the HHS Community Living Council comprised of all the HHS entities involved in Long-Term Services and Supports to ensure HHS-wide coordination of the Department's work in this area, including its work on Olmstead. On the regulatory front, after extensive HHS-wide review and public input, CMS issued the Home and Community-Based Services Settings Final Rule establishing requirements for the qualities of settings that are eligible for reimbursements under Medicaid. In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Protection of Vulnerable Older Americans **-** The Committee urges the Long-term Care Ombudsman program to include ombudsman training on the possible dangers of chemical and physical restraints, including portable adult bedrails, and how to safely minimize their use.

Actions Taken or To Be Taken - Since the early 1980's States' Long-Term Care Ombudsman Programs have worked to eliminate or reduce the use of chemical and physical restraints. The Administration for Community Living (ACL) funds the National Ombudsman Resource Center (NORC) which provides ongoing training and technical assistance to long-term care ombudsman programs, including training on chemical and physical restraint reduction in long-term care facilities.

In the past two years, the NORC, and its host agency, The National Consumer Voice for Quality Long-Term Care, have increased their focus on developing training materials related to chemical restraint reduction, specifically the reduction in the misuse of anti-psychotics. These materials can be found at: http://www.theconsumervoice.org/advocate/antipsychotic-drugs. Recent activities include:

- Hosting a webinar entitled "Ending Misuse of Anti-Psychotics in Long-Term Care."
- In-person training "The Antipsychotic Initiative and the Role of the Ombudsman" at a national training conference for State LTC Ombudsmen.
- Promoting LTC Ombudsman participation in Advancing Excellence in America's Nursing Homes, which has a medications goal that focuses on reduction of inappropriate use of antipsychotic drugs.
- Supporting the CMS initiative to reduce the misuse of antipsychotic drugs in nursing homes by inviting CMS to participate in training opportunities and by promoting their training materials and webinars.

These activities in turn give State LTC Ombudsmen the tools to participate in state-level partnerships to focus on reducing chemical and physical restraints and often include training of long-term care providers, ombudsmen, residents and their families.

Further, ACL's Office of Long-Term Care Ombudsman Programs works directly with long-term care provider associations and Advancing Excellence in America's Nursing Homes Campaign on restraint reduction and related issues on a regular basis. ACL works closely with CMS on review of policies, resources, and proposed regulations for appropriate care in nursing facilities, including restraint reduction. A recent example was ACL's review and comment on CMS-developed training for nursing home staff on person-centered dementia care, which directly relates to antipsychotic reduction and eliminating physical restraints.

Most recently, ACL initiated a new collaboration with the Consumer Products Safety Commission (CPSC) to promote consumer awareness of bedrail hazards which has resulted in the following outcomes:

- CPSC developed a one page safety fact sheet on adult bed rail hazards see: http://www.cpsc.gov/en/Safety-Education/Neighborhood-Safety-Network/Posters/Adult-Bed-Rails/
- CPSC has convened a voluntary standards workgroup which includes a consumer advocate.
- CPSC, the Food and Drug Administration (FDA), ACL and other federal partners worked to develop consumer information resulting in a "Bedrail Safety" webpage which includes information for consumers and long-term care providers on adult portable bedrail safety. See

http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm

- These web-based resources were also shared with long-term care ombudsmen through the NORC and to the aging and disability networks through the ACL e-newsletter and other venues.
- The CPSC posted a "Petition Requesting a Ban or Standard on Adult Portable Bed Rails;" about a dozen local and state LTC Ombudsmen provided public comments to the CPSC.
- ACL is working to develop a safety focus for Older American's month in May 2014 with a theme "Safe Today. Healthy Tomorrow." which will include information on bedrail safety. See http://www.acl.gov/NewsRoom/Observances/oam/2014/Index.aspx

Improving Transportation for Older Americans **-** The Committee is aware of the growing need for transportation services for older Americans and urges ACL to support efforts to encourage private-public partnerships to carry out section 416 of the OAA.

Actions Taken or To Be Taken - ACL is the co-chair of the United We Ride Health and Transportation Workgroup. In December 2013, this workgroup began holding monthly listening sessions in webinar format for all federal agencies involved in the Coordinating Council on Access and Mobility. The goal of the listening sessions is to learn about transportation innovation, discover synergies and encourage cross-collaboration to avoid duplication. To date, sessions have highlighted innovations that intersect health and transportation by the Federal Highways Administration, the Department of Transportation's Office of the Secretary, and the Veteran's Administration (VA). ACL is also working closely with Federal Transit Administration (FTA) and their National Center for Mobility Management (NCMM) to stimulate mobility management at all levels to help encourage private-public partnerships to increase rides at the same or reduced cost.

In addition, ACL's Inclusive Transportation Project, in coordination with FTA, seeks to identify and translate the process used by community transportation systems to fully include older adults and people with disabilities in project work groups that identify barriers, identify solutions, implement solutions, and evaluate progress. The intent of the inclusive process is to improve community transportation by incorporating older adults and people with disabilities into the planning/work process, including the promotion of private-public partnerships.

Adult Protective Services Demonstration **-** This new program, as authorized in the Elder Justice Act, will provide competitive grants to States to test and evaluate innovative approaches to preventing and responding to elder abuse. The Committee encourages ACL to test innovative practices in local communities that develop partnerships across disciplines for the prevention, investigation, and prosecution of abuse, including financial abuse against the elderly.

Actions Taken or To Be Taken - Currently, most communities do not have comprehensive elder abuse prevention efforts that engage a broad set of individuals and institutions that can play a role in combating abuse, such as health professionals, law enforcement and legal services agencies, social workers, clergy, and community organizations. However, promising multidisciplinary models and certain strategies from other family violence prevention programs exist that could qualify for pilot testing elder abuse interventions. In FY 2012, ACL received $5.5 million from the Prevention and Public Health Fund to test and evaluate comprehensive approaches to preventing elder abuse. Five states received funding to test interventions, and all the projects include multidisciplinary approaches that involve the state unit on aging; adult protective services; local community social services, health, and behavioral health providers; and law enforcement. Using the results of these prevention projects, ACL will develop a compendium of best practices and lessons learned that APS programs across the nation can use to improve their programs.

Aging and Disability Resource Centers- These centers provide information, one-on-one counseling, and access for individuals to learn about their long-term services and support options with the goal of allowing seniors and individuals with disabilities to maintain their independence. The Committee urges ACL to improve coordination among ADRCs, area agencies on aging, and centers for independent living to ensure that there is `no wrong door' to access services.

Actions Taken or To Be Taken - ACL will continue to partner with CMS and the Veteran's Health Administration to promote the development of a no wrong door model that serves all LTSS populations and that involve a broad range of local organizations with the capacity to serve the various LTSS populations, including the area agencies on aging and the centers for independent living, in the operations of a state's no wrong door system. This is one of the main objectives of the special 3-year funding that was made available to 8 states in 2012 as they work with ACL, CMS and the VHA to develop national standards for a No Wrong Door Systems that will serve all LTSS populations and all LTSS payers.

Community Living **-** The Committee encourages CMS and ACL to continue their joint expansion and support of home- and community-based services for individuals with disabilities through the Money Follows the Person program, the Community First Choice Option, and other programs. In support of this effort, the Committee encourages CMS and ACL to provide regulatory guidance and technical assistance to States and other interested parties regarding the various Federal tools that have been created to help them expand access to home- and community-based long-term services and supports. In addition, the Committee encourages CMS and ACL to create an interagency task force on implementing the Olmstead decision.

Actions Taken or To Be Taken - CMS and ACL will continue to collaborate on the joint expansion, financing, and oversight of the full range of CMS and ACL initiatives that will help states develop consumer-centered systems of long-term services and supports. This past year, at the direction of the HHS Secretary, CMS and ACL co-convened the HHS Community Living Council comprised of all the HHS entities involved in LTSS to ensure HHS-wide coordination of the Department's work in this area, including its work on Olmstead. On the regulatory front, after extensive HHS-wide review and public input, CMS issued the Home and Community-Based Services Settings Final Rule establishing requirements for the qualities of setting s that are eligible for reimbursements under Medicaid. In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

***Protection of Vulnerable Older Americans* -** The Committee urges the Long-term Care Ombudsman program to include ombudsman training on the possible dangers of chemical and physical restraints, including portable adult bedrails, and how to safely minimize their use.

Actions Taken or To Be Taken - Since the early 1980's, state Long-Term Care Ombudsman Programs have worked to eliminate or reduce the use of chemical and physical restraints. The Administration for Community Living (ACL) funds the National Ombudsman Resource Center (NORC) which provides ongoing training and technical assistance to long-term care ombudsman programs, including training on chemical and physical restraint reduction in long-term care facilities.

In the past two years, the NORC, and its host agency, The National Consumer Voice for Quality Long-Term Care, have increased their focus on developing training materials related to chemical restraint reduction, specifically the reduction in the misuse of anti-psychotics. These materials can be found at: http://www.theconsumervoice.org/advocate/antipsychotic-drugs.

Recent activities include:

- Hosting a webinar entitled "Ending Misuse of Anti-Psychotics in Long-Term Care."
- In-person training "The Antipsychotic Initiative and the Role of the Ombudsman" at a national training conference for State LTC Ombudsmen.

- Promoting LTC Ombudsman participation in Advancing Excellence in America's Nursing Homes, which has a medications goal that focuses on reduction of inappropriate use of antipsychotic drugs.
- Supporting the CMS initiative to reduce the misuse of antipsychotic drugs in nursing homes by inviting CMS to participate in training opportunities and by promoting their training materials and webinars.
- These activities in turn give State LTC Ombudsmen the tools to participate in state-level partnerships to focus on reducing chemical and physical restraints and often include training of long-term care providers, ombudsmen, residents and their families.

Further, ACL's Office of Long-Term Care Ombudsman Programs works directly with long-term care provider associations and Advancing Excellence in America's Nursing Homes Campaign on restraint reduction and related issues on a regular basis. ACL works closely with CMS on review of policies, resources, and proposed regulations for appropriate care in nursing facilities, including restraint reduction. A recent example was ACL's review and comment on CMS-developed training for nursing home staff on person-centered dementia care, which directly relates to antipsychotic reduction and eliminating physical restraints.

Most recently, ACL initiated a new collaboration with the Consumer Products Safety Commission (CPSC) to promote consumer awareness of bedrail hazards which has resulted in the following outcomes:

- CPSC developed a one page safety fact sheet on adult bed rail hazards see: http://www.cpsc.gov/en/Safety-Education/Neighborhood-Safety-Network/Posters/Adult-Bed-Rails/
- CPSC has convened a voluntary standards workgroup which includes a consumer advocate.
- CPSC, the Food and Drug Administration (FDA), ACL and other federal partners worked to develop consumer information resulting in a "Bedrail Safety" webpage which includes information for consumers and long-term care providers on adult portable bedrail safety. See http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/default.htm
- These web-based resources were also shared with long-term care ombudsmen through the NORC and to the aging and disability networks through the ACL e-newsletter and other venues.
- The CPSC posted a "Petition Requesting a Ban or Standard on Adult Portable Bed Rails;" about a dozen local and state LTC Ombudsmen provided public comments to the CPSC.

- The ACL/AoA is working to develop a safety focus for Older American's month in May, 2014 with a theme "Safe Today. Healthy Tomorrow." which will include information on bedrail safety. See http://www.acl.gov/NewsRoom/Observances/oam/2014/Index.aspx

Improving Transportation for Older Americans **-** The Committee is aware of the growing need for transportation services for older Americans and urges ACL to support efforts to encourage private-public partnerships to carry out section 416 of the OAA.

Actions Taken or To Be Taken - ACL is the co-chair of the United We Ride Health and Transportation Workgroup. In December 2013, this workgroup began holding monthly listening sessions in webinar format for all federal agencies involved in the Coordinating Council on Access and Mobility. The goal of the listening sessions is to learn about transportation innovation, discover synergies and encourage cross-collaboration to avoid duplication. To date, sessions have highlighted innovations that intersect health and transportation by FHWA, DoT's Office of the Secretary, and the VA. Attached is the February 2014 listening session announcement, which featured the VA's mobility management initiative and ROI metrics.

In addition, ACL is working closely with FTA and their National Center for Mobility Management (NCMM) (see attached flyer). Currently, FTA, NCMM and ACL are working to stimulate mobility management at all levels to help encourage private-public partnerships to increase rides at the same or reduced cost.

Lastly, the ACL Inclusive Transportation Project, in coordination with FTA, seeks to identify and translate the process used by community transportation systems to fully include older adults and people with disabilities in project work groups that identify barriers, identify solutions, implement solutions, and evaluate progress. The intent of the inclusive process is to improve community transportation by incorporating older adults and people with disabilities into the planning/work process, including the promotion of private-public partnerships.

Adult Protective Services Demonstration **-** This new program, as authorized in the Elder Justice Act, will provide competitive grants to States to test and evaluate innovative approaches to preventing and responding to elder abuse. The Committee encourages ACL to test innovative practices in local communities that develop partnerships across disciplines for the prevention, investigation, and prosecution of abuse, including financial abuse against the elderly.

Actions Taken or To Be Taken - Currently, most communities do not have comprehensive elder abuse prevention efforts that engage a broad set of individuals and institutions that can play a role in combating abuse, such as health professionals, law enforcement and legal services agencies, social workers, clergy, and community organizations. However, promising multidisciplinary models and certain strategies from other family violence prevention programs

exist that could qualify for pilot testing elder abuse interventions. In FY 2012, ACL received $5.5 million from the Prevention and Public Health Fund, as well as $2 million in FY 2013, to test and evaluate comprehensive approaches to preventing elder abuse. Five states received funding to test interventions, and all the projects include multidisciplinary approaches that involve the state unit on aging; adult protective services; local community social services, health, and behavioral health providers; and law enforcement. Using the results of these prevention projects, AoA will develop a compendium of best practices and lessons learned that APS programs across the nation can use to improve their programs. The information garnered from this investment will be used as a starting place in FY 2015 for expanding best practices into developing standards to detect and report elder abuse, neglect and exploitation, as outlined under the Elder Justice Initiative.

Aging and Disability Resource Centers- These centers provide information, one-on-one counseling, and access for individuals to learn about their long-term services and support options with the goal of allowing seniors and individuals with disabilities to maintain their independence. The Committee urges ACL to improve coordination among ADRCs, area agencies on aging, and centers for independent living to ensure that there is `no wrong door' to access services.

Actions Taken or To Be Taken - ACL will continue to partner with CMS and the Veteran's Health Administration to promote the development of a no wrong door model that serves all LTSS populations and that involve a broad range of local organizations with the capacity to serve the various LTSS populations, including the area agencies on aging and the centers for independent living, in the operations of a state's no wrong door system. This is one of the main objectives of the special 3-year funding that was made available to 8 states in 2012 as they work with ACL, CMS and the VHA to develop national standards for a No Wrong Door Systems that will serve all LTSS populations and all LTSS payers.

State Health Insurance Assistance Program-The Committee concurs with the administration's proposal to transfer this grant program to ACL from CMS and includes bill language that reflects this transfer. About two-thirds of the 54 State SHIPs are already administered by State units on aging. SHIP activities are aligned with ACL's mission to develop a comprehensive system of home- and community-based services to help seniors maintain their health and independence.

Actions Taken or To Be Taken - ACL and CMS welcome Congress's decision to include the transfer of the SHIPs in the budget it sent to the President, and the ACL and CMS Administrators have already sent a joint communique to the SHIPs stating their commitment to an orderly and timely transfer of the program that will be seamless for the state SHIP operations. To that end, an ACL/SHIP team has been established and is already working on the many operational details that will need to be addressed as part of the orderly transfer.