DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2012

Administration on Aging

Justification of Estimates for Appropriations Committee

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FROM THE ADMINISTRATION ON AGING

I am pleased to present the Administration on Aging (AoA) FY 2012 Congressional Justification.

AoA and the national aging services network annually serve nearly 11 million seniors and their caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission.

From 2010 to 2015, the population age 60 and older will increase by 15 percent, from 57 million to 65.7 million. During this period, the number of seniors with severe disabilities who are at greatest risk of nursing home admission and Medicaid eligibility will increase by more than 13 percent. Further, demographic trends indicate at least 300,000 more seniors will be living in poverty in FY 2012.

As Assistant Secretary for Aging, my goal is to insure that all older Americans have the opportunity to live independently, with dignity, in their homes and communities for as long as they are able and choose to do so. I believe that with the FY 2012 budget, we will make significant progress toward this goal. The FY 2012 request of $2.2 billion will continue to support the vibrant, far reaching array of services and supports for older Americans and their caregivers that have been the hallmark of the Older Americans Act, while elevating our focus on preventing elder abuse—physical, emotional, financial—and emphasizing elder justice. It will encompass a new, voluntary self-directed long-term care insurance resource for American workers that will allow participants to purchase community living assistance services and supports so that they can remain as independent as possible under a variety of future health circumstances. Finally, it will bring two existing programs into the AoA fold, melding activities that are already key to helping seniors maintain their health and economic independence with the supports provided by AoA's existing Aging Services programs. The whole promises to be far more efficient, effective and beneficial to seniors.

In light of AoA's past performance and cost-effectiveness, this budget entrusts AoA with a variety of new opportunities to build on our record of success. It is our privilege to continue to help prepare the country for the increasing numbers of older Americans and continue to provide vital support programs for this country's most vulnerable citizens so that they can remain in their homes and communities for as long as possible, which is what they prefer.

Kathy Greenlee
Assistant Secretary for Aging

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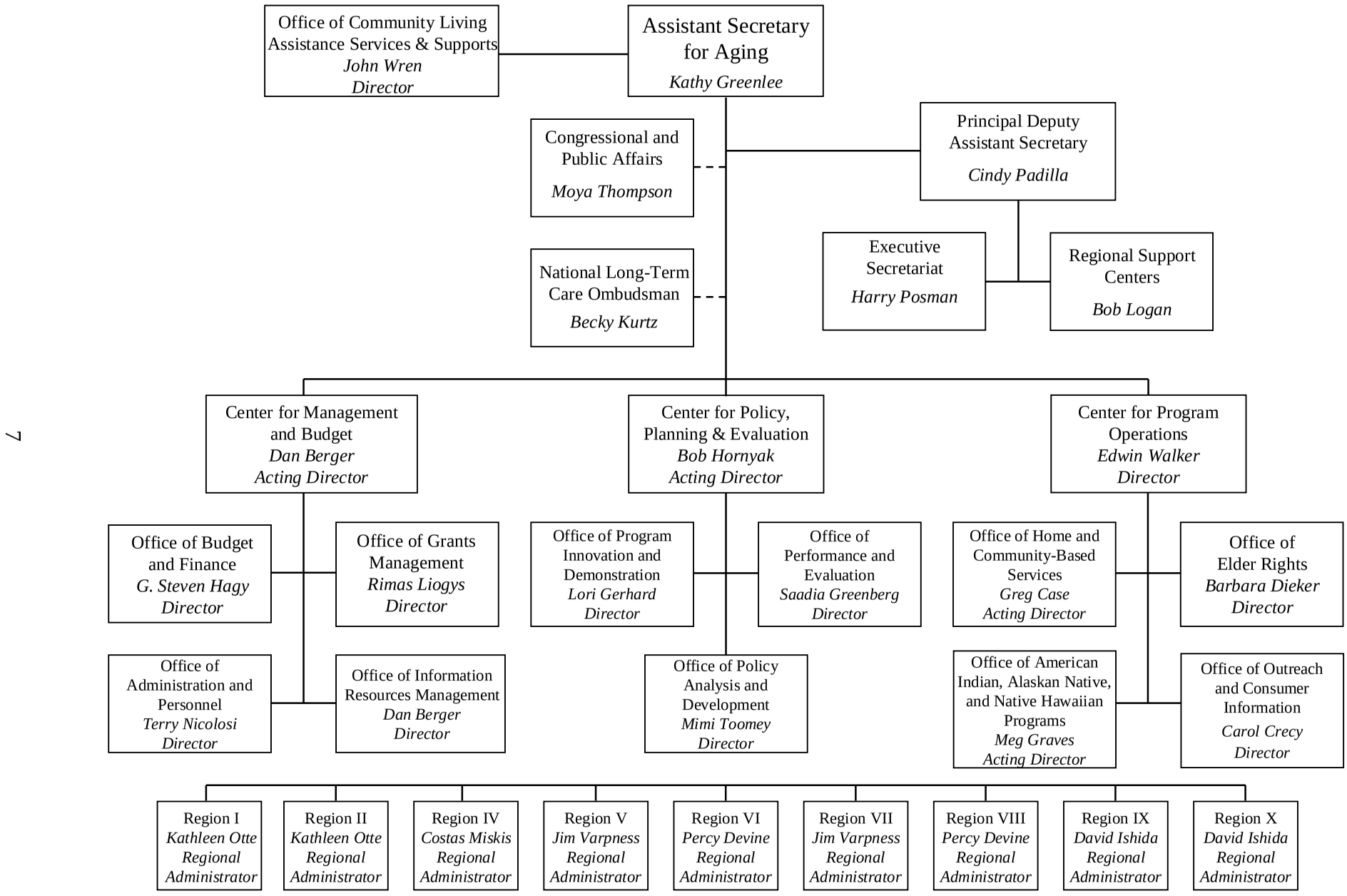
Administration on Aging Organizational Chart



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Executive Summary

Agency Overview

The Administration on Aging (AoA), an Agency of the U.S. Department of Health and Human Services (DHHS), is the principal Federal Agency charged with helping elderly individuals maintain their dignity and independence in their homes and communities. 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, coordinated home and community-based care that is responsive to the needs and preferences of older people and their caregivers. The network, led by AoA at the Federal level, is comprised of 56 State and Territorial Units on Aging (SUA), 629 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) and administered by the national aging services network, help families keep their loved ones at home for as long as possible. These services complement existing medical and health care systems, help to prevent hospital readmissions, provide transport to doctors appointments, and support some of life's most basic functions, such as providing assistance in elders' homes to help them with bathing or providing or preparing food. The network also helps consumers learn about and access the services and supports that are available in the community and addresses issues related to caregivers. OAA services are less expensive than institutional care and performance data show that they are very effective. The most recent data available (FY 2009) show that AoA and its national network rendered direct services to nearly 11 million elderly individuals age 60 and over (nearly 20 percent of the country's elderly population) and their caregivers, including nearly three million clients who received intensive in-home services. Critical supports, such as respite care and a peer support network, were provided to nearly 850,000 caregivers.

AoA is also the agency chosen to administer the Community Living Assistance Services and Supports (CLASS), a new self-funded, voluntary insurance program created under the Affordable Care Act. AoA's expertise in the field of aging services as well as its connection to the aging services network will help ensure that the CLASS program is solvent and successful as it begins to take effect in 2013.

In the ongoing management of its programs and strategic planning process, AoA is guided by a set of core values in developing and carrying out its mission. These values include listening to older people, their family caregivers, and AoA partners who serve them; responding to the changing needs and preferences of our increasingly diverse and rapidly growing elderly population; producing measurable outcomes that significantly impact the well-being of older people and their family caregivers; and valuing and developing AoA staff.

Vision

In order to serve a growing senior population, AoA envisions ensuring the continuation of a vibrant aging services network at State, Territory, local and Tribal levels through funding of lower-cost, non-medical services and supports that provide the means by which many more

seniors can remain out of institutions and live independently in their communities for as long as possible.

Mission

The mission of AoA is 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.

Overview of Budget Request

The FY 2012 President's Budget request for AoA is $2,237,944,000, a net decrease of -$150,513,000 below the FY 2010 enacted level. This decrease is due to the inclusion in the FY 2010 base of one-time, special funding totaling $225,000,000 for Community Service Employment for Older Americans, commonly known as Senior Community Service Employment Program (SCSEP), that is proposed for transfer to AoA from the Department of Labor. After adjusting for this one-time funding, the request provides increases of +$74,487,000 for AoA.

The FY 2012 request will continue to support a vibrant, far reaching array of services and supports for elderly Americans and their caregivers. The budget proposes new funding for Adult Protective Services Demonstration Grants (APS), authorized by the Elder Justice Act of 2010, part of a larger enhanced AoA focus on elder rights and elder justice that will focus on addressing and combating the many forms of elder abuse. It provides increases for core caregiver and supportive services programs that help seniors remain in the community. Existing AoA programs for seniors will be reinforced in FY 2012 by the transfer to AoA of the State Health Insurance Assistance Programs (SHIPs) from the Centers for Medicare & Medicaid Services (CMS) and the SCSEP from the Department of Labor. The budget also reflects the inclusion of the newly-created Community Living Assistance for Services and Supports (CLASS) program created by the Affordable Care Act.

AoA's enhanced focus on elder rights and elder justice provides increases of +$21.5 million to support a variety of programs that address issues of elder abuse and neglect. 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.[1] Additional adverse health impacts include an increased likelihood of heart attacks, dementia, depression, chronic diseases and psychological distress leading a growing number of seniors to access the healthcare system more frequently (including emergency room visits and hospital admissions), and ultimately to leave their homes and communities prematurely.[2]

[1] 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.

[2] 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.

AoA's enhanced focus on elder justice and elder rights includes $16.5 million to support State Adult Protective Services (APS) programs through the Adult Protective Services State Demonstrations program, which will allow AoA to provide leadership and program coordination functions as well as the development and dissemination of best practices across State and local APS agencies. In addition to these APS improvements, the budget provides an additional +$5 million to improve resident advocacy to elders who live in long-term care settings through increased support to the Long-Term Care Ombudsman Program.

This enhanced focus on elder justice and elder rights will allow the Protection of Vulnerable Adults programs to improve the protection of vulnerable adults 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 and reduce health-care fraud and abuse. 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.

The FY 2012 request continues to expand support for existing programs that focus on Health and Independence for seniors including Nutrition programs, Preventive Health Programs and Home and Community-Based Supportive Services and on its programs that provide caregivers with support and respite. These last two programs would receive increases of +$48 million and +$40 million respectively compared to FY 2010 enacted levels. The program also increases funding for the Lifespan Respite Care Act to $10 million. These increases are in keeping with efforts by the White House Task Force on Middle Class Families to focus additional support on middle class families struggling to care for their aging relatives. The Task Force has been concerned about families that struggle to hold down a job and care for an aging parent; those juggling caring for their own children with the need to drive aging parents to doctor appointments and the grocery store; and those who provide extensive hands-on care and simply need a break. Caregiving responsibilities demand time and money from families who too often are already strapped for both, and these increase will help families to balance these dual responsibilities so that older adults can remain in the community for as long as possible.

AoA's expanded emphasis on community living and helping seniors and people with disabilities to live independently is further strengthened by the transfer of SHIPs from CMS and the decision to establish the CLASS program at AoA. SHIPs, funded at $46,960,000, provide one-on-one counseling to help aging and disabled beneficiaries and coming-of-agers navigate complex health and long-term care-related topics. Moving this funding to AoA will enable grantees, about two-thirds of which are State Units on Aging receiving grants from AoA under other programs, to further streamline their interaction within the national aging services network and to complement AoA's existing Aging and Disability Resource Centers (ADRCs) that serve as community level "one stop shop" entry points into long-term services and supports for people of all ages who have chronic conditions and disabilities. At the same time, the CLASS program, a voluntary, self-directed insurance resource for participating adults, for which the FY 2012 budget includes $120,000,000 in administrative funding, will allow participants to prepare themselves

financially to be able to afford the services and supports that they may one day need to remain independent and in the community.

Finally, the proposal to shift the Senior Community Service Employment Program (authorized under Title V of the Older Americans Act) reflects the recognition that the SCSEP program can be at its most effective when its services are closely integrated with the supports that are provided by AoA's existing aging services programs. At the same time, the wages earned by participants while in this program and after finding unsubsidized employment, will be key to allowing more seniors to remain independent and in their communities.

Program Increases

- *Health and Independence Programs (Excluding Senior Community Service Employment Program) (+57,936,000):*
  An additional +$48 million for Home and Community-Based Supportive Services is requested to expand services, including adult day care as a respite service for families; transportation assistance, case management, minor home modifications, and information and referrals that help seniors ability to remain at home; in-home services such as personal care, chore, and help with eating, dressing and bathing; and community services such as physical fitness programs. Health and Independence Programs will support more than six million hours of adult day care; 18.3 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and 25 million hours of personal care assistance to seniors unable to perform daily activities. The request also includes new funding totaling +$10 million to maintain Chronic Disease Self-Management programs, an evidence-based model that utilizes state-of-the-art techniques to help those with chronic disease to manage their conditions, improve their health status, and reduce their need for more costly medical care.

- *Caregiver Services Programs (+$47,523,000):*
  As part of a continuing effort to address the needs of caregivers, an additional +$40 million over the FY 2010 enacted level is requested for the core National Family Caregiver Support Program (including +$2 million for Native American caregivers). The budget also quadruples funding for the Lifespan Respite Care program, an increase of +$7.5 million. These programs support family and informal caregivers by providing information, assistance, counseling, training, respite, and other services which help them care for their loved ones at home. These funds will increase the number of caregivers receiving support to 919,000 caregivers. Overall, the $192 million in family caregiver funds will provide 7 million hours of respite care or temporary relief from their caregiving responsibilities and more than 450,000 sessions of counseling, peer support groups, and training to help caregivers better cope with the stresses of caregiving.

- *Protection of Vulnerable Older Americans Programs (+$21,033,000):*
  In FY 2012, AoA is requesting +$21 million in additional funding for programs that provide a range of services designed to ensure the safety and well-being of seniors who are in danger of being mistreated or neglected. This budget will direct $16.5 million of the $21 million requested to provide first time funding for demonstrations to help develop

best practices and approaches related to Adult Protective Services, newly authorized in the Elder Justice Act of 2010 and the Older Americans Act. The outcomes of these demonstrations will be made available to States to use in increasing consistency in areas such as receipt and investigation of reports of adult abuse; case planning, monitoring, reporting and evaluation; and the coordination of services between adult protective services (half of which are directly administered by State Units on Aging), and related systems including law enforcement, protection and advocacy, licensure and certification, and victim assistance. The budget also adds $5 million to expand State support for long-term care Ombudsmen, who advocate on behalf of residents of long-term care facilities to ensure the protection of their rights and their welfare. Altogether, nearly 10,000 volunteers participate in the Long-Term Care Ombudsman Program.

- *Program Administration (+$124,567,000, +50 FTE):*
  Additional resources for Program Administration will be needed in FY 2012 to accommodate both the absorption of new programs and creation of others. Of the Program Administration increase, +$120,000,000 and +40 FTE is needed to manage AoA's new CLASS program, including significant investments in the development of a national IT system and national education and outreach to potential participants and employers to explain the opportunities presented by this program. Similar funding will not be required in subsequent years as this program becomes self-sustaining once participants begin paying enrollment fees. An additional +$4,567,000 and +21 FTE will be used to address needs of AoA's aging services programs, especially regional needs, and to provide for costs associated with AoA's headquarters lease renewal. An additional +15 FTE associated with transferred and new programs will be funded from program dollars rather than Program Administration, and are reflected in individual programs' requests.

Program Decreases

- *Health and Independence Programs—Senior Community Service Employment Program (-$375,475,000):*
  The budget includes a proposal to transfer SCSEP from the Department of Labor to the AoA in FY 2012. A total of $450,000,000 in funding would be provided, a decrease of -$375,475,000 from the comparable FY 2010 enacted level. However, $225,000,000 of this reduction represents the expiration of one-time funding that was provided in FY 2010. The remaining reduction reflects the tight budget environment in which all discretionary programs are operating in FY 2012. Placing this program within AoA will better integrate training and job placement for seniors seeking to return to the labor market with the supportive services they need to remain independent, while also allowing the program to refocus on the provision of community service to a greater degree as was originally intended.

- *Consumer Information, Access and Outreach (-$10,250,000):*
  Two reductions in Aging and Disability Resource Center (ADRC) funding are reflected in this section. The first is a $10 million decrease to offset additional funding now being

provided through a mandatory Affordable Care Act ADRC appropriation; the second is a reduction of $250,000 that reflects projected savings from program contract efficiencies.

- *Program Innovations (-$16,364,000):*
  Funding for Program Innovations is reduced both because no funding is requested to continue one-time Congressional earmarks and because some funding is being directed to other, higher priority program needs. In part, this second reduction necessitated the proposed elimination of funding for Community Innovations for Aging in Place. Finally, the lower Program Innovations level also includes $500,000 in projected savings as a result of greater program contracting efficiencies.

The Older Americans Act is due for reauthorization in FY 2012. AoA convened three national listening sessions, held one joint session with the Department of Labor, and sparked hundreds of national, state and local sessions convened by stakeholders and involving all states and area agencies. In addition, targeted outreach to national minority aging organization representing diverse cultures and populations was conducted. As a result, the critical internal and external stakeholders representing thousands of older individuals and their caregivers were engaged in providing input and recommendations for the next reauthorization. We look forward to working with Congress to strengthen and update these critical programs with an eye towards efficiency and effectiveness, and strengthening and building the capacity of the aging services network to deliver high-quality services that improve outcomes for seniors.

EXECUTIVE SUMMARY

Overview of Performance

AoA program activities have a fundamental common purpose which reflects the legislative intent of the Older Americans Act (OAA) and the AoA Mission: to help elderly individuals – and increasingly individuals with disabilities - maintain their dignity and independence in their homes and communities through comprehensive, coordinated, and cost effective systems of long-term care, and livable communities across the U.S. To reflect this unified purpose, AoA has aggregated all budget line items into a single Government Performance and Results Act (GPRA) program, AoA's Aging Services Program, for purposes of performance measurement.

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

In addition to the basic performance measurement requirements of GPRA, which are discussed in detail below, and in recognition of this Administration's guidance on transparency and accountability, AoA has taken several steps to improve the analysis and availability of performance information while also enhancing the rigor of program evaluations that are currently in development. To this end, AoA has:

- Expanded the availability of performance information via an on-line system that enables Aging Network professionals and the public to develop benchmarks and examine trends nationally and at the state level (http://www.data.aoa.gov).

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

- Further analyzed the results from the 2008 and 2009 National surveys to help inform decision makers. Results show:
    - AoA is effectively reaching those most at risk of institutionalization.
    - Service recipients report Title III services enable them to remain in their own homes.

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

- Tested through the Performance Outcomes Measurement Project (POMP) several methods for measuring the impact of services. Preliminary analysis for 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 placement) with increases in the total number of services used.

- Employed more rigorous program evaluation methods such as longitudinal data collection and experimental design.
  - The Title III-C Elderly Nutrition Services program evaluation employs a complex design that includes three major components and several subcomponents. The major components include a process study that surveys each component of the Aging Network on a large array of topics; a costs study that measures the actual cost of providing a meal by cost category (e.g. labor, food, overhead); and an individual outcome study. The individual outcomes study will measure the program's success at meeting the legislative intent of the program (reduce hunger and social isolation while improving health and well-being of consumers). In addition, AoA and CMS have recently entered into an Inter-Agency Agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost data of program participants compared to a matched group of seniors who do not participate in the program.
  - The evaluation of the Title III-E National Family Caregiver Support program will be the first for this OAA program. It is designed as a longitudinal study with a comparison group so that the effects of the five service categories can be measured over time.
  - AoA is working with AHRQ and research contractors to finalize a design for an evaluation of the Chronic Disease Self-Management program utilizing an experimental design and working on an evaluation of Aging and Disability Resource Centers.

Current Performance Information

An analysis of AoA's performance trends shows that through FY 2009 most indicators have steadily improved. It also points to some key observations about the potential of AoA and the national aging services network in meeting the challenges posed by the growth of the vulnerable older adult population, the changing care preferences of aging baby boomers, the fiscal difficulties faced by State budgets, and the expanding needs of both the elderly and their caregivers. Below are some examples of these observations:

- **OAA programs help older Americans with severe disabilities remain independent and in the community**: Older adults that have three or more impairments in Activities of Daily

Living are at a high risk for nursing home placement. Measures of the Aging Network's success at serving this vulnerable population is a proxy for success at nursing home delay and diversion. In FY 2003, the Aging Network served home-delivered meals to 280,454 clients with three or more ADL impairments and by FY 2009 that number grew by 27 percent to 357,403 clients. Another approach to measuring AoA's success is the newly developed nursing home predictor score. The components of this composite score are predictive of nursing home placement based on scientific literature and AoA's POMP which develops and tests performance measures. The components include such items as percent of clients that are transportation disadvantaged and the percent of congregate meal clients that live alone. As the score increases, the prevalence of nursing home predictors in the OAA service population increases. In 2003, the nursing home predictor score was 46.57 and has increased to 61.0 in FY 2009.This increase indicates that AoA programs are serving a larger share of individuals who, without community support, would be more likely to move into institutional settings.

- **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; as an example, AoA has significantly increased the number of clients served per million dollars of AoA funding. Without controlling for inflation, OAA programs have increased efficiency by over 36 percent between FY 2002 and FY 2009, serving 8,524 clients per million dollars of AoA in FY 2009 compared to 6,103 clients served per million dollars of AoA funding in FY 2002 without diluting the quality of the services provided. This increase in efficiency is understated since the purchasing power of a million dollars in 2009 is significantly less than in 2002 due to inflation.

- **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 grew from 24 states to 45 states with 205 sites participating in this key program in FY 2009.

OAA clients report that these services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services. In 2009, over 96 percent of transportation clients rated services good to excellent and 95 percent of caregivers rated services good to excellent. To help ensure the continuation of these trends in core programs, AoA makes extensive use of its discretionary funding to test innovative service delivery models for State and local program entities to attain measurable improvements in program activities. For example, AoA has worked with the Centers for Medicare & Medicaid Services 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 2012

Federal support for Older Americans Act programs is not expected to cover the cost of serving every senior. Federal funds for FY 2012 are expected to be the same level as the previous year for core programs. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donations that contribute funds in greater proportions than OAA programs. Despite States only having to match these programs at 15 percent or 25 percent of their Federal allocation, States have normally leveraged resources of $2 or $3 per every Older Americans Act dollar. Therefore, AoA expects a decline in performance for nutrition and home and community-based services in FY 2012 compared to FY 2011. Substantial declines in performance, in conjunction with a level Federal investment, are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.[3]

Performance at the FY 2012 budget request level of $2,251,256,000 is expected to remain constant or show declines from prior year performance per the assumptions noted above.

Performance Detail

Taken as a whole, AoA's performance measures and indicators form an a system of performance measurement holding up AoA's mission and strategic goals, including:

1. Empower older people, their families, and other consumers to make informed decisions about, and to be able to easily access, existing health and long-term care options;
2. Enable seniors to remain in their own homes with a high quality of life for as long as possible through the provision of home and community-based services, including supports for family caregivers;
3. Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare;
4. Ensure the rights of older people and prevent their abuse, neglect and exploitation; and
5. Maintain effective and responsive management.

Below is a summary of each measurement area, its indicators and their relationship to AoA's strategic goals.

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

[3] AoA's projections are based on the following assumptions: 1) CPI-U or a CPI index; 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

communities increasingly improve their capacity to serve elderly individuals efficiently and effectively with both Federal and State funds.

Improvements in program efficiency support all of AoA's Strategic Goals. Through optimal utilization of resources, improvements in program efficiency ensure that affordable and accessible community-based long-term care is available to promote the well-being of seniors and their family caregivers.

For FY 2012, there are four efficiency indicators for AoA program activities. Indicator 1.1 addresses performance efficiency at all levels of the National aging services network in the provision of home and community-based services, including caregiver services. Indicator 1.3 demonstrates the efficiency of AoA in providing services to Native Americans. Indicator 1.5 assesses the efficiency of the Senior Medicare Patrol program and Indicator ALZ.1 assesses more efficient program operation in the Alzheimer's Disease Supportive Services Program (ADSSP).

A summary of program efficiency indicators for FY 2012 follows:

> **Indicator 1.1:** For Home and Community-based Services, including Nutrition Services, and Caregiver services, increase the number of clients served per million dollars of AoA funding.
>
> **Indicator 1.3**: Increase the number of units of service provided to Native Americans per thousand dollars of AoA funding.
>
> **Indicator 1.5:** SMP projects will increase the total dollar amount referred for further action because of the potential of fraudulent activity.
>
> **Indicator ALZ.1:** Increase the percent of ADSSP grant funds dedicated to evidence-based programs.

Measure 2: Improve Client Outcomes

While improving efficiency, AoA is committed to maintaining quality and improving client outcomes. The FY 2012 performance budget includes eight core performance indicators supporting AoA's commitment to improving client outcomes. AoA has multiple quality assessment indicators in this plan reflecting separate assessments provided by elders for services such as meals, transportation and caregiver assistance. Also, in developing the outcome indicators, AoA included measures to assess AoA's fundamental outcomes: to keep elders at home and in the community, and to measure results important to family caregivers. The measures for the Ombudsman program focus on the core purposes of this program: advocacy on behalf of older adults.

Although this measurement area supports all of AoA's Strategic Goals, it is most strongly tied to Goal 2 to enable seniors to remain in their own homes with a high quality of life for as long as

possible, Goal 3 to empower older adults to stay active and healthy, and Goal 4 to ensure the rights of older people and prevent their abuse, neglect and exploitation.

A summary of the client outcome indicators for FY 2012 follows:

Indicator 2.6: Reduce the percent of caregivers who report difficulty in getting services.

Indicator 2.9a: 90 percent of home delivered meal clients rate services good to excellent.

Indicator 2.9b: 90 percent of transportation clients rate services good to excellent.

Indicator 2.9c: 90 percent of National Family Caregiver Support Program clients rate services good to excellent.

Indicator 2.10: Improve well-being and prolong independence for elderly individuals as a result of AoA's Title III home and community-based services.

Indicator 2.11: Increase the percentage of transportation clients who live alone.

Indicator 2.12: Decrease the number of complaints per long-term care facility.

Indicator 2.13: Decrease the percentage of complaints for abuse, neglect and exploitation in nursing homes.

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. Without targeting measures, efforts to improve efficiency and outcomes could result in unintended consequences whereby entities might attempt to focus their efforts toward individuals who are not the most vulnerable. Such an outcome would be inconsistent with the intent of the OAA, which specifically requires the network to target services to the most vulnerable elders. It would also be inconsistent with the mission of AoA, which is to help vulnerable elders maintain their independence in the community. 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: older persons who are disabled, poor, and residing in rural areas.

Effective targeting of OAA services supports AoA's Strategic Goal 1 by ensuring access to long-term care options for the economically and socially vulnerable; Goal 2 by enabling the most vulnerable seniors to remain in their own homes with a high quality of life; Goal 3 by empowering those likely to experience health disparities to stay active and healthy through OAA services; and Goal 4 by ensuring the rights of vulnerable elders. Thus, AoA's four indicators for effective targeting are crucial for ensuring that services are targeted to the most vulnerable client groups.

Indicator 3.1: Increase the number of caregivers served.

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

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

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

AoA has invested significant resources and continues to work with national partners including Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and National Institute on Aging in the adoption of evidence-based programs at the community level which is reflected in our positive performance results.

Aging Services Program – Performance Summary

AoA has used a streamlined approach to performance measurement since FY 2005, by design. Most of the current performance indicators are cross-cutting and the established performance targets are usually dependent on multiple budget line items. The following table provides an overview of all targets established for each fiscal year.

Summary of Performance Targets and Results Table

Fiscal Year	Total Targets	Targets with Results Reported	Percent of Targets with Results Reported	Total Targets Met	Percent of Targets Met
2006	15	15	100 percent	13	87 percent
2007	16	16	100 percent	13	81 percent
2008	14	14	100 percent	9	64 percent
2009	15	14	93 percent	10	71 percent
2010	15	NA	NA	NA	NA
2011	16	NA	NA	NA	NA
2012	16	NA	NA	NA	NA

Information Technology

AoA's FY 2012 IT Exhibits 300 may be found at http://itdashboard.gov.

Administration on Aging

All-Purpose Table

(Dollars in thousands)

Program	FY 2010 Enacted 1/	FY 2011 Annualized CR	FY 2012 President's Request	FY 2012 +/- FY 2010
Health and Independence:				
Home & Community-Based Supportive Services	$ 368,290	$ 368,348	$ 416,476	$ 48,186
Congregate Nutrition Services (non-add)	440,718	440,783	440,718	--
Home-Delivered Nutrition Services (non-add)	217,644	217,676	217,644	--
Nutrition Services Incentive Program	160,991	161,015	160,991	--
Preventive Health Services	21,026	21,026	21,026	--
Chronic Disease Self-Management Programs	/3	--	10,000	--
Community Service Employment for Older Americans	825,425	825,425	450,000	(375,425)
Native American Nutrition & Supportive Services	27,704	27,708	27,704	--
Aging Network Support Activities	8,198	8,200	7,948	(250.)
Subtotal, Health and Independence	$ 2,069,996	$ 2,070,181	$ 1,752,507	$ (317,489)
Caregiver Services:				
Family Caregiver Support Services	$ 154,197	$ 154,220	$ 192,220	$ 38,023
Native American Caregiver Support Services	6,388	6,389	8,388	2,000
Alzheimer's Disease Supportive Services Program	11,462	11,464	11,462	--
Lifespan Respite Care	2,500	2,500	10,000	7,500
Subtotal, Caregiver Services	$ 174,547	$ 174,573	$ 222,070	$ 47,523
Protection of Vulnerable Adults:				
Adult Protective Services	$ --	$ --	$ 16,500	$ 16,500
Long-Term Care Ombudsman Program	16,825	16,827	21,825	5,000
Prevention of Elder Abuse & Neglect	5,055	5,056	5,055	--
Senior Medicare Patrol Program 5/	13,217	12,751	12,750	(467)
Elder Rights Support Activities 6/	4,103	4,104	4,103	--
Subtotal, Vulnerable Adults	$ 39,200	$ 38,738	$ 60,233	$ 21,033
Consumer Information, Access & Outreach				
Aging and Disability Resource Centers 4/	$ 23,684	$ 23,684	$ 13,434	$ (10,250)
State Health Insurance Assistance Program 8/	46,960	46,960	46,960	--
Medicare Enrollment Assistance 9/	30,000	--	--	(30,000)
Subtotal, Consumer	$ 100,644	$ 70,644	$ 60,394	$ (40,250)
Program Innovations 7/	$ 27,873	$ 27,879	$ 11,509	$ (16,364)
Program Administration:				
Aging Services Programs Administration	$ 19,976	$ 19,979	$ 24,543	$ 4,567
CLASS Administration 10/	--	--	120,000	120,000
Subtotal, Program Administration	$ 19,976	$ 19,979	$ 144,543	$ 124,567
Subtotal, Program Level	**$ 2,432,236**	**$ 2,401,994**	**$ 2,251,256**	**$ (180,980)**
Less Funds From Other Sources:				
Aging and Disability Resource Centers (mandatory) 4/	(10,000)	(10,000)	(10,000)	
Health Care Fraud and Abuse Control 5/	(3,779)	3,312	(3,312)	467
Medicare Enrollment Assistance (mandatory) 9/	(30,000)	--	--	30,000
Total, Discretionary Budget Authority	**$ 2,388,457**	**$ 2,395,306**	**$ 2,237,944**	**$ (150,513)**

1/ Reflects the Secretary's transfer of June 18, 2010 to assist those living with HIV/AIDS on waiting lists for lifesaving medication.

2/ Includes $2,722,303 in FY 2010 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19. Combines AoA's meal programs consistent with the Older Americans Act reauthorization proposal.

3/ In FY 2010, $30 million in Recovery Act funding was transferred from the Centers for Disease Control and Prevention through an intra-departmental delegation of authority as part of the Recovery Act's $650 million "Prevention and Wellness Fund." In FY 2010, an additional $2.5 million was transferred from CDC to CMS for related evaluation and quality improvement purposes.

4/ Includes $10 million in mandatory funds per section 2405 of P.L. 111-148 (Affordable Care Act).

5/ AoA received $3,789,000 from the Health Care Fraud and Abuse Control wedge funds recovered from fighting fraud. $3,279,000 is a placeholder amount for FY 2011 and FY 2012. The Secretary and the Attorney General will determine the final amount.

6/ In FY 2010 and FY 2011, activities were previously appropriated and requested in Aging Network Support Activities and Program Innovations.

7/ Activities in FY 2010 and FY 2011 were innovation activities requested under the Health and Long-term Care Programs. Aging and Disability Resource Centers are requested separately in FY 2012 and comparably adjusted in FY 2010 and FY 2011.

8/ Reflects Secretary's decision to transfer the State Health Insurance Assistance Program from CMS to AoA. Transfer of discretionary funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

9/ Transfer of mandatory funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for benefits outreach to low-income seniors per section 3306 of P.L. 111-148 (Affordable Care Act).

10/ Activities in FY 2010 and FY 2011 were funded from the Affordable Care Act Implementation Fund.

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Administration on Aging

Recovery Act Information

(dollars in millions)

ARRA Implementation Plan	Total Resources Available	FY 2009/ FY 2010 Outlays	FY 2011 Outlays	FY 2012 Outlays
Congregate Nutrition	65	60	65	65
Home-Delivered Nutrition	32	30	32	32
Native American Nutrition	3	2.3	3	3
Total Outlays	100	92	100	100

Performance Measures:

Congregate Nutrition

Outcome / Achievement	Units	Type	12/31/09 10/Q1	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	Program End (3/31/11)
People Served	#	Target	63,213	142,230	144,488	146,746	146,746
		Actual	453,037	729,690	763,204		
Meals Served	#	Target	3,590,525	8,078,681	8,206,914	8,335,147	8,335,147
		Actual	6,886,561	12,526,874	13,173,333		

Home-Delivered Meals

Outcome / Achievement	Units	Type	12/31/09 10/Q1	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	Program End (3/31/11)
People served	#	Target	15,762	30,538	31,031	31,524	31,524
		Actual	143,974	330,791	377,719		
Meals served	#	Target	2,536,074	4,913,643	4,992,895	5,072,147	5,072,147
		Actual	3,881,698	7,916,270	8,684,497		

Nutrition Services for Native Americans

Outcome / Achievement	Units	Type	12/31/09 10/Q1	9/30/10 10/Q4	12/31/10 11/Q1	3/31/11 11/Q2	Program End
Home-Delivered meals served	#	Target	452,563	678,844	678,844	678,844	678,844
		Actual	113,871	408,436	498,616		
Congregate Meals served	#	Target	254,566	381,849	381,849	381,849	381,849
		Actual	72,596	358,462	426,264		

Appropriations Language

Administration on Aging
Aging Services Programs

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965 ("OAA"), section 398 and title XXIX of the Public Health Service Act, section 119 of the Medicare Improvements for Patients and Providers Act of 2008, subtitle B of title XX of the Social Security Act, and for necessary administrative expenses to carry out titles XVII and XXXII of the Public Health Service Act, $2,190,984,000, together with $46,960,000 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, of the amount appropriated under this heading, $192,220,000 shall be for carrying out part E of title III of the OAA and $8,388,000 shall be for carrying out section 631 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 to the satisfaction of the Secretary of Health and Human Services 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 amounts available under this heading for the cost of administering the program under title XXXII of the Public Health Service Act shall be in addition to any amounts available under such title for such purposes: Provided further, That, of the amount under this heading, $450,000,000 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, 2013, and may be recaptured and reobligated in accordance with section 517(c) of the OAA.

General Provision to transfer Older American Community Service Employment Program from Labor to HHS/AoA

SEC. 519 TRANSFER OF OLDER AMERICAN COMMUNITY SERVICE EMPLOYMENT PROGRAM TO DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Older American Community Service Employment (OACSE) program under title V of the Older Americans Act of 1965 (42 U.S.C. 3056), and the authority to administer such program, shall be permanently transferred from the Secretary of Labor to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging.

(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Labor relating to the OACSE program shall be transferred to the Secretary of Health and Human Services.

(c) EFFECTIVE DATE OF TRANSFER.---The transfer under this section shall be effective no later than the last day of the second full fiscal quarter following the quarter in which this section is enacted.

Language Analysis

Administration on Aging
Aging Services Programs

Language Provision	Explanation
subtitle B of title XX of the Social Security Act,	Adds subtitle B of title XX of the Social Security Act to provide AoA the authority to carry out provisions of the Elder Justice Act of 2010. Such activities include activities of the Advisory Board on Elder Abuse, Neglect, and Exploitation and Adult Protective Services demonstration grants.
and for necessary administrative expenses to carry out titles XVII and XXXII of the Public Health Service Act,	Adds Titles XVII of the Public Health Service Act to the activities that can be supported with Program Administration dollars for the purposes of administering funds provided to AoA from the Prevention and Wellness Fund of the American Recovery and Reinvestment Act of 2009. Such activities include ongoing lifecycle management of grants, contracts, and other awards that will be obligated in FY 2010. Also adds Title XXXII of the Public Health Service Act to provide AoA with the authority to administer funds provided for the purpose of carrying out the Community Living Assistance Services and Supports (CLASS) program.
together with $46,960,000 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:	Indicates that in addition to the regular appropriation, $46,960,000 will be transferred to AoA from the Medicare Trust Funds to carry out the State Health Insurance Assistance Program (SHIPs) which is being transferred from the Centers for Medicare and Medicare Services (CMS) to AoA.
Provided, That, of the amount appropriated under this heading,	Adds specific appropriations amounts for the National Family Caregiver Support

Language Provision	Explanation
$192,220,000 shall be for carrying out part E of title III of the OAA and $8,388,000 shall be for carrying out section 631 of such Act:	Services and Native American Caregiver Support Services programs because the requested appropriation amount exceeds the authorization levels in the Older Americans Act. This language ensures AoA will be able to expend these higher sums without violating the Antideficiency 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 to the satisfaction of the Secretary of Health and Human Services to be evidence-based and effective:	Requires that States use the amounts that are appropriated for Preventive Health Services only for evidence-based disease prevention and health promotion programs and activities that have been demonstrated to the Secretary of HHS's satisfaction to be 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:	Allows up to 1% of amounts appropriated to carry out Home and Community-Based Services programs, Nutrition Programs, Preventive Health Programs and Caregiver Programs under Title III of the Older Americans Act to be used for conducting evaluations, training and technical assistance related to these programs.
Provided further, That amounts available under this heading for the cost of administering the program under title XXXII of the Public Health Service Act shall be in addition to any amounts available under such title for such purposes:	Provides that amounts appropriated under Aging Services Programs for the administration of Community Living Assistance Services and Supports (CLASS) activities shall be in addition to any other amounts otherwise provided for this same purpose under the CLASS authorizing legislation.
Provided further, That, of the amount under this heading, $450,000,000 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, 2013, and may be recaptured and reobligated in	Provides $450,000,000 to carry out the Senior Community Service Employment Program (SCSEP) which is being transferred to AoA from the Department of Labor. Additionally, provides that any unexpended funds under SCSEP at the end of the program year can be recaptured

Language Provision	Explanation
accordance with section 517(c) of the OAA.	by the Secretary and reobligated within the two succeeding program years for incentive grants to State or national grantees, for technical assistance, or for grants or contracts for any other activity under this time. Finally, provides that the $450,000,000 will be available from the time of appropriation through the end of the FY 2012 program year on June 30, 2013. This reflects both the fact that SCSEP funds are forward funded and appropriated for a fiscal year that begins on July 1 rather than October 1.
General Provision:	A general provision has been drafted to effect the transfer of the Older American Community Service Employment Program, more commonly know as the Senior Community Service Employment Program (SCSEP) and the authority to administer this program from the Department of Labor to the Administration on Aging within the Department of Health and Human Services.
Transfer of Older American Community Service Employment Program to Department of Health and Human Services. *(a) IN GENERAL.—Notwithstanding any other provision of law, the Older American Community Service Employment (OACSE) program under title V of the Older Americans Act of 1965 (42 U.S.C. 3056), and the authority to administer such program, shall be permanently transferred from the Secretary of Labor to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging.*	
(b) TRANSFER OF FUNCTIONS, ASSETS, AND LIABILITIES.—The functions, assets, and liabilities of the Secretary of Labor relating to the OACSE program shall be transferred to the Secretary of Health and Human Services.	Makes clear that the transfer will include all existing functions, assets and liabilities of the SCSEP program.
(c) EFFECTIVE DATE OF TRANSFER.---The transfer under this section shall be effective no later than the last day of the second full fiscal quarter following the quarter in which this section is enacted.	Directs that the transfer will be effective no later than the end of the second full fiscal quarter following the quarter in which the provision is enacted.

Administration on Aging

Amounts Available for Obligation

(Dollars in thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
General Fund Discretionary Appropriation:			
Appropriation (Annual)	2,341,721	2,341,722	2,190,984
Secretarial Transfer	(224)	--	--
Subtotal, adjusted appropriation	2,341,497	2,341,722	2,190,984
Transfers:			
Transfer of Funds to: Department of Agriculture	(2,268)	--	--
Subtotal, adjusted general fund discr. appropriation	2,339,229	2,341,722	2,190,984
Trust Fund Discretionary Appropriation:			
Appropriation Lines	46,960	46,960	46,960
Subtotal, adjusted trust fund discr. appropriation	46,960	46,960	46,960
Total, Discretionary Appropriation	2,386,189	2,388,682	2,237,944
Mandatory Appropriation:			
Appropriation (PPACA)	10,000	10,000	10,000
Subtotal, adjusted mandatory. appropriation	10,000	10,000	10,000
Offsetting collections from:			
Trust Funds: HCFAC	3,779	3,312	3,312
Trust Funds: MIPPA	30,000	--	--
Unobligated balance, start of year			
Unobligated balance, start of year			
Unobligated balance, end of year			
Unobligated balance, lapsing	(268)		
Unobligated balance, Recovery Act start of year			
Unobligated balance, Recovery Act end of year			
Subtotal, Offsetting Collections	33,511	3,312	3,312
Total obligations	**2,429,700**	**2,401,994**	**2,251,256**

Administration on Aging

Summary of Changes
(Dollars in thousands)

2010
Total estimated discretionary budget authority..... 2,388,457

2012
Total estimated discretionary budget authority..... 2,237,944

Net Change..... (150,513)

	FY 2010 Estimate FTE	FY 2010 Estimate Budget Authority	FY 2012 Change from Base FTE	FY 2012 Change from Base Budget Authority
Increases:				
A. Built-in:				
1. Aging Services Pgms Admin--Incr in Ext Cost, Taps..... and Systems Upgrades.....		19,976		1,025
2. Aging Services Pgms Admin--Relocation/Moving/..... build-out Costs.....	--	19,976	--	2,143
Subtotal, Built-in Increases.....				3,168
A. Program:				
1. Home & Community-Based Supportive Services.....	--	368,290	--	48,186
2. Chronic Disease Self-Management Programs 1/.....	--	--	--	10,000
3. Family Caregiver Support Services.....	--	154,197	--	38,023
4. Native American Caregiver Support Services.....	--	6,388	--	2,000
5. Lifespan Respite Care.....	--	2,500	--	7,500
6. Adult Protective Services 2/.....	--	--	--	16,500
7. Long-Term Care Ombudsman Program.....	--	--	--	5,000
8. Aging Svcs Pgms Admin--Proposed staff increase 3/.....	100	19,976	21	1,399
9. CLASS Act 4/.....	--	--	--	120,000
Subtotal, Program Increases.....				248,608
Total Increases.....				251,776
Decreases:				
A. Program:				
1. Comm. Service Employment Older Americans 5/.....	--	825,425	--	(375,425)
2. Aging Network Support Activities.....	--	8,198	--	(250)
3. Aging and Disability Resource Centers 6/.....	--	23,684	--	(10,250)
5. Program Innovations 7/.....	--	27,873	--	(16,364)
Total Decreases.....				(402,289)
Net Change.....				(150,513)

1/ In FY 2010, $30 million in Recovery Act funding was transferred from the Centers for Disease Control and Prevention through an intra-departmental delegation of authority as part of the Recovery Act's $650 million "Prevention and Wellness Fund." In FY 2010, an additional $2.5 million was transferred from CDC to CMS for related evaluation and quality improvement purposes.

2/ Funding was first authorized for this program in the Elder Justice Act of 2012

3/ FY 2011 staff on board through the first quarter of the year approximate 111 FTE. The dollars reflected in this table are only for the additional +10 FTE in 2012.

4/The Community Living Assistance Services and Supports Act (CLASS Act) Activities in FY 2010 and FY 2011 were funded from the Affordable Care Act Implementation Fund.

5/ This program will be moving from the Department of Labor to the Administration on Aging starting in FY 2012. The FY 2012 budget request shown here reflects the Administration on Aging budget, and the FY 2010 is the actual Department of Labor budget.

6/ Includes $10 million in mandatory funds per section 2405 of P.L. 111-148 (Affordable Care Act).

7/ Activities in FY 2010 and FY 2011 were innovation activities requested under the Health and Long-term Care Programs. Aging and Disability Resource Centers are requested separately in FY 2012 and comparably adjusted in FY 2010 and FY 2011.

Administration on Aging

Budget Authority by Activity

(Dollars in thousands)

	FY 2010 Actual	FY 2011 CR	FY 2012 PB
Health and Independence:			
Home & Community-Based Supportive Services	$ 368,290	$ 368,348	$ 416,476
Nutrition Services 2/	658,362	658,459	658,362
Nutrition Services Incentive Program	160,991	161,015	160,991
Preventive Health Services	21,026	21,026	21,026
Chronic Disease Self-Management Programs 3/	--	--	10,000
Community Service Employment for Older Americans	825,425	825,425	450,000
Native American Nutrition & Supportive Services	27,704	27,708	27,704
Aging Network Support Activities	8,198	8,200	7,948
Subtotal, Health and Independence	$2,069,996	$ 2,070,181	$ 1,752,507
Caregiver Services:			
Family Caregiver Support Services	$ 154,197	$ 154,220	$ 192,220
Native American Caregiver Support Services	6,388	6,389	8,388
Alzheimer's Disease Supportive Services Program	11,462	11,464	11,462
Lifespan Respite Care	2,500	2,500	10,000
Subtotal, Caregiver Services	$ 174,547	$ 174,573	$ 222,070
Protection of Vulnerable Adults:			
Adult Protective Services	$ --	$ --	$ 15,000
Long-Term Care Ombudsman Program	16,825	16,827	21,825
Prevention of Elder Abuse & Neglect	5,055	5,056	5,055
Native American Elder Rights Program	--	--	1,500
Senior Medicare Patrol Program 5/	9,438	9,439	9,438
Elder Rights Support Activities 6/	4,103	4,104	4,103
Subtotal, Vulnerable Adults	$ 35,421	$ 35,426	$ 56,921
Consumer Information, Access & Outreach			
Aging and Disability Resource Centers 4/	$ 13,684	$ 13,684	$ 3,434
State Health Insurance Assistance Program 8/	46,960	46,960	46,960
Medicare Enrollment Assistance 9/	-	-	-
Subtotal, Consumer	$ 60,644	$ 60,644	$ 50,394
Program Innovations 7/	$ 27,873	$ 27,879	$ 11,509
Program Administration:			
Aging Services Programs Administration	$ 19,976	$ 19,979	$ 24,543
CLASS Administration 10/	--	--	120,000
Subtotal, Program Administration	$ 19,976	$ 19,979	$ 144,543
Total, Discretionary Budget Authority	**$2,388,457**	**$ 2,388,682**	**$ 2,237,944**
Aging and Disability Resource Centers (mandatory) 4/	10,000	$ 10,000	$ 10,000
Health Care Fraud and Abuse Control 5/	3,779	$ 3,312	$ 3,312
Medicare Enrollment Assistance (mandatory) 9/	30,000	$ -	$ -
Total, Program Level	**$2,432,236**	**$ 2,401,994**	**$ 2,251,256**
Total, FTE	**100**	**111**	**176**

1/ Reflects the Secretary's transfer of June 18, 2010, to assist those living with HIV/AIDS on waiting lists for lifesaving medication.

2/ Includes $2,722,303 in FY 2010 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19. Combines AoA's meal programs consistent with the Older Americans Act reauthorization proposal.

3/ In FY 2010, $30 million in Recovery Act funding was transferred from the Centers for Disease Control and Prevention through an intra-departmental delegation of authority as part of the Recovery Act's $650 million "Prevention and Wellness Fund." In FY 2010, an additional $2.5 million was transferred from CDC to CMS for related evaluation and quality improvement purposes.

4/ Includes $10 million in mandatory funds per section 2405 of P.L. 111-148 (Affordable Care Act).

5/ AoA received $3,375,000 in FY 2010 and $3,726,000 in FY 2011 from the Health Care Fraud and Abuse Control wedge funds recovered from fighting fraud. $3,312,000 is a placeholder amount for FY 2012. The Secretary and the Attorney General will determine the final amount.

6/ In FY 2010 and FY 2011, activities were previously appropriated and requested in Aging Network Support Activities and Program Innovations.

7/ Activities in FY 2010 and FY 2011 were innovation activities requested under the Health and Long-term Care Programs. Aging and Disability Resource Centers are requested separately in FY 2012 and comparably adjusted in FY 2010 and FY 2011.

8/ Reflects Secretary's decision to transfer the State Health Insurance Assistance Program from CMS to AoA. Transfer of discretionary funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

9/ Transfer of mandatory funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for benefits outreach to low-income seniors per section 3306 of P.L. 111-148 (Affordable Care Act).

10/ Activities in FY 2010 and FY 2011 were funded from the Affordable Care Act Implementation Fund.

Administration on Aging
Authorizing Legislation

	FY 2010 Amount Authorized	FY 2010 Appropriation	FY 2012 Amount Authorized	FY 2012 Pres. Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Such Sums	$368,290,000	Expired	$416,476,000
2) Nutrition Services Services: OAA Sections 331 and 336	Such Sums	$658,362,000	Expired	$658,362,000
3) Nutrition Services Incentive Program: OAA Section 311 1/	Such Sums	$160,991,000	Expired	$160,991,000
4) Preventive Health Services: OAA Section 361	Such Sums	$21,026,000	Expired	$21,026,000
5) Chronic Disease Self-Management Programs OAA Title IV	Such Sums	$0	Expired	$10,000,000
5) National Family Caregiver Support Program: OAA Section 371	$180,000,000	$154,197,000	Expired	$192,220,000
6) Community Service Employment for Older Americans Title V OAA Section 371	Such Sums	$825,425,000	Expired	$450,000,000
6) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Such Sums	$27,704,000	Expired	$27,704,000
7) Native American Caregiver Support Program: OAA Section 631	$7,500,000	$6,388,000	Expired	$8,388,000
8) Long-Term Care Ombudsman Program: OAA Section 712	Such Sums	$16,825,000	Expired	$21,825,000
9) Prevention of Elder Abuse and Neglect: OAA Section 721	Such Sums	$5,055,000	Expired	$5,055,000
10) Native American Organization and Elder Justice Provisions: OAA Sections 751 and 752…….	Such Sums	$0	Expired	$1,500,000

	FY 2010 Amount Authorized	FY 2010 Appropriation	FY 2012 Amount Authorized	FY 2012 Pres. Budget
11) Senior Medicare Patrol Program OAA Sections 201 and 202, as amended.....	Such Sums	$13,217,000	Expired	$12,750,000
12) Elder Rights Support Activities OAA Sections 201, 202, and 411, as amended.....	Such Sums	$4,103,000	Expired	$4,103,000
13) Program Innovations: OAA Section 411.....	Such Sums	$27,873,000	Expired	$11,509,000
14) Aging Network Support Activities: OAA Sections 202, 215 and 411.....	Such Sums	$8,198,000	Expired	$7,948,000
15) Alzheimer's Disease Demonstration Grants: PHSA Section 398.....	Expired	$11,462,000	Expired	$11,462,000
16) Lifespan Respite Care Lifespan Respite Care Act of 2006..... Title XXIX of the Public Health Service Act.....	$71,110,000	$2,500,000	Expired	$10,000,000
17) Program Administration: OAA Section 205.....	Such Sums	$19,976,000	Expired	$24,543,000
18) State Health Insurance Assistance Program: Omnibus Budget Reconciliation Act of 1990..... Section 4360.....	Such Sums	$46,960,000	Expired	$46,960,000
19) Adult Protective Services Section 6703, Patient Protection and Affordable Care.... Act, Subtitle B, Section 2042 (P.L. 111-148).....	$129,000,000	$0	Unspecified	$15,000,000
18) Community Living Assistance and Supports Act: CLASS Act Administration, Implementation Fund..... Health Care and Education Reconciliation Act..... Patient Protection and Affordable Care Act..... (P.L. 111-152, P.L. 111-148).....	n/a	$0	Unspecified	$120,000,000
Total Request Level.....		$2,378,552,000		$2,237,822,000

Unfunded Authorizations:

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

1/ 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.

Administration on Aging

Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2003	1,341,344,000	1,355,844,000	1,369,290,000	1,376,001,000
FY 2003 Rescission	--	--	--	-8,944,007
FY 2004	1,343,701,000	1,377,421,000	1,361,193,000	1,382,189,000
FY 2004 Rescission /1	--	--	--	-8,271,225
FY 2005	1,376,527,000	1,403,479,000	1,395,117,000	1,404,634,000
FY 2005 Rescission /2	--	--	--	-11,292,624
FY 2006	1,369,028,000	1,376,217,000	1,391,699,000	1,376,624,000
FY 2006 Rescission	--	--	--	-13,766,240
FY 2006 Transfer	--	--	--	-936,197
FY 2007	1,334,835,000	1,390,306,000	1,380,516,000	1,383,007,000
FY 2008 /3	1,335,146,000	1,417,189,000	1,451,585,000	1,438,567,000
FY 2008 Rescission	--	--	--	-25,131,765
FY 2009 /4	1,381,384,000	1,492,741,000	1,478,156,000	1,491,343,000
FY 2009 ARRA /5	--	--	--	100,000,000
FY 2010 /6	1,491,343,000	1,530,881,000	1,495,038,000	1,516,297,000
FY 2010 Transfer /7				-224,298
FY 2011	1,624,733,000	1,651,178,000	1,659,383,000	/8
FY 2012	2,237,944,000			

1/ Reflects two separate rescissions of - $8,154,255 and -$117,000.
2/ Reflects two separate rescissions of - $11,236,624 and -$56,000.
3/ 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.
4/ 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.
5/ American Recovery and Reinvestment Act of 2009, Public Law 111-5.
6/ 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.
7/ Reflects the Secretary's transfer of June 18, 2010 to assist those living with HIV/AIDS on waiting lists for lifesaving medication.
8/ Final appropriations have not been made for FY 2011. An annualized CR would appropriate $1,516,297,000.

Administration on Aging

Appropriations Not Authorized by Law

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	CR Appropriations in FY 2011
Alzheimer's Disease Supportive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$11,464,000
Older Americans Act	FY 2011	Such Sums	$2,341,722,000	$2,341,722,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,500,000	$2,500,000
State Health Insurance Assistance Programs: Omnibus Budget Reconciliation Act of 1990	FY 1996	$10,000,000	N/A	$46,960,000

Health and Independence

Summary of Request

AoA's Health and Independence Programs provide a foundation of supports that assist older individuals to remain healthy and independent in their homes and communities, avoiding more expensive nursing home care. For example, 62 percent of congregate and 93 percent of home-delivered meal recipients reported that the meals enabled them to continue living in their own homes and 53 percent of seniors using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[4]

From 2010 to 2015, the number of Americans age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[5] During this period, the number of seniors with severe disabilities (defined as 3 or more limitations in activities of daily living) who are at greatest risk of nursing home admission and Medicaid eligibility (through the "spend down" provisions) will increase by more than 13 percent.[6] These programs help seniors in need maintain their health and independence.

The FY 2012 funding request for Health and Independence services is $1,752,507,000, a decrease of $317,489,000 from the FY 2010 enacted level. Of this decrease, $225,000,000 is a result of the expiration of a one-time additional appropriation for the SCSEP program in FY 2010. This request includes additional funding for caregivers and supportive services programs initially proposed for FY 2011 as a result of the work by the White House Task Force on Middle Class Families. Health and Independence Programs include:

- $416,476,000 for Home and Community-Based Supportive Services (HCBS), an increase of +$48,185,598 over FY 2010. HCBS 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 community services such as physical fitness programs. These services also aid caregivers, who might otherwise 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. In addition to these services, the HCBS program also funds services at multi-purpose senior centers, which coordinate and integrate services for the elderly.

- $819,352,779 for Nutrition Services, the same amount as the FY 2010 enacted level. Nutrition Services help over two million older adults receive the meals they need to stay healthy and decrease their risk of disability. The meals provided through these programs

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[4] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

[5] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html>.

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

fulfill the standards of the Dietary Guidelines for Americans and provide a minimum of 33 percent of the Dietary Reference Intake. With these funds in FY 2012, the aging services network will provide an estimated 193 million meals. This represents approximately 36 million fewer home-delivered and congregate meals than at the FY 2010 enacted level, primarily due to declining leveraged funds, as State, local, and private budgets face economic hardships. These meals are especially critical for the health of the 28 percent of meal recipients who report these meals as the only or the majority of their food intake for the day. AoA's budget request reflects a reauthorization proposal to consolidate the funding streams from the congregate and home-delivered nutrition programs.

- $21,026,000 for Preventive Health Services, the same amount as enacted in FY 2010. 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 proposing appropriations language that would require States to use their Preventive Health Services funds in support of one or more proven evidence-based models, such as the chronic disease self-management program, that enhance the wellness and fitness of the aging community.

- $10,000,000 for Chronic Disease Self-Management Programs (CDSMP). Chronic disease self-management programs teach evidence-based disease prevention models that use state-of-the-art techniques to help people better self-manage their conditions and reduce their need for more costly medical care. CDSMPs have been demonstrated to be especially effective and have shown the value of focusing dollars on proven interventions. This program was funded in FY 2010 and FY 2011 using funds provided under ARRA to CMS and transferred in FY 2010 to AoA for a two-year project period.

- $450,000,000 for Community Service Employment for Older Americans, a reduction of -$375,425,000 from the FY 2010 level ($225,000,000 of which is a result of the expiration of a one-time special appropriation). Commonly known as the Senior Community Service Employment Program (SCSEP), the program offers part-time, community-service employment opportunities at 501(c)(3) non-profits or government agencies (to prepare participants to enter or re-enter the workforce. Transferring this program to AoA will allow the program to increase the efficiency with which it serves participants by better integrating it with other OAA community-based programs, while also refocusing the program on community service opportunities.

- $27,703,901 for Native American Nutrition and Supportive Services, the same amount as the FY 2010 enacted level. These funds will provide approximately 4.5 million meals and 800,000 rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

- $7,948,000 for Aging Network Support Activities, a reduction of $250,000 from the FY 2010 enacted level, reflecting greater contracting efficiencies. While a new grouping of existing AoA programs, these funds support competitive grants and contracts for

eleven ongoing activities which help seniors and their families obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services carry out their mission to help older people remain independent and live in their own homes and communities.

In concert with other Older Americans Act (OAA) programs, these services assist nearly 11.5 million elderly individuals and caregivers. AoA's services are especially critical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission. These services help to keep these individuals from joining the 1.7 million seniors who live in nursing homes. These increases will also help the national aging services network improve its capacity to assist the rapidly growing senior population.

State and Territory Flexibility

Under the core State formula grant programs for Home and Community-Based Supportive Services and Nutrition Services, States and Territories have the flexibility to allocate resources to best meet local needs through intra-State funding formulas which distribute funds to Area Agencies on Aging (AAAs). These formulas vary by State and allow States to take into account their own local circumstances to best serve their population. States are required to submit their formulas to AoA for approval and must take into account the geographic distribution of older persons and the distribution of older persons in greatest social and economic need. AAAs administer these grants and provide grants or contracts to local service providers based on identified needs.

The OAA allows a State to transfer up to 40 percent of the funds between congregate and home-delivered meals for use as the State considers appropriate to meet the needs of the area served. Additionally, for any fiscal year if the transferred funds are insufficient to satisfy the need for nutrition services, then the Assistant Secretary for Aging may grant a waiver that permits the State to transfer an additional 10 percent of the funds to meet those needs. The OAA provides further flexibility to States by allowing them to transfer up to 30 percent for any fiscal year between Supportive Services programs and Nutrition Services programs, for use as the State considers appropriate. These are options open only to States and Territories. A State agency may not delegate to an Area Agency on Aging or any other entity the authority to make such transfers.

In 2009, the last year of available data, States transferred over $76 million from congregate nutrition to home and community-based services and home-delivered meals, as illustrated in the following table.

Table 1. FY 2009 Transfer of Federal funds within Title III of the OAA

	Part B – Home and Community-Based Supportive Services	Part C1 – Congregate Nutrition	Part C2 – Home-Delivered Meals
Initial Allotment	$359,188,415	$431,673,607	$213,177,293
Final Allotment after Transfers	$407,516,171	$355,106,340	$241,416,804
Net Transfer	+$48,327,756	($76,567,267)	+$28,239,511
Net Percent Change	13.45	(17.73)	13.24

Waiting List Information

AoA does not record or require State agencies or area agencies on aging to establish waiting list information on Older Americans Act programs. This is done to reduce the reporting burden on these entities, and also in recognition of the significant methodological issues in determining and maintaining accurate measures on such lists. To optimally provide services to older adults and their family caregivers, State agencies and AAAs ensure that available dollars are targeted to those seniors in greatest social and economic need and serve as many seniors as possible by pulling together Federal, State, local and individual dollars.

State agencies and Area Agencies on Aging may maintain local waiting lists. These lists frequently serve as a management tool at the local level to ensure that those most in need are the first to receive services. In particular, a survey by the National Association of State Units on Aging determined that the Recovery Act funding helped 20 percent of the States eliminate waiting lists for seniors requesting home-delivered meals as of November 2009.[7]

[7] The Economic Crisis and Its Impact on State Aging Programs. National Association of State Units on Aging. November 2009.

Home and Community-Based Supportive Services

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Home and Community-based Supportive Services	$368,290,000	$368,348,000	$416,476,000	+$48,186,000

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

FY 2012 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Home and Community-Based Supportive Services (HCBS) 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 programs, like the HCBS program, serve seniors holistically; while each service is valuable in and of itself, it is often the combination of supports, when tailored to the needs of the individual, that ensures clients remain in their own homes and communities instead of entering nursing homes.

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

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

Data from AoA's national surveys of elderly clients show that Home and Community-Based Supportive Services are providing seniors with the services and information they need to help them remain at home. For example, 48 percent of seniors using transportation services rely on them for the majority of their transportation needs and would otherwise be homebound, while 80 percent of clients receiving case management reported that as a result of the services arranged

by the case manager that they were better able to care for themselves.[8] In addition, a study published in the Journal of Aging and Health shows that the services provided by the HCBS 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.[9]

Services provided by the HCBS program in FY 2009, the most recent available data, include:

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

- *Transportation Services* provided nearly 28 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).

- *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).

In continuing with AoA's commitment to provide services to those in most need, nearly 50 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:

- 67 percent of riders had a doctor tell them they had vision problems (including glaucoma, macular degeneration or cataracts);
- 7 percent have Alzheimer's or dementia;
- 2 percent have Multiple Sclerosis;
- 14 percent have had a stroke;
- 3 percent have epilepsy; and
- 3 percent have Parkinson's disease.

[8] 2009 National Survey of Older Americans Act Participants. Which should be posted on AGID by the time the CJ comes out http://www.data.aoa.gov, select AGID.

[9] 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.

Of the transportation participants 95 percent take daily medications, with 17 percent taking 10 to 20 medications daily.[10]

Funding History:

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

FY 2002.....$356,981,000
FY 2003.....$355,673,000
FY 2004.....$353,889,000
FY 2005.....$354,136,000
FY 2006.....$350,354,000
FY 2007.....$350,595,000
FY 2008.....$351,348,000
FY 2009.....$361,348,000
FY 2010.....$368,290,000
FY 2011 CR.....$368,348,000

Budget Request:

The FY 2012 request for Home and Community-Based Supportive Services is $416,476,000, an increase of +$48,186,000 over FY 2010. The +$48 million increase, which continues funding originally proposed in FY 2011 by the White House Middle Class Task Force, will expand services, including transportation assistance, case management, and information and referrals; in-home services such as personal care, chore, and help with eating, dressing, and bathing; and community services such as adult day care and physical fitness programs. These services -- particularly adult day care, personal care, and chore services – also aid caregivers, who might otherwise have to be even more intensively involved with the care of their loved ones, taking time away from work and their other family responsibilities. The budget request will support 6.4 million hours of adult day care for older adults; over 18 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and more than 25 million hours of assistance to seniors who are unable to perform daily activities.

Funding for these services is a cost-effective means of enabling a growing senior population to remain healthy and independent, thereby avoiding more expensive nursing home care and medical interventions that increase costs to the Medicaid and Medicare programs. From 2010 to 2015, the population age 60 and older will increase by 15 percent, from 57 million to 65.7 million.[11] During this period, the number of seniors with severe disabilities (defined as 3 or more limitations in activities of daily living) who are at greatest risk of nursing home admission

[10] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[11] U.S. Census Bureau, "2008 National Population Projections," released August 2008, <http://www.census.gov/population/www/projections/2008projections.html >.

and Medicaid eligibility (through the "spend down" provisions) will increase by more than 13 percent.[12]

AoA's core formula grant programs reach one in five seniors, serving over a half million seniors in their own communities who meet the disability criteria for nursing home admission, helping to keep them from joining the 1.7 million seniors who live in nursing homes. Nationally, about 26 percent of individuals 60 and older live alone, and in FY 2011 AoA projects 72 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 HCBS 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. Additionally, recent research has 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.[13]

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. Despite States only having to match this program at 25 percent of their Federal allocation, States have normally leveraged resources of $2 or $3 per every Older Americans Act dollar. AoA expects a decline in performance for home and community-based services in FY 2012 compared to FY 2010. Declines in outputs are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.[14]

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

[13] "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.

[14] AoA's projections are based on the following two assumptions: 1) CPI-U or a CPI-specific index and 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

Outputs and Outcomes Table:

Home and Community-Based Supportive Services Outputs and Outcomes

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.9b: 90% of transportation clients rate services good to excellent. *(Outcome)*	FY 2009: 96.7%	90%	90%	Maintain
2.11: Increase the percentage of transportation clients who live alone. *(Outcome)*	FY 2009: 72.4% (Target Exceeded)	70%	72%	Maintain

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output C: Transportation Services units *(Output)*	FY 2009: 27.6 M	25.5 M	18.3 M	-7.2 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2009: 28.7 M	31.8 M	25.4 M	-6.4 M
Output E: Adult Day Care/Day Health units *(Output)*	FY 2009: 7.9 M	8 M	6.4 M	-1.6 M
Output F: Case Management Services units *(Output)*	FY 2009: 3.9 M	4.2 M	3.5 M	-.7 M

Note: 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 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	56	56	56
Average Award	$6,511,866	$7,360,438	$7,360,438
Range of Awards	$227,915 - $36,241,336	$257,615 - $41,789,087	$257,615 - $41,789,087

HOME AND COMMUNITY-BASED SUPPORTIVE SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
Alabama	5,655,995	5,593,005	6,486,796	830,801
Alaska	1,830,190	1,823,323	2,061,556	231,366
Arizona	7,536,954	7,425,075	8,644,045	1,107,091
Arkansas	3,575,124	3,532,379	4,100,269	525,145
California	36,448,142	36,119,099	41,801,954	5,353,812
Colorado	4,762,294	4,847,248	5,461,820	699,526
Connecticut	4,414,911	4,404,337	4,842,864	427,953
Delaware	1,830,190	1,823,323	2,061,556	231,366
District of Columbia	1,830,190	1,823,323	2,061,556	231,366
Florida	26,729,390	26,156,381	30,655,629	3,926,239
Georgia	9,120,376	9,165,703	10,460,054	1,339,678
Hawaii	1,830,190	1,823,323	2,061,556	231,366
Idaho	1,830,190	1,823,323	2,061,556	231,366
Illinois	14,559,760	14,524,890	15,880,743	1,320,983
Indiana	7,178,800	7,142,991	8,233,283	1,054,483
Iowa	4,271,107	4,260,878	4,350,292	79,185
Kansas	3,441,149	3,432,908	3,658,599	217,450
Kentucky	5,039,351	4,973,926	5,779,573	740,222
Louisiana	4,819,982	4,823,336	5,527,982	708,000
Maine	1,830,190	1,823,323	2,061,556	231,366
Maryland	6,134,814	6,130,571	7,035,948	901,134
Massachusetts	8,228,803	8,209,095	8,810,131	581,328
Michigan	11,593,775	11,610,075	13,296,767	1,702,992
Minnesota	5,741,350	5,765,773	6,584,688	843,338
Mississippi	3,284,196	3,272,711	3,766,606	482,410
Missouri	7,135,518	7,118,429	8,103,032	967,514
Montana	1,830,190	1,823,323	2,061,556	231,366
Nebraska	2,300,448	2,294,938	2,374,748	74,300
Nevada	2,749,585	2,746,654	3,153,467	403,882
New Hampshire	1,830,190	1,823,323	2,061,556	231,366

HOME AND COMMUNITY-BASED SUPPORTIVE SERVICES

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

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
New Jersey	10,287,611	10,262,972	11,614,843	1,327,232
New Mexico	2,249,693	2,230,003	2,580,147	330,454
New York	24,341,729	24,283,431	26,256,310	1,914,581
North Carolina	10,329,835	10,451,253	11,847,169	1,517,334
North Dakota	1,830,190	1,823,323	2,061,556	231,366
Ohio	13,849,980	13,816,810	15,753,112	1,903,132
Oklahoma	4,311,211	4,278,286	4,944,479	633,268
Oregon	4,555,027	4,561,952	5,224,108	669,081
Pennsylvania	17,922,902	17,879,977	18,804,162	881,260
Rhode Island	1,830,190	1,823,323	2,061,556	231,366
South Carolina	5,403,971	5,462,652	6,197,752	793,781
South Dakota	1,830,190	1,823,323	2,061,556	231,366
Tennessee	7,355,714	7,341,822	8,436,184	1,080,470
Texas	22,369,742	22,369,548	25,655,599	3,285,857
Utah	2,184,965	2,174,299	2,505,911	320,946
Vermont	1,830,190	1,823,323	2,061,556	231,366
Virginia	8,507,855	8,472,386	9,757,560	1,249,705
Washington	7,172,705	7,199,310	8,226,292	1,053,587
West Virginia	2,780,196	2,773,538	2,868,481	88,285
Wisconsin	6,566,139	6,519,059	7,530,629	964,490
Wyoming	1,830,190	1,823,323	2,061,556	231,366
Subtotal, States	358,703,569	357,330,889	404,012,256	45,308,687
American Samoa	473,451	472,317	472,317	(1,134)
Guam	915,095	911,661	1,030,461	115,683
Northern Mariana Islands	228,774	227,915	257,615	28,921
Puerto Rico	4,802,050	4,810,067	5,546,846	705,366
Virgin Islands	915,095	911,661	1,030,461	115,683
Subtotal, States and Territories	366,038,034	364,664,520	412,311,240	46,273,206
Undistributed 15/	2,252,368	3,625,480	4,164,760	1,912,392
TOTAL 2/	**368,290,402**	**368,290,000**	**416,476,000**	**48,185,598**

15/ Funds held for statutory related requirements are reflected in the undistributed line.

2/ FY 2010 level reflects the Secretary's transfer of June 18, 2010 to assist those living with HIV/AIDS on waiting lists for lifesaving medication.

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Nutrition Services

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Congregate Nutrition	$440,718,000	$440,783,000	$440,718,000	--
Home-Delivered Nutrition	$217,644,000	$217,676,000	$217,644,000	--
Nutrition Services Incentive Program	$160,991,000	$161,015,000	$160,991,000	--
Total BA	$819,353,000	$819,474,000	$819,353,000	--

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

FY 2012 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 home-delivery to seniors who are homebound due to illness, disability, or geographic isolation. Nutrition Services, which help seniors remain healthy and independent in their communities, include:

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

- Home-Delivered Nutrition Services (Title III-C2): Provides funding for the delivery of meals and related services to 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, by helping them maintain their own health and well-being.

- Nutrition Services Incentive Program (Title III-A): Provides additional funding to States, Territories, and eligible Tribal Organizations that is used exclusively to provide meals and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to States and Tribes based on the number of meals served in the prior

Federal fiscal year. States and Tribes have the option to purchase commodities directly from the U.S. Department of Agriculture with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors. States and Tribes elected to spend approximately $2.7 million on commodities, including $182,238 assessed as administrative expenses by USDA, in FY 2010.

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

Data from AoA's national surveys of elderly clients show that the Nutrition Services are effectively helping seniors to improve their nutritional intake and remain at home. For example, 73 percent of congregate and 85 percent of home-delivered meal recipients say they eat healthier meals due to the programs, and 58 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enabled them to continue living in their own homes.[16] In addition, home-delivered meal and congregate meal participants had significantly better food energy intake, protein, vitamins A, B_6 & D, Riboflavin, Calcium, Phosphorous, Potassium, Magnesium and Zinc intakes compared to matched non-participant group of senior citizens.[17] Seniors with deficiencies of these nutrients can experience osteoporosis, night blindness, decreased resistance to infection, fatigue, vasodilatation, and other illnesses.

AoA's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Ninety-one percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the number of home-delivered meal recipients with severe disabilities (3+ ADL) totaled more than 342,000 in 2009 (Outcome 3.2). This level of disability is

[16] 2008 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[17] *Serving Elders at Risk – National Evaluation of the Elderly Nutrition Program, 1993-1995,* pp.117-118

frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs are helping seniors remain healthy and independent in their homes include:

- *Home-Delivered Nutrition Services* provided nearly 149 million meals to over 880,000 individuals in FY 2009 (Output G).

- *Congregate Nutrition Services* provided over 92.4 million meals to nearly 1.7 million seniors in a variety of community settings in FY 2009 (Output H).

Funding History:

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

FY 2002.....$716,170,000
FY 2003.....$714,274,000
FY 2004.....$714,462,000
FY 2005.....$718,696,000
FY 2006.....$714,578,000
FY 2007.....$735,070,000
FY 2008.....$758,003,000
FY 2009*.....$809,743,000
FY 2010.....$819,353,000
FY 2011 CR.....$819,474,000

* The FY 2009 funding level shown here does not include $97 million in Recovery Act Nutrition Services funding to States.

Budget Request:

The FY 2012 request for Nutrition Services is $819,353,000, the same amount as the 2010 level. At this level, the budget request will support over 193 million home-delivered and congregate meals to approximately two million elderly individuals in a variety of community settings. This represents approximately 36 million fewer home-delivered and congregate meals than at the FY 2010 appropriation, primarily due to declining leveraged funds, as State, local, and private budgets face economic hardships. In FY 2012 these programs are expected to continue to provide home-delivered meals that clients rate good to excellent (Outcome 2.9a) ensuring that clients continue to receive high quality services; however, as State and local funding tightens, some providers may look at cost cutting measures such as reducing menu choices or the frequency of deliveries. This could affect client satisfaction with the quality of service.

Consistent with AoA's commitment to provide services to those in need to help maintain their health and independence, approximately 73 percent of home-delivered meal recipients have annual incomes at or below $20,000. These meals are especially critical for the survival of the 28 percent of meal recipients who report these meals as the sole or majority of their food intake for the day and for the 297,000 home-delivered meal recipients with severe disabilities who are

projected to be served in FY 2012 (Outcome 3.2). This population with severe disabilities is important to serve since this level of disability is frequently an eligibility requirement for more costly nursing home admission.

In addition, all too often, caregivers are unable to be continuously available in the homes of those in need, particularly as 21 percent of caregivers work full or part time. Home-delivered meals ensure proper nutrition for an individual who might otherwise not have access to a meal nor the ability to travel to a congregate meal site.

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 donations that contribute funding. In FY 2009, State and local funding comprised approximately 66 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, congregate and home-delivered meals have a higher rate of State and local support than many other OAA services.

AoA expects a decline in congregate and home-delivered meals in FY 2012 compared to FY 2010. Declines in meal counts are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships and are projected to only comprise 57 percent of all the funding for home-delivered meals and congregate meals at the FY 2012 request.[18] With this budget request, annual Federal funding for congregate meals will have increased from FY 2004 to 2012 by over $59 million or 15 percent, while the CPI increased 15.2 percent between 2004 and 2010. Should State budgets rebound higher than projected in FY 2012, States may elect to provide additional support for meals.

[18] AoA's projections are based on the following assumptions: 1) 3.2 percent inflationary increase using the U.S. Department of Agriculture's "food away from home" inflation index, consistent with the economic assumptions used in preparation of the President's budget; 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

Outcomes and Outputs Table:

Nutrition Services Outcomes and Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2009: 8,544 (Target Exceeded)	7,742	8,650	+908
2.9a: 90% of home delivered meal clients rate services good to excellent. *(Outcome)*	FY 2009: 91.1%[19] (Target Met)	90%	90%	Maintain
3.2: Increase the number of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	FY 2009: 342,084 (Target Not Met)	325,000	271,000	-54,000

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output G: Number of Home-Delivered meals served *(Output)*	FY 2009: 149 M	136.5 M	118 M	-18.5 M
Output H: Number of Congregate meals served *(Output)*	FY 2009: 92.4 M	92.4 M	75.4 M	-17 M
Outputs G& H: Total Number of Meals *(Outputs)*	FY 2009: 241.4 M	228.9 M	193.4 M	-35.5 M

Note: For presentation within the budget AoA highlighted specific measures that are most directly related to Nutrition 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.

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

Grant Awards Tables:

Nutrition Programs Grant Awards

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	56	56	56
Average Award	$11,640,614	$11,783,422	$11,783,422
Range of Awards	$407,421 - $65,242,165	$412,420 - $66,366,137	$412,420 - $66,884,436

Nutrition Services Incentive Program Grant Awards

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	299	299	299
Average Award	$533,127[20]	$533,127[17]	$533,127[17]
Range of Awards	$503 - $16,858,820	$503 - $16,858,820	$503 - $16,858,820

[20] If the 244 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,842,854.

NUTRITION SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Nutrition Services (CFDA 93.045)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
Alabama	10,174,752	10,083,437	10,241,925	67,173
Alaska	3,271,659	3,259,372	3,258,892	(12,767)
Arizona	13,558,468	13,386,412	13,647,981	89,513
Arkansas	6,431,406	6,368,405	6,473,866	42,460
California	65,567,733	65,117,886	66,000,609	432,876
Colorado	8,567,043	8,738,937	8,623,602	56,559
Connecticut	7,820,541	7,769,943	7,646,341	(174,200)
Delaware	3,271,659	3,259,372	3,258,892	(12,767)
District of Columbia	3,271,659	3,259,372	3,258,892	(12,767)
Florida	48,084,357	47,156,444	48,401,810	317,453
Georgia	16,406,937	16,524,532	16,515,255	108,318
Hawaii	3,271,659	3,259,372	3,258,892	(12,767)
Idaho	3,271,659	3,259,372	3,258,892	(12,767)
Illinois	25,744,599	25,565,249	25,073,917	(670,682)
Indiana	12,914,175	12,877,854	12,999,434	85,259
Iowa	7,400,901	7,320,373	7,082,927	(317,974)
Kansas	6,039,225	5,981,237	5,776,519	(262,706)
Kentucky	9,065,450	8,967,320	9,125,300	59,850
Louisiana	8,670,820	8,695,828	8,728,065	57,245
Maine	3,271,659	3,259,372	3,258,892	(12,767)
Maryland	11,036,114	11,052,598	11,108,975	72,861
Massachusetts	14,473,871	14,434,155	13,910,211	(563,660)
Michigan	20,856,415	20,931,407	20,994,108	137,693
Minnesota	10,328,299	10,394,915	10,396,487	68,188
Mississippi	5,908,045	5,845,456	5,947,050	39,005
Missouri	12,780,216	12,709,983	12,793,782	13,566
Montana	3,271,659	3,259,372	3,258,892	(12,767)
Nebraska	4,004,674	3,964,201	3,815,132	(189,542)
Nevada	4,946,316	4,951,849	4,978,972	32,656
New Hampshire	3,271,659	3,259,372	3,258,892	(12,767)

NUTRITION SERVICES

PROGRAM: Nutrition Services (CFDA 93.045)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
New Jersey	18,373,342	18,251,357	18,338,539	(34,803)
New Mexico	4,047,045	4,020,397	4,073,764	26,719
New York	42,950,628	42,576,118	41,455,778	(1,494,850)
North Carolina	18,582,671	18,842,206	18,705,354	122,683
North Dakota	3,271,659	3,259,372	3,258,892	(12,767)
Ohio	24,778,549	24,776,855	24,872,402	93,853
Oklahoma	7,755,577	7,649,076	7,806,779	51,202
Oregon	8,194,185	8,224,587	8,248,283	54,098
Pennsylvania	31,300,504	31,114,709	30,057,088	(1,243,416)
Rhode Island	3,271,659	3,259,372	3,258,892	(12,767)
South Carolina	9,721,377	9,848,429	9,785,557	64,180
South Dakota	3,271,659	3,259,372	3,258,892	(12,767)
Tennessee	13,232,431	13,236,320	13,319,791	87,360
Texas	40,241,648	40,329,292	40,507,322	265,674
Utah	3,930,604	3,919,969	3,956,553	25,949
Vermont	3,271,659	3,259,372	3,258,892	(12,767)
Virginia	15,305,053	15,274,576	15,406,097	101,044
Washington	12,903,209	12,979,390	12,988,395	85,186
West Virginia	4,834,990	4,797,844	4,625,605	(209,385)
Wisconsin	11,812,039	11,752,988	11,890,021	77,982
Wyoming	3,271,659	3,259,372	3,258,892	12,767
Subtotal, States	641,275,776	638,804,370	638,685,192	(2,590,584)
American Samoa	736,859	731,341	731,341	(5,518)
Guam	1,635,829	1,629,686	1,629,446	(6,383)
Northern Mariana Islands	408,958	407,421	407,361	(1,597)
Puerto Rico	8,638,563	8,671,906	8,695,594	57,031
Virgin Islands	1,635,829	1,629,686	1,629,446	(6,383)
Subtotal, States and Territories	654,331,814	651,874,410	651,778,380	(2,553,434)
Undistributed 21/	4,029,783	6,584,590	6,583,620	2,553,837
TOTAL 2/	**658,361,597**	**658,459,000**	**658,362,000**	**403**

21/ Funds held for statutory related requirements are reflected in the undistributed line.
2/ FY 2010 level reflects the Secretary's transfer to assist those living with HIV/AIDS on medication waiting lists

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
Alabama	2,724,877	2,714,445	2,714,033	(10,844)
Alaska	320,721	319,493	319,445	(1,276)
Arizona	2,266,704	2,258,026	2,257,683	(9,021)
Arkansas	2,638,692	2,628,590	2,628,191	(10,501)
California	12,346,182	12,298,915	12,297,046	(49,136)
Colorado	1,379,870	1,374,587	1,374,378	(5,492)
Connecticut	1,456,389	1,450,813	1,450,592	(5,797)
Delaware	637,915	635,472	635,376	(2,539)
District of Columbia	639,886	637,436	637,339	(2,547)
Florida	6,978,546	6,951,829	6,950,772	(27,774)
Georgia	2,725,424	2,714,989	2,714,577	(10,847)
Hawaii	487,594	485,727	485,654	(1,940)
Idaho	651,030	648,538	648,439	(2,591)
Illinois	7,030,610	7,003,693	7,002,628	(27,982)
Indiana	1,856,248	1,849,141	1,848,860	(7,388)
Iowa	1,896,738	1,889,478	1,889,190	(7,548)
Kansas	2,264,572	2,255,901	2,255,559	(9,013)
Kentucky	1,809,827	1,802,898	1,802,624	(7,203)
Louisiana	3,213,739	3,201,436	3,200,949	(12,790)
Maine	524,039	522,033	521,953	(2,086)
Maryland	1,843,421	1,836,363	1,836,084	(7,337)
Massachusetts	5,953,303	5,930,511	5,929,610	(23,693)
Michigan	7,439,014	7,410,533	7,409,407	(29,607)
Minnesota	1,984,038	1,976,442	1,976,142	(7,896)
Mississippi	2,113,771	2,105,679	2,105,359	(8,412)
Missouri	4,199,819	4,183,740	4,183,104	(16,715)
Montana	1,147,844	1,143,450	1,143,276	(4,568)
Nebraska	1,351,963	1,346,787	1,346,582	(5,381)
Nevada	977,863	974,119	973,971	(3,892)
New Hampshire	1,114,365	1,110,099	1,109,930	(4,435)

PROGRAM: Nutrition Services Incentive Program (CFDA 93.053)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
New Jersey	3,946,325	3,931,216	3,930,619	(15,706)
New Mexico	2,054,916	2,047,049	2,046,738	(8,178)
New York	16,923,613	16,858,820	16,856,258	(67,355)
North Carolina	3,322,232	3,309,513	3,309,010	(13,222)
North Dakota	809,231	806,133	806,010	(3,221)
Ohio	5,716,593	5,694,707	5,693,842	(22,751)
Oklahoma	2,556,199	2,546,412	2,546,025	(10,174)
Oregon	1,765,224	1,758,466	1,758,199	(7,025)
Pennsylvania	5,980,007	5,957,113	5,956,207	(23,800)
Rhode Island	501,008	499,090	499,014	(1,994)
South Carolina	1,612,591	1,606,417	1,606,173	(6,418)
South Dakota	986,347	982,570	982,421	(3,926)
Tennessee	1,695,578	1,689,086	1,688,830	(6,748)
Texas	12,180,903	12,134,269	12,132,425	(48,478)
Utah	1,426,187	1,420,726	1,420,510	(5,677)
Vermont	730,946	728,147	728,037	(2,909)
Virginia	2,299,971	2,291,165	2,290,817	(9,154)
Washington	1,913,507	1,906,181	1,905,892	(7,615)
West Virginia	1,724,020	1,717,420	1,717,159	(6,861)
Wisconsin	2,709,222	2,698,849	2,698,439	(10,783)
Wyoming	760,086	757,176	757,061	(3,025)
Subtotal, States	153,589,710	153,001,688	152,978,439	(611,271)
American Samoa	--	--	--	--
Guam	358,586	357,214	357,159	(1,427)
Northern Mariana Islands	61,433	61,197	61,188	(245)
Puerto Rico	2,775,055	2,764,432	2,764,011	(11,044)
Virgin Islands	173,105	172,442	172,416	(689)
Subtotal, States and Territories	156,957,889	156,356,973	156,333,213	(624,676)
Tribal Organizations	3,047,877	3,047,877	3,047,877	--
Undistributed 22/	985,416	1,610,150	1,609,910	624,494
TOTAL	**160,991,182**	**161,015,000**	**160,991,000**	**(182)**

22/ Funds held for statutory related requirements are reflected in the undistributed line.

Preventive Health Services

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Preventive Health Services…	$21,026,000	$21,026,000	$21,026,000	--

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

FY 2012 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Preventive Health Services, established in 1987, provides formula grants to States and Territories, based on their share of the population aged 60 and over, to support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help to prevent or delay chronic disease and disability, thereby reducing the need for more costly medical interventions.

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to almost 78 years today. On average an American turning age 65 today can expect to live an additional 18.6 years. The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly and is projected to total 5.8 million by 2010 and 8.7 million by the year 2030. One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, or depression as well as the greater probability of injury from a fall, which quickly limits physical activity.

In recent years, States and Territories have been statutorily required to use at least a portion of this funding for medication management, screening, and education activities, but otherwise have had flexibility to allocate resources among the preventive health activities of their choice to best meet local needs. Priority has been given to providing services to those elders living in medically underserved areas of the state or who have the greatest economic need. Services currently provided through the Preventive Health Service program include:

- *Information and Outreach,* including the distribution of information to seniors through Aging and Disability Resource Centers, Area Agencies on Aging, senior centers, community parks and recreation programs, housing programs, faith based organizations, Chronic Disease Self-Management Programs, congregate meal sites, and the home-delivered meals program about healthy lifestyles and behaviors.

- *Health Screenings and Risk Assessments* for a variety of conditions, including hypertension, diabetes, dental issues, high cholesterol, hearing and vision loss, and glaucoma.

- *Evidence-based Prevention Programs*, as described below.

Over the last few years, some States have begun to shift their funding to provide greater support to evidence-based approaches, especially in helping individuals manage chronic diseases. 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 models include Enhanced Fitness, Enhanced Wellness, falls prevention, and chronic disease self-management programs, all of which have been demonstrated to be especially effective and have shown the value of focusing dollars on proven interventions. AoA has encouraged States and the aging services network to adopt evidence-based prevention programs and more and more States are using these and other resources to do so. Some examples of evidence-based interventions are:

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

- *Falls prevention:* Falls prevention programs teach participants to improve strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. Recent studies have shown that in the United States more than one-third of adults age 65 and over fall each year. Of those who fall, 20 to 30 percent will experience serious injuries, such as head trauma, broken bones, or hip fractures. These injuries may limit the ability of older adults to get around or live independently. Those who are not injured may develop a fear of falling, which may increase their actual risk of falling. Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[23]

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

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

- *Chronic disease self-management programs:* Older Americans are disproportionately affected by a vast array of chronic conditions, including diabetes, obesity, heart disease, cancer, arthritis, and depression, that collectively account for seven out of every 10 deaths and contribute to more than three-quarters of all Medicare expenditures.[24] Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. Chronic disease self-management programs teach evidence-based disease prevention models that utilize state-of-the-art techniques to help people better self-manage their conditions and reduce their need for more costly medical care. Programs often consist of a series of workshops in community settings comfortable to seniors such as churches, libraries, YW/MCAs, senior centers, public housing programs, community health centers, and cooperative extension programs. Workshops are facilitated by leaders who are trained and certified and help those with chronic diseases learn that they can change their health behaviors through action plans and goal setting.

Preventive Health Services have been carried out at multi-purpose senior centers, meal sites, and other community-based settings, as well as through individualized counseling and services for vulnerable elders. States reported 5.9 million seniors served in these health-related programs which received $16 million in additional funding from States and local entities.

Funding History:

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

FY 2007	$21,400,000
FY 2008	$21,026,000
FY 2009	$21,026,000
FY 2010	$21,026,000
FY 2011 CR	$21,026,000

[24] Deaths: Leading Causes for 2004. National Vital Statistics Report, V. 56, No. 5. Centers for Disease Control and Prevention. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf . Accessed December 30, 2009.

Follow the Money -- Controlling Expenditures by Improving Care for Patients Needing Costly Services. Bodenheimer, T., and Berry-Millett, R. New England Journal of Medicine. 15 October 2009.

PREVENTITIVE HEALTH SERVICES

Budget Request:

The FY 2012 budget request for Preventive Health Services is $21,026,000, the same as the FY 2010 enacted level. In appropriations language, AoA proposes a key change for the Preventive Health Services program -- the inclusion of language that would require States to use their Preventive Health Services funds to support proven evidence-based models that enhance the wellness and fitness of the aging community. Recognizing that the development of evidence-based programs is ongoing, AoA will provide guidance regarding what meets the evidence-based requirement.

States are increasingly supporting evidence-based prevention programs, as discussed previously. In addition, this key change helps States build on the $27 million in competitive awards announced in FY 2010 using Recovery Act Prevention and Wellness funds to support evidence-based chronic disease self-management programs. The grant period for these funds concludes in mid-FY 2012. States would continue to have the flexibility to use funding provided under the Home and Community-Based Services Program to fund other health services, such as health screenings, that do not meet these evidence-based requirements.

States' ability to support evidence-based programs is further increased by this budget's request to eliminate the appropriations requirement to use a minimally-mandated level of funding for medication management, screening, and education activities. Evidence-based medication management activities however, would continue to be permissible under this proposal, provided the programs meet the evidence-based criteria proposed by AoA.

Performance Measurement

Since AoA is promoting evidence-based systems, the performance measure developed to address this area -- the number of States, the District of Columbia, and territories using Title III funds to implement evidence-based disease prevention programs -- is especially appropriate.

Output Table:

Preventive Health Services Output

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output AB: The number of people served with health and disease prevention programs *(Output)*	N/A	Baseline	TBD	TBD

PREVENTITIVE HEALTH SERVICES

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	56	56	56
Average Award	$375,464	$375,464	$375,464
Range of Awards	$13,141 - $2,132,032	$13,141 - $2,132,032	$13,141 - $2,132,032

PREVENTITIVE HEALTH SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
Alabama	333,168	333,168	333,168	--
Alaska	105,130	105,130	105,130	--
Arizona	405,273	405,273	405,273	--
Arkansas	211,585	211,585	211,585	--
California	2,132,032	2,132,032	2,132,032	--
Colorado	256,172	256,172	256,172	--
Connecticut	261,174	261,174	261,174	--
Delaware	105,130	105,130	105,130	--
District of Columbia	105,130	105,130	105,130	--
Florida	1,557,571	1,557,571	1,557,571	--
Georgia	487,659	487,659	487,659	--
Hawaii	105,130	105,130	105,130	--
Idaho	105,130	105,130	105,130	--
Illinois	841,161	841,161	841,161	--
Indiana	427,123	427,123	427,123	--
Iowa	232,252	232,252	232,252	--
Kansas	191,697	191,697	191,697	--
Kentucky	292,333	292,333	292,333	--
Louisiana	295,701	295,701	295,701	--
Maine	105,333	105,333	105,333	--
Maryland	361,152	361,152	361,152	--
Massachusetts	465,465	465,465	465,465	--
Michigan	693,994	693,994	693,994	--
Minnesota	339,094	339,094	339,094	--
Mississippi	196,251	196,251	196,251	--
Missouri	423,251	423,251	423,251	--
Montana	105,130	105,130	105,130	--
Nebraska	124,900	124,900	124,900	--
Nevada	151,762	151,762	151,762	--
New Hampshire	105,130	105,130	105,130	--

PREVENTITIVE HEALTH SERVICES

PROGRAM: Preventive Health Services (CFDA 93.043)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
New Jersey	620,946	620,946	620,946	--
New Mexico	127,394	127,394	127,394	--
New York	1,376,603	1,376,603	1,376,603	--
North Carolina	577,661	577,661	577,661	--
North Dakota	105,130	105,130	105,130	--
Ohio	835,879	835,879	835,879	--
Oklahoma	257,429	257,429	257,429	--
Oregon	254,913	254,913	254,913	--
Pennsylvania	1,018,552	1,018,552	1,018,552	--
Rhode Island	105,130	105,130	105,130	--
South Carolina	295,433	295,433	295,433	--
South Dakota	105,130	105,130	105,130	--
Tennessee	416,815	416,815	416,815	--
Texas	1,253,246	1,253,246	1,253,246	--
Utah	115,100	115,100	115,100	--
Vermont	105,130	105,130	105,130	--
Virginia	484,930	484,930	484,930	--
Washington	397,692	397,692	397,692	--
West Virginia	153,137	153,137	153,137	--
Wisconsin	391,448	391,448	391,448	--
Wyoming	105,130	105,130	105,130	--
Subtotal, States	20,624,841	20,624,841	20,624,841	--
American Samoa	13,141	13,141	13,141	--
Guam	52,565	52,565	52,565	--
Northern Mariana Islands	13,141	13,141	13,141	--
Puerto Rico	269,747	269,747	269,747	--
Virgin Islands	52,565	52,565	52,565	--
Subtotal, States and Territories	21,026,000	21,026,000	21,026,000	--
TOTAL	**21,026,000**	**21,026,000**	**21,026,000**	**--**

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Chronic Disease Self-Management Programs

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Chronic Disease Self-Management Programs.....	--	--	$10,000,000	+$10,000,000

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

FY 2011 Authorization..... Expired

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

Program Description and Accomplishments

Funded by AoA as part of its evidence-based prevention since 2003, the Chronic Disease Self-Management Program (CDSMP) is a low-cost evidence-based disease prevention model that utilizes state-of-the-art techniques to help those with chronic disease to manage their conditions, improve their health status, and reduce their need for more costly medical care. Older Americans are disproportionately affected by a vast array of chronic conditions (including diabetes, obesity, cancer, arthritis, and depression) that collectively account for seven out of every 10 deaths and more than three-quarters of all health expenditures.[25] Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in adverse outcomes including mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice, all of which lead to higher health costs and greater outlays for programs like Medicare and Medicaid. CDSMP is helping to reduce these adverse outcomes by empowering individuals, particularly those who have two or more chronic health conditions, to address issues related to the management and treatment of chronic disease.

CDSMP has been shown repeatedly through multiple studies (including randomized control experiments, with both English and Spanish speaking populations) to be effective at helping participants to adopt healthy behaviors, improve their health status and reduce their use of hospital stays and emergency room visits. The program been shown to significantly improve participant health status, reduce the use of hospital care and physician services[26] as well as reduce health care costs.

CDSMP was developed by Stanford University and emphasizes a patient's role in managing his/her illness. The program consists of a series of workshops that are conducted once a week for two and a half hours over six weeks in community settings such as churches, libraries,

[25] National Center for Chronic Disease Prevention and Promotion (NCCDPHP). Physical Activity and Good Nutrition: Essential Elements to Prevent Chronic Diseases and Obesity. Available at http://www.cdc.gov/nccdphp/aag/aag_dnpa.htm. Accessed September 14, 2004.

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

YW/MCAs, senior centers, public housing projects, community health centers and cooperative extension programs. People with different chronic health problems attend together, and the workshops are facilitated by two leaders who are trained and certified by Stanford University, one or both of whom are non-health professionals or lay people with chronic diseases themselves. Topics covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with health professionals; and 5) nutrition.

Since 2003, AoA has supported the deployment of CDSMP through its Aging Network, in partnership with AHRQ, CDC, CMS, HRSA and over 30 private foundations. In the 2006 reauthorization of the OAA, the Congress directed AoA to promote the nationwide implementation of evidence-based prevention programs through its network of community-based service provider organizations; and beginning in FY 2008, the Congress appropriated funding specifically to support this initiative. AoA and its partners have invested over $50 million since 2003 in developing an infrastructure for delivering evidence-based programs at the community level. This infrastructure now includes 1,200 community-based delivery sites, a national technical assistance center on evidence-based prevention programs for the elderly, a national CDSMP training and certification center at Stanford, local program training materials and guides, marketing materials, quality assurance mechanisms and fidelity protocols, and a variety of technologies, including an AHRQ sponsored Knowledge Transfer Program to support rapid diffusion. Over 12,000 individuals have participated in the CDSMP programs offered through this infrastructure.

Funding for CDSMP is awarded in the form of competitive grants to states. Grantees are required to provide a match equal to 25 percent of the project's total cost. External experts review project proposals, and project awards are made for periods of one to three years. In FY 2010 AoA funded 47 State grants for CDSMPs, with an average award of $574,468, using funding provided under the Recovery Act. AoA also funded a Technical Assistance Resource Center through a grant to the National Council on Aging. Competitive grants and contracts are also used to support evaluation and technical assistance activities.

Funding History

Stand-alone funding for the nationwide deployment of CDSMP through the aging services network is requested for the first time in FY 2012.[27] In FY 2010, $30 million in Recovery Act funding was transferred from the Centers for Disease Control and Prevention through an intra-departmental delegation of authority as part of the Recovery Act's $650 million "Prevention and Wellness Fund." An additional $2.5 million was also transferred from CDC to CMS for related evaluation and quality improvement purposes.

[27] Evidence-Based Programs including the Chronic Disease Self Management Program, together with Long-Term Care Programs (ADRCs and Community Living Programs) were previously and collectively known as the Choices for Independence Initiative. Funding for Choices for Independence, which did not break out funding for its individual components, was appropriated in FY 2008 and FY 2009.

Budget Request

The FY 2012 request for CDSMP is $10,000,000. This investment will allow AoA, in coordination with its existing HHS partners and private philanthropy, to build on AoA's existing service delivery infrastructure and continue to take CDSMP to scale nationwide.

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. Over 80 percent of adults 65 and over have at least one chronic condition, and roughly half suffer from two.[28] Nearly half of older adults have hypertension and roughly one in five has heart disease, with a similar proportion having some type of cancer.[29] The average 75-year old has three chronic conditions and takes 4.5 medications.[30] More than 65 percent of Americans aged 65 and over have some form of cardiovascular disease. One million adults age 75+ have diabetes, a number that is expected to grow to 4 million by 2050 if nothing is done to change current growth rates.[31] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. For example, among adults age 65+, 65 percent of Blacks had hypertension, compared to 47% of Whites; and 25% of Hispanics have diabetes, compared to 14% of Whites.

The Stanford University CDSMP represents the state-of-the-art in chronic disease self-management and is ideally suited for delivery through AoA's network of community based organizations, including senior centers, congregate meal programs, faith-based organizations and senior housing projects. Nationwide implementation will be accomplished at the community level by aging services provider organizations working in collaboration with public health agencies and health care providers. Participant referrals to the CDSMP program will come from both clinical and community-based organizations. Clinical referrals will come from community-health centers, physicians, hospitals, managed care organizations, and other health system components. Community referrals will come from a variety of sources, including the Aging and Disability Resources Centers that are currently funded by HHS (AoA and CMS). ADRCs serve as community-level "one stop shop" entry points into long-term care for people of all ages who have chronic conditions.

In FY 2012, AoA will invest $10 million to support the nationwide implementation and expansion of the CDSMP. Funds will help States and Territories to move towards State-wide coverage and enable 17,000 individuals to complete this program in the first year. Funds will support:

- Competitive grants to States;

- An interagency agreement with CMS to evaluate the impact of CDSMP on participant health care utilization and cost by linking Medicare claims data to

[28] NCCDPHP. Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans. Available at http://www.cdc.gov/nccdphp/aag/aag_aging.htm. Accessed September 14, 2004.
[29] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Health Interview Survey, 2000-2001.
[30] Alliance for Aging Research. Ten Reasons Why America Is Not Ready for the Coming Aging Boom. 2002.
[31] NCCDPHP. Available at http://www.cdc.gov/nccdphp/bb_aging/index.htm. Accessed September 14, 2004.

CDSMP Medicare participants (both elderly and younger people with disabilities);

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

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

Accountability and quality assurance will include tracking a combination of inputs and outputs. AoA will track via State reports 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 CDSMP participants' Medicare claims data to assess the impact of CDSMP on health care utilization.

AoA will continue to monitor the performance of the CDSMP with the output measure that was provided in both the FY 2009 and FY 2010 budget submissions.

Outputs and Outcomes Table

Measure/Outputs	Most Recent Result	FY 2010 Target	FY 2012 Target
Total number of individuals with chronic conditions completing the CDSMP program *(Output)*	FY 2009: 8,426	18,000	20,000[32]
Percentage of individuals that report 1 or more health benefits (e.g. improved health status, increased physical activity, less fatigue, greater mobility, etc.) after completing the CDSMP program *(Outcome)*	N/A	N/A	Baseline

Evaluation

AoA is partnering with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to rigorously evaluate the effectiveness of CDSMPs. In FY 2010, AoA initiated a design contract for recommendations on how to best carry-out an evaluation. The evaluation design recommendations will be completed by spring 2011. AoA will seek to begin implementation of an evaluation in late FY 2011 or in FY 2012 based on the availability of funds. The results of an evaluation would influence future performance measures and indicators of the program.

[32] The 2012 target takes into account the FY 2010 ARRA grant expenditures, which grants are active until March 31, 2012, as well as the FY 2012 request.

Community Service Employment for Older Americans

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Community Service Employment for Older Americans[33]	$825,425,000	$825,425,000	$450,000,000	-$375,425,000
FTE	--	--	8	+8

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

FY 2012 Older Americans Act Authorization..... Expired

Allocation Method ..... Formula & Competitive Grants

Program Description and Accomplishments

The Community Service Employment for Older Americans (CSEOA) program is authorized by Title V of the Older Americans Act. Commonly known as the Senior Community Service Employment Program (SCSEP), Title V was the only part of the Older Americans Act that was implemented by the Department of Labor instead of the Department of Health and Human Services. The budget proposes to transfer the responsibility for Title V to the Administration on Aging.

SCSEP was established to increase workers' incomes and narrow the wage and income inequality faced by senior workers. Participants must be unemployed persons 55 years or older with incomes no more than 125 percent of the Federal poverty level, which was $13,612 in FY 2011. The program offers part-time, community-service employment opportunities at 501(c)(3) non-profits or government agencies (also referred to as host agencies) to prepare participants to enter or re-enter the workforce. Participants are paid the highest of the Federal, state, or local minimum wage.

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.

[33] FY 2010 and 2011 include a special appropriation of $225,000,000 to serve low-income seniors affected by the recession.

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). SCSEP's focus on assuring that workers are equipped with the skills and knowledge necessary to succeed will remain in place while HHS shifts the program toward a community service orientation, producing better outcomes for seniors.

SCSEP is funded by a formula set forth in Title V of the Older Americans Act. The formula 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. Prior to the 2006 reauthorization, funds were allocated to and administered through one-year grants to the governor of the state and national non-profit agencies. Approximately 22 percent of formula funds are awarded to the governors, with 78 percent awarded to national non-profit agencies for services across the country. In 2006, DoL conducted a competition for the national grantees. As a result, 18 organizations received CSEOA funds, including three organizations under the Indian and Pacific Islands /Asian Americans set-aside. Under the OAA 2006 amendments, these grants are to be renewed annually for four years, with an optional one year extension. In Program Year (PY) 2008[34], the 74 national, state, and territorial CSEOA grantees enrolled over 89,000 individuals. CSEOA participants provided 48,611,568 hours of service to their local communities.

The next competition for national grantees will be conducted in 2011. AoA will collaborate with DOL on this competition in order to ensure a smooth transition of the program. Through this collaboration AoA will be able to input its suggestions as to priorities, targeting, and with the input of OMB and Congress develop appropriate performance measures.

In general, 75 percent of Federal funds must be spent on wages and benefits to participants with the remaining funds for other participant costs. There is a cap on administrative expenses of 13.5 percent. The Federal funds provided each of the 74 grantees can be no more than 90% of the total project amount, with the non-federal matching requirement in either cash or in-kind. In addition to direct services to eligible individuals, the 2006 amendments also permit up to 1.5 percent of the program's appropriation be used for pilot, demonstration and evaluation projects.

Funding History

Funding for Community Service for Older Americans during the past five years is as follows:

FY 2007.....$483,611,000
FY 2008.....$521,625,000
FY 2009.....$571,925,000
FY 2010[35] $825,425,000
FY 2011[35] CR $825,425,000

[34] Funding for SCSEP is appropriated from July 1 – June 30, rather than on the typical fiscal year schedule.
[35] Includes a one-time special appropriation of $225,000,000 to serve low-income seniors affected by the recession.

COMMUNITY SERVICE EMPLOYEMENT FOR OLDER AMERICANS

Budget Request

The FY 2012 request for SCSEP is $450,000,000, a reduction of -$375,425,000 from the FY 2010 level. Of this reduction, -$225,000,000 reflects the non-continuing, one-time special appropriation in FY 2010 in response to the economic downturn. The balance of the reduction reflects both the tight budgetary environment that currently exists, and the expectation that by tying SCSEP services more closely to the supports available through other AoA programs, greater efficiencies can be achieved that will offset, in part, these reductions. Funds will be used to provide formula grants to States and competitive grants to national contractors, as well as to provide necessary administrative support, monitoring, and technical assistance.

The Administration proposes transferring responsibility for Title V of the Older Americans Act to the Administration on Aging, which administers all other OAA programs. In an economic climate where low-income older workers have fared worse than other segments of the working population, SCSEP helps these individuals maintain their economic independence. Transferring SCSEP to the Administration on Aging would place the program in an Agency that shares 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 program is most effective when its services are closely integrated with the supports provided by AoA's existing Aging Services programs. AoA's substantial aging services network is an invaluable resource for an effective Title V program, and its mission of helping seniors to remain active and in their community makes the program a natural fit.

Demographic analysis indicates that older workers will account for an increasingly large portion of the available workforce in the decades ahead. SCSEP will continue to help employers recognize the value of older workers as both needed employees and mentors to younger workers. AoA will leverage the experience of the Department of Labor to continue encouraging and expanding job opportunities for aging workers, and work with the One-Stop Career Center system to place job-ready older workers in unsubsidized employment, helping to break down the barriers to fair and diverse workplaces for these senior workers.

AoA will use the requested funds in order to continue the vital work done by SCSEP as well as create efficiencies within the context of the aging services network. Millions of hours of community service are provided by SCSEP participants each year to non-profit organizations and government agencies; more than 45,000,000 hours in each of the last few years. Community service is an equally valuable aspect of SCSEP funding that is inextricably linked to the public service employment wages and training that seniors receive while in the program. In FY 2012, AoA, in cooperation with the aging services network, will continue to explore creative ways to highlight the community service aspect of SCSEP that will increase the opportunities for seniors to serve their communities and other seniors while they obtain expanded training options.

Outcome Table

Measure	Most Recent Result	PY 2010 Projection	PY 2012 Projection	FY 2012 +/- FY 2010
1.1: Average earnings in the second and third quarters after exit (Outcome)	PY 2008: $6,795	$6,590	TBD	TBD
1.3: Percent of participants employed in the first quarter after exit (Outcome)	PY 2008: 48.1%	46.5%	TBD	TBD
1.4: Percent of participants employed in the first quarter after exit still employed in the second and third quarters after exit (Outcome)	PY 2008: 71.1%	69.9%	TBD	TBD

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

Native American Nutrition and Supportive Services

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Native American Nutrition & Supportive Services	$27,704,000	$27,708,000	$27,704,000	--

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

FY 2012 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 2009 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 part Native Americans or Alaskan Natives.

Native American Nutrition and Supportive Services grants fund a broad range of services to older Native Americans, including adult day care, transportation, congregate and home-delivered meals, information and referral, 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 2009, the most recent available data, include:

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

- *Home-Delivered Nutrition Services* nearly 2.5 million meals to nearly 20,500 homebound Native American elders, as well as critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound elders (Output M).

- *Congregate Nutrition Services* provided 2.1 million meals to more than 45,900 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* provided nearly one million hours of outreach and information on services and programs to Native American elders and their families, thereby empowering them to make informed choices about their service and care needs (Output O).

The Native American Nutrition and Supportive Services program also provides training and technical assistance to Tribal organizations to support the development of comprehensive and coordinated systems of services to meet the needs of Native American elders. Training and technical assistance is provided through national meetings, site visits, e-newsletters, telephone and written consultation, 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 2010 grants were awarded to 246 Tribal organizations (representing 400 Tribes), including two organizations serving Native Hawaiian elders, with an average award of $109,499 and a range of grant awards from $76,160 to $1,505,000.

Funding History:

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

FY 2007	$26,134,000
FY 2008	$26,898,000
FY 2009	$27,208,000
FY 2010	$27,704,000
FY 2011 CR	$27,708,000

Budget Request:

The FY 2012 request for Native American Nutrition and Supportive Services is $27,704,000, the same as the FY 2010 enacted level. These funds help Tribal organizations provide services, including adult day care, transportation assistance, case management, and information and referrals; home-delivered meals; in-home services such as personal care, chore, and help with eating dressing and bathing; and community services such as physical fitness programs. These services - particularly adult day care, personal care, chore services, and home-delivered meals – also aid caregivers, who might otherwise have to be even more intensively involved with the care of their loved ones.

These funds will provide 1 million rides (Output L), 2.4 million meals at home (Output M), and 2.1 million meals at congregate sites (Output N) to approximately 65,600 Native American seniors. These 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, which is what they prefer.

In FY 2011 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 320, a 45 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 contributions from tribal organizations which value these programs. It should be noted that performance for FY 2012 is expected to decline due to the economic downturn impacting Tribal government budgets. For FY 2010 the efficiency measure shows performance trends declining because of declining leveraged funds, as State, tribal, and private budgets face economic hardships.[36] Tribal representatives participating in listening sessions have consistently indicated that the types of home and community-based supportive services that AoA is able to provide are important for meeting the needs of elderly Native Americans.

Outcome and Outputs Table:

Native American Nutrition & Supportive Services Outcome and Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
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 2009: 317 (Target Exceeded)	300	300	Maintain

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output L: Transportation Services units *(Output)*	FY 2009: 894,376	798,000	800,000	+2,000
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2009: 2.49 M	2.35 M	2.35 M	Maintain
Output N: Congregate Nutrition meals *(Output)*	FY 2009: 2.1 M	1.8 M	1.8 M	Maintain
Output O: Information, Referral and Outreach units *(Output)*	FY 2009: 987,071	992,000	1.0 M	+8,000

Grant Awards Table:

[36] AoA's projections are based on the following two assumptions: 1) CPI-U or a CPI-specific index and 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

NATIVE AMERICAN NUTRITION AND SUPPORTIVE SERVICES

Native American Nutrition & Supportive Services Grant Awards

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	246	246	246
Average Award	$109,499	$117,424	$117,424
Range of Awards	$76,160 - $1,505,000	$81,301 - $1,606,588	$81,301 - $1,606,588

Aging Network Support Activities

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Aging Network Support Activities	$8,198,000	$8,200,000	$7,948,000	-$250,000

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

FY 2012 Older Americans Act Authorization..... Expired

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

Program Description and Accomplishments:

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

Competitive grants, cooperative agreements, and contracts for Aging Network Support Activities are awarded to eligible public or private agencies and organizations, States and Area Agencies on Aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project's total cost. Project proposals are reviewed by external experts, and project awards are made for periods of one to four years. In FY 2010, Aging Network Support Activities funded 23 grants with an average award of $346,910 and a range of grant awards from $127,000 to $1,112,000.

National Eldercare Locator

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 helps seniors and their families navigate this complex environment by connecting those needing assistance with State and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving over 300,000 individuals a year.

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. 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. In the 12-month period ending July 31, 2009, the National Alzheimer's Call Center handled over 250,000 calls through its national and local partners, and its on-line message board community recorded over 4.8 million page views, with nearly 75,000 individual postings. Services focus on consumers, not professionals. 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 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 27 States. Data for the program shows that:

- Pension Counseling projects have successfully obtained a return of more than $5.50 for every Federal dollar invested in the program.

- Projects have directly served over 35,000 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 acquisitions; 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, health, and planning for long-term care. This project has made user friendly financial

education and retirement planning tools available to traditionally hard-to-reach women, including average and low-income women, women of color, women with limited English speaking proficiency, rural, and other "underserved" women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and publications in hard copy and Web based formats. Since its establishment, the Center has conducted more than 20,000 workshops on strategies to access financial and retirement planning information for women and disseminated over 10,000 pieces of financial and retirement planning information tailored to the specific needs of hard-to-reach women.

National Resource Centers on Native American Elders

The National Resource Centers on Native American Elders (Resource Centers) 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 three 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.

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, and American Indian and Alaska Native elders. Each NMAO project pilots a practical, nontraditional, community-based intervention for reaching older individuals who experience barriers to accessing home and community-based services. Strategies 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.

National Technical Assistance Resource Center for LGBT Elders

Older lesbian, gay, bisexual and transgender (LGBT) adults face a number of unique challenges as they strive to maintain their independence. To begin to address the special needs of LGBT elders, in FY 2010 AoA funded the National Technical Assistance Resource Center for LGBT Elders. The Resource Center strives to meet three primary objectives: educate mainstream aging services organizations about the existence and special needs of LGBT elders; sensitize LGBT organizations about the existence and special needs of older adults; and educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national resource center will formally begin services in September 2010 with the launching of a website including training curricula and social networking tools. In 2012 it is anticipated that the Resource Center will be focused on the provision of training and technical assistance for community providers across the country.

Multigenerational Civic Engagement
The Multi-Generational Civic Engagement (MGCE) initiative enhances discovery, documentation and support for existing, exceptional locally-developed program models and volunteer engagement strategies. Nineteen model programs in FY 2009 engage older adults in civic engagement projects aimed at increasing services to frail elders, families of children with special needs, and grandparents raising grandchildren. These model programs are also supported by the Corporation of National and Community Service.

Program Performance and Technical Assistance
This program supports cooperative efforts between AoA and selected States and AAAs to develop and test outcome measures, various performance measurement instruments, and sampling methods 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 assessment, and performance measurement.

Funding History:

Comparable funding for Aging Network Support Activities is as follows:

FY 2007	$7,657,280
FY 2008	$10,007,067
FY 2009	$8,200,000
FY 2010	$8,198,000
FY 2011 CR	$8,200,000

Budget Request and Anticipated Accomplishments:

The FY 2012 request for Aging Network Support Activities is $7,948,000, a reduction of $250,000 from the FY 2010 appropriation due to increased contracting efficiencies. The FY 2012 budget realigns some activities that were previously under Program Innovations and Aging Network Support and better classifies them as either Aging Network Support or Elder Rights Support Activities. The request continues support very near FY 2010 funding levels for these important Aging Network Support activities. In FY 2012, AoA has designated a specific line to support the National Technical Assistance Resource Center for LGBT Elders. This resource center was supported with existing funds in FY 2010 and FY 2011 and is more clearly identified in this request.

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

AGING NETWORK SUPPORT ACTIVITIES

Aging Network Support Activities includes funding for the following projects[37]:

Activity	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Aging Network Support Activities:			
National Eldercare Locator	$ 1,477,820	$ 1,478,000	$ 1,478,000
National Alzheimer's Call Center	999,784	1,000,000	1,000,000
National Education & Resource Center on Women & Retirement	248,946	249,000	249,000
Pension Information and Counseling Program	1,718,738	1,719,000	1,719,000
National Resource Centers on Native Americans	692,851	693,000	693,000
National Minority Aging Organizations: Asian-Pacific Americans	356,923	357,000	357,000
National Minority Aging Organizations: Native Americans	128,972	129,000	129,000
National Minority Aging Organizations: Hispanic & African-Americans	447,903	448,000	448,000
National Technical Assistance Resource Center for LGBT Elders	300,000	300,000	300,000
Multigenerational Civic Engagement	981,788	982,000	730,000
Program Performance and Technical Assistance	844,688	845,000	845,000
Total, Aging Network Support Activities	**$ 8,198,413**	**$ 8,200,000**	**$ 7,948,000**

[37] Several projects have been moved to Elder Justice Support Activities and are comparably adjusted.

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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. This request provides additional support for AoA's services programs that focus on keeping seniors healthy and independent and address and support the needs of their caregivers.

Better 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 2004, approximately 34 million adult caregivers provided uncompensated care to those 50 years of age and older.[38] The economic value of replacing unpaid caregiving in 2007 was estimated to be about $375 billion, an increase from $350 billion in 2006 (cost if that care had to be replaced with paid services).[39]

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.[40] 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. Eighty-three percent of the caregivers served by AoA programs report that AoA services allow them to provide care longer than they otherwise could.[41]

At the same time, AoA recognizes that it must also address the growing need for more caregivers every day. By 2015, AoA projects that there will be 12.9 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of almost +2 million seniors or +18 percent since 2008, needing caregiver assistance.[42]

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[38] National Alliance for Caregiving and AARP. Caregiving in the U.S. Bethesda: National Alliance for Caregiving, and Washington, DC: AARP, 2004.

[39] Gibson M.J., & Houser, A.N. *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update*. Washington, D.C.: AARP Public Policy Institute: 2008 November, Insight on the Issues #13.

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

[41] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

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

CAREGIVER SERVICES – SUMMARY OF REQUEST

To address these caregiver-related needs, AoA requests a total of $222,070,000, an increase of $47,523,000 above the FY2010 enacted level .The request includes:

- $192,220,000 for Family Caregiver Support Services, an increase of +$38,023,000 above the FY 2010 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.

- $8,388,000 for Native American Caregiver Support Services, an increase of +$2,000,000 above the FY 2010 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.

- $11,462,000 for Alzheimer's Disease Supportive Services, the same amount that was enacted in FY 2010. 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 diagnostic and support services to those with Alzheimer's.

- $10,000,000 for Lifespan Respite Care, an increase of +$7,500,000 above the FY 2010 enacted level. This program funds grants to improve the quality and access to respite care for family caregivers of children or adults of any age with special needs.

As a group, these programs support caregivers and elders 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.

Family Caregiver Support Services

	FY 2010 Appropriation	FY 2011 CR	FY 2012 Budget Request	FY 2012 + / - FY 2010
Family Caregiver Support Services……	$154,197,000	$154,220,000	$192,220,000	+38,023,000

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

FY 2012 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 Health and Independence Services, such as transportation services, homemaker services, home-delivered meals, and adult day care, to provide a coordinated set of supports for seniors that caregivers can access on their behalf.

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 assisting with personal care and homemaking to more complex health-related interventions like medication administration and wound care. The economic value of replacing unpaid caregiving in 2007 was estimated to be about $375 billion (cost if that care had to be replaced with paid services).[43] 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.

In 2009, at least 43.5 million adult caregivers, or approximately 19 percent of all adults, provided uncompensated care to those 50 years of age and older.[44] By 2015, AoA projects that there will be 12.9 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of almost +2 million seniors or +18 percent since 2008, needing caregiver assistance.[45]

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[43] Gibson M.J., & Houser, A.N. *Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update*. Washington, D.C.: AARP Public Policy Institute: 2008 November, Insight on the Issues #13.

[44] 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>

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

FAMILY CAREGIVER SUPPORT SERVICES

The availability of a skilled caregiver -- whether an informal caregiver, a paraprofessional worker or an unrelated volunteer -- all too often determines whether an individual remains independent or is admitted to a nursing home. Research has shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in AoA's 2009 National Survey of Older Americans Act (OAA) Participants, 25 percent of caregivers are assisting two or more individuals. Sixty-five percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and nearly one-third describe their own health as fair to poor.[46] 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.[47] 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.

Family Caregiver Support Services provide a variety of supports to family and informal caregivers. Based on FY 2009 data, the most recent available, services provided included:

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

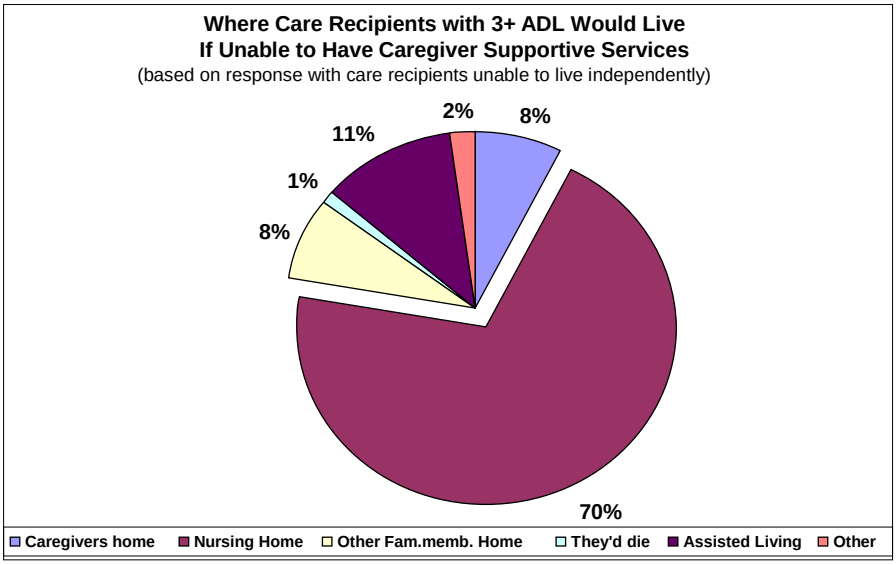
- *Counseling and Training Services* provided more than 137,000 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

- *Respite Care Services* provided more than 69,000 caregivers with 6.4 million hours with temporary relief -- at home, or in an adult day care or nursing home setting -- from their caregiving responsibilities (Output K).

Studies have shown that these types of supports can reduce caregiver depression, anxiety, and stress and enable them to provide care longer, thereby avoiding or delaying the need for costly institutional care for their loved ones. A study, *Intervention to Delay Nursing Home Placement of Patients with Alzheimer's Disease*, 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.

[46] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.
[47] Schulz R, Beach SR. Caregiving as a risk factor for mortality. The Caregiver Health Effects study. JAMA December 15, 1999;282:2215-9.

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 83 percent of caregivers of program clients reported in 2009 that services enabled them to provide care longer than otherwise would have been possible.[48] 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. Nearly half 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, 70 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see below).



Funding History:

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

FY 2007 ..... $156,167,000
FY 2008 ..... $153,439,000
FY 2009 ..... $154,220,000
FY 2010 ..... $154,197,000
FY 2011 President's Budget $154,220,000

Budget Request:

The FY 2012 request for Family Caregiver Support Services is $192,220,000, an increase of +$38,023,000 above the FY2010 enacted level, which continues funding originally proposed in FY 2011 by the White House Middle Class Task Force to aid caregivers. This Support for caregivers is critical since often it is their availability -- whether they are informal family

[48] 2009 National Survey of Older Americans Act Participants. http://www.data.aoa.gov, select AGID.

caregivers, paraprofessionals or unrelated friends and neighbors who volunteer their time -- that determines whether an older person can remain in his or her home.

With this proposed funding, 919,000 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 165,000 caregivers will also participate in counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

A recent MetLife survey shows the average cost in a nursing home is $219 per day. If only 476 seniors who were unable to receive caregivers services – 0.5% of the nursing home eligible seniors who are projected to be helped by this initiative -- move into a nursing home rather than remaining in their own home, their annual expenditures would be equivalent to the cost of the FY 2012 proposed increase for this program. Caregivers state that these programs help keep their loved ones at home, as 83 percent of caregivers report these supportive services enable them to provide care longer.

In FY 2012, AoA expects the aging services network to meet or exceed the target of only 30 percent of caregivers experiencing difficulty obtaining services (Outcome 2.6). This is a substantial accomplishment since baseline levels from 2003 showed that 64 percent of caregivers had difficulty getting services, and by 2009 that rate had been reduced by more than half to 30 percent of caregivers reporting difficulty getting services.

For FY 2012, the performance target for Family Caregiver Support Services Program participants who rate services good to excellent will remain consistently high at 90 percent (Outcome 2.9c). The substantive improvements in program performance can be attributed to successful implementation of the National Family Caregiver Support Program. While client reported assessment of service quality and program outcomes is expected to remain at high levels, many service outputs are expected to decline in FY 2012 compared to FY 2010. Declines are projected to be largely attributable to declining leveraged funds, as State, local, and private budgets face economic hardships.[49]

[49] AoA's projections are based on the following two assumptions: 1) CPI-U or a CPI-specific index and 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

FAMILY CAREGIVER SUPPORT SERVICES

Outcomes and Outputs Table:

Family Caregiver Support Services Outcomes and Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.6: Reduce the percent of caregivers who report difficulty in getting services. *(Outcome)*	FY 2009: 30% (Target Exceeded)	30%	30%	Maintain
2.9c: 90% of NFCSP clients rate services good to excellent. *(Outcome)*	FY 2009: 95.3% (Target Exceeded)	90%	90%	Maintain
3.1: Increase the number of caregivers served. *(Outcome)*	FY 2009: 855,000 (Target Exceeded)	560,000	919,000	+359,000

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Target	FY 2012 +/- FY 2011
Output I: Caregivers access assistance units of service. *(Output)*	FY 2009: 1.0 Million	1.2 Million	1.275 Million	+75,000
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2009: 137,203	137,000	163,000	+26,000
Output K: Caregivers receiving respite care services. *(Output)*	FY 2009: 69,017	74,000	67,000	-7,000

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 Tables:

Family Caregiver Support Services Grant Awards

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Number of Awards	56	56	56
Average Award	$2,736,667	$2,726,389	$3,398,175
Range of Awards	$95,783 - $15,564,926	$95,424 - $15,325,772	$118,936 - $19,102,063

FAMILY CAREGIVER SUPPORT SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Family Caregivers Support Services (CFDA 93.052)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
Alabama	$2,394,015	$2,381,771	$2,968,642	$574,627
Alaska	$766,267	$763,389	$951,489	$185,222
Arizona	$3,287,930	$3,221,475	$4,015,252	$727,322
Arkansas	$1,523,673	$1,515,357	$1,888,743	$365,070
California	$15,564,926	$15,325,772	$19,102,063	$3,537,137
Colorado	$1,863,239	$1,898,595	$2,366,412	$503,173
Connecticut	$1,828,019	$1,817,374	$2,265,177	$437,158
Delaware	$766,267	$763,389	$951,489	$185,222
District of Columbia	$766,267	$763,389	$951,489	$185,222
Florida	$12,466,239	$12,230,935	$15,244,653	$2,778,414
Georgia	$3,507,709	$3,559,892	$4,437,054	$929,345
Hawaii	$766,267	$763,389	$951,489	$185,222
Idaho	$766,267	$763,389	$951,489	$185,222
Illinois	$5,948,072	$5,896,106	$7,348,914	$1,400,842
Indiana	$3,054,571	$3,053,227	$3,805,546	$750,975
Iowa	$1,740,403	$1,704,505	$2,124,497	$384,094
Kansas	$1,418,364	$1,389,793	$1,732,239	$313,875
Kentucky	$2,082,732	$2,065,766	$2,574,774	$492,042
Louisiana	$2,008,607	$2,020,993	$2,518,968	$510,361
Maine	$766,267	$763,389	$951,489	$185,222
Maryland	$2,501,853	$2,504,404	$3,121,493	$619,640
Massachusetts	$3,353,928	$3,349,508	$4,174,831	$820,903
Michigan	$4,878,303	$4,898,828	$6,105,906	$1,227,603
Minnesota	$2,461,149	$2,491,677	$3,105,629	$644,480
Mississippi	$1,388,506	$1,384,971	$1,726,229	$337,723
Missouri	$3,035,089	$3,034,328	$3,781,990	$746,901
Montana	$766,267	$763,389	$951,489	$185,222
Nebraska	$939,403	$917,695	$1,143,816	$204,413
Nevada	$1,048,359	$1,064,239	$1,326,469	$278,110
New Hampshire	$766,267	$763,389	$951,489	$185,222

FAMILY CAREGIVER SUPPORT SERVICES

PROGRAM: Family Caregivers Support Services (CFDA 93.052)

State/Territory	FY 2010 Estimate	FY 2011 Estimate	FY 2012 Estimate	Difference +/-FY 2010
New Jersey	$4,365,417	$4,355,327	$5,428,484	$1,063,067
New Mexico	$959,260	$942,510	$1,174,744	$215,484
New York	$9,906,970	$9,740,093	$12,140,064	$2,233,094
North Carolina	$4,188,342	$4,297,663	$5,356,613	$1,168,271
North Dakota	$766,267	$763,389	$951,489	$185,222
Ohio	$5,957,778	$5,978,699	$7,451,858	$1,494,080
Oklahoma	$1,841,367	$1,823,351	$2,272,627	$431,260
Oregon	$1,881,639	$1,877,096	$2,339,615	$457,976
Pennsylvania	$7,449,148	$7,427,164	$9,257,226	$1,808,078
Rhode Island	$766,267	$763,389	$951,489	$185,222
South Carolina	$2,180,698	$2,232,779	$2,782,939	$602,241
South Dakota	$766,267	$763,389	$951,489	$185,222
Tennessee	$3,005,220	$3,027,221	$3,773,132	$767,912
Texas	$9,149,374	$9,196,791	$11,462,892	$2,313,518
Utah	$911,931	$908,202	$1,131,984	$220,053
Vermont	$766,267	$763,389	$951,489	$185,222
Virginia	$3,437,386	$3,439,323	$4,286,776	$849,390
Washington	$2,894,555	$2,894,702	$3,607,960	$713,405
West Virginia	$1,073,857	$1,065,631	$1,328,203	$254,346
Wisconsin	$2,861,507	$2,847,654	$3,549,320	$687,813
Wyoming	$766,267	$763,389	$951,489	$185,222
				--
Subtotal, States	$150,321,009	$149,705,474	$186,593,091	$36,272,082
				--
American Samoa	$95,783	$95,424	$118,936	$23,153
Guam	$383,133	$381,695	$475,745	$92,612
Northern Mariana Islands	$95,783	$95,424	$118,936	$23,153
Puerto Rico	$1,974,516	$2,018,088	$2,515,347	$540,831
Virgin Islands	$383,133	$381,695	$475,745	$92,612
				--
Subtotal, States and Territories	$153,253,357	$152,677,800	$190,297,800	$37,044,443
				--
Undistributed 50/	$943,830	$1,519,200	$1,922,200	$978,370
				--
TOTAL	$154,197,187	$154,197,000	$192,220,000	$38,022,813

50/ Funds held for statutory related requirements are reflected in the undistributed line.

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Native American Caregiver Support Services

	FY 2010 Appropriation	FY 2010 CR	FY 2012 Budget Request	FY 2012 +/- FY 2010
Native American Caregiver Support Services……	$6,388,000	$6,389,000	$8,388,000	+2,000,000

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

FY 2012 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Native American Caregiver Supportive Services provide grants to eligible Tribal organizations to provide support for family and informal caregivers of Native American, Alaskan Native and Native Hawaiian elders. 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.

Formula grants for the Native Americans Caregiver Supportive Services programs are 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 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. In FY 2010 grants for Caregiver Support Services were awarded to 204 Tribal organizations, including one organization serving Native Hawaiian elders, with an average award of $31,240 and a range of grant awards from $14,410 to $58,837.

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, as expressed by Tribal leaders, is that the program should not replace the tradition of families caring for their elders. Rather, it provides support that strengthens the family caregiver role.

NATIVE AMERICAN CAREGIVER SUPPORTIVE SERVICES

Funding History:

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

FY 2007	$6,241,000
FY 2008	$6,316,000
FY 2009	$6,389,000
FY 2010	$6,388,000
FY 2011 CR	$6,389,000

Budget Request:

The FY 2012 request for Native American Caregiver Support Services is $8,388,000, an increase of +$2,000,000 over the FY2010 enacted level which continues funding originally proposed in FY 2011 by the White House Middle Class Task Force to aid caregivers. 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 2000 Census, approximately 213,000 persons age 60 and over identified themselves as American Indians or Alaskan Natives, and another 182,000 persons age 60 and over identified themselves as part American Indians or Alaskan Natives. Caregiver support services will 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, which is what they prefer. 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 performance for FY 2010 is expected to decline due to the economic downturn impacting Tribal government budgets. For FY 2011 the efficiency measure shows performance trends declining because of declining leveraged funds, as State, tribal, and private budgets face economic hardships.[51]

In FY 2012 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, or on the reservation. It is estimated that in FY 2011 more than 320,000 units of caregiver-related services including respite care, information and referral, caregiver training, lending closets, and support groups will be provided by Native American Tribal organizations.

[51] AoA's projections are based on the following two assumptions: 1) CPI-U or a CPI-specific index and 2) declining State budgets of -8.5 percent each year from FY 2010-2012, consistent with the decline in 2009 state government tax collections reported by the U.S. Census in March 2010.

NATIVE AMERICAN CAREGIVER SUPPORTIVE SERVICES

Outcome Table:

Native American Caregivers Supportive Services Outcome

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
3.1: Increase the number of caregivers served. *(Outcome)*	FY 2009: 855,000 (Target Exceeded)	560,000	919,000	+359,000

Grant Awards Table:

Native American Caregivers Supportive Services Grant Awards

	FY 2010 Enacted	FY 2011 President's Budget	FY 2012 Request
Number of Awards	204	204	204
Average Award	$31,240	$34,021	$34,021
Range of Awards	$14,410 - $58,837	$15,692 - $64,073	$15,692 - $64,073

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Alzheimer's Disease Supportive Services Program

	FY 2010 Appropriation	FY 2011 CR	FY 2012 Budget Request	FY 2012 +/- FY 2010
Alzheimer's Disease Supportive Services Program……	$11,462,000	$11,464,000	$11,462,000	--

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

FY 2012 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 for States to expand the availability of diagnostic and support services that help persons with Alzheimer's and dementia and the family members who care for them. A critical focus of these grants is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with Alzheimer's and dementia to continue living in the community. In order to maintain the quality of life of the caregiver and their family members, the ADSSP provides respite care, personal care, counseling, and informational assistance, using proven and innovative direct care practices and enhances the responsiveness and readiness of the home and community-based care system by improving service coordination and educating service providers about proven dementia care strategies.

ADSSP grants enable States to develop service and outreach programs that are specific to State needs and resources. The primary components of the ADSSP program include:

- Delivering supportive services including respite care, home health care, personal care, adult day care, and companion services to assist caregivers, families, and persons with Alzheimer's disease.

- Translating and replicating evidence-based interventions for dementia 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.

- Providing individualized and public information, education, and referrals about diagnostic, treatment and related services; sources of assistance for services; and legal rights of people affected by Alzheimer's disease.

- Linking public and non-profit agencies that develop and operate respite care and other community-based supports, educational, and diagnostic services within the State to people who need services.

In 2008, a programmatic review was performed to determine the future direction of the program and how to enhance the program's operation and results. As a result of this review, AoA issued two grant funding opportunities in FY 2009 reflecting the new directions of the ADSSP that encourage States to 1) translate and replicate evidence-based interventions for people with dementia and their caregivers; and 2) develop or expand innovative service models for people with dementia and their caregivers, including a focus to expand services available to people in the early stages of dementia and to provide chronic care management.

In FY 2010 the ADSSP funded 32 grants with an average award of $321,625 and a range of grant awards from $163,393 to $500,000. Through these grant projects, seven States are in the process of translating four evidence-based interventions into practice and nine States are offering innovative programming for caregivers and their loved ones with dementia. One example of these promising interventions is a spousal caregiver support program in New York City that, in a randomized-controlled trial, delayed institutionalization of persons with dementia by an average of 557 days.[52] In 2009, the average nursing home cost was $219 daily ($79,935 annually), which would mean an average savings of nearly $122,000 in institutional costs per person with dementia.[53] Minnesota is translating this intervention now; early results indicate that the project is achieving the outcomes that were found in the original study. Other FY 2010 grant projects focus on innovations in areas of great need, such as programs to identify and provide appropriate services for persons in the earliest stages of Alzheimer's disease. 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.

With the FY 2011 grants, AoA will continue to build and expand its portfolio of evidence-based interventions that help persons with Alzheimer's disease and their family caregivers, as well as strengthen services in areas where there is less research in these areas – but great need for services – through innovative projects. Enhancing Federal, State, and local partnerships will be a key focus of these grants, including those with the Veteran's Administration and its constituencies, the Centers for Medicare and Medicaid Services, and state National Family Caregiver Support Programs (Older Americans Act, Title III-E).

[52] 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.

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

ALZHEIMER'S DISEASE SUPPORTIVE SERVICES PROGRAM

Funding History:

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

FY 2007	$11,668,000
FY 2008	$11,464,000
FY 2009	$11,464,000
FY 2010	$11,462,000
FY 2011 CR	$11,464,000

Budget Request and Anticipated Accomplishments:

The FY 2012 request for the ADSSP is $11,462,000, the same as the FY 2010 enacted level. Funds will be used to address the needs of a growing population: One study estimates that there were 411,000 new cases of Alzheimer's disease in 2000; by 2030 the number of new cases is projected to be 615,000 and by 2050, 959,000[54]. Consistent with a decision to incorporate evidence-based approaches into the ADSSP, this request will fund grants to States to pilot test and implement evidence-based and other innovative approaches that help individuals with Alzheimer's disease and their caregivers while also providing funding to demonstrate and expand the service delivery of home and community-based services.

While an anticipated $172 billion was expected to be spent in 2010 on care for persons with Alzheimer's disease and related disorders[55], 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-competent community-based social and health care services.

[54] Alzheimer's Association, (2010). "Alzheimer's Disease Facts and Figures"., p. 14 and p. 34. Accessed August 17, 2010 from: http://www.alz.org/alzheimers_disease_facts_figures.asp
[55] *Id.*

ALZHEIMER'S DISEASE SUPPORTIVE SERVICES PROGRAM

Outcome and Outputs Table:

Alzheimer's Disease Supportive Services Program Outcome and Outputs

Measure	Most Recent Result	FY 2010 Target	FY 2012 Target	FY 2012 +/- FY 2010
ALZ.1: Percent of ADSSP grant funds dedicated to implementing evidence-based programs *(Outcome)*	FY 2009: 64%	60%	60%	Maintain

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output AC: Number of individuals served *(Output)*	FY 2009: 3,954	Baseline	TBD	N/A
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	N/A	Baseline	TBD	N/A

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.

Lifespan Respite Care

	FY 2010 Appropriation	FY 2011 CR	FY 2012 Budget Request	FY 2012 +/- FY 2010
Lifespan Respite Care……	$2,500,000	$2,500,000	$10,000,000	+$7,500,000

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

FY 2012 Authorization..... Expired

Allocation Method ..... Competitive Grants

Program Description and Accomplishments:

The Lifespan Respite Care program provides grants to eligible State organizations to improve the quality and access of respite care for family caregivers of children or adults of any age with special needs while promoting the statewide dissemination and coordination of community-based respite care services. Respite care services are highly valued by caregivers. In the most recent National Survey of Older Americans Act (OAA) service recipients a random sample of 1,795 caregivers (which represented over 223,626 active caregivers) answered questions about the impact of the caregiver program. Eighty-four percent of caregivers received respite care within the past twelve months. The respite care service recipients reported that as a result of the services they received:

- 77 percent had less stress;
- 81 percent said it was easier to care for their loved one;
- 59 percent reported they now know more about caring for their loved one's condition;
- 77 percent reported that it was the most helpful service they received;
- 95 percent reported the care recipient benefited from the service; and
- 82 percent said that the services enabled them to care longer.

The activities funded by the Lifespan Respite Care program help to address this growing need, providing respite care services for family caregivers, training and recruitment of respite care workers and volunteers, information and outreach, access assistance, and program development.

The program also supports a grant to establish a National Lifespan Respite Resource Center to maintain a national database on lifespan respite care; provide training and technical assistance to State, community, and nonprofit respite care programs; and provide information, referral, and education programs to the public on lifespan respite care.

Grants for Lifespan Respite Care are awarded to eligible State organizations with a 25 percent matching requirement. Eligible State agencies include any of the following: the State agency that administers the State's OAA programs, the State's Medicaid program under Title XIX of the

Social Security Act; or any other State-level agency designated by the Governor. Additionally, the eligible State agency must work in collaboration with Aging and Disability Resource Centers and a public or private non-profit statewide respite care coalition or organization. Priority consideration is given to applicants who demonstrate the greatest likelihood of implementing or enhancing lifespan respite care statewide and who are building or improving the capacity of their long-term care systems to respond to the comprehensive needs of care recipients.

The first grants for the program were awarded in FY 2009 to twelve recipients for up to $200,000 for three-year project periods.

Funding History:

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

FY 2007	$0
FY 2008	$0
FY 2009	$2,500,000
FY 2010	$2,500,000
FY 2011 CR	$2,500,000

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

Budget Request and Anticipated Accomplishments:

The FY 2012 request for the Lifespan Respite Care Program is $10,000,000, an increase of +$7,500,000 over the FY2010 enacted level, which continues funding originally proposed in FY 2011 as part of the White House Middle Class Task Force. The Lifespan Respite Care program demonstrates AoA's commitment to providing caregivers and their families with the support they need to continue caring for their loved ones by expanding support to include caregivers of children or adults of any age with special needs.

According to a November 2009 study by the National Alliance for Caregiving, of six national policies or programs presented to caregivers as potential ways to help them, 26 percent of respondents ranked respite services as either their first or second most preferred option.[56] By providing opportunities for family caregivers to receive the much needed short-term relief from caring for their loved ones, the Lifespan Respite Care program helps to sustain family caregiver health and well-being, reduces the likelihood of abuse and neglect, and allows care recipients to remain in their own homes for as long as possible.

[56] National Alliance for Caregiving and AARP. Caregiving in the U.S. Bethesda: National Alliance for Caregiving, and Washington, DC: AARP, 2009.

LIFESPAN RESPITE CARE

States providing Lifespan Respite Care will, at a minimum:

- Expand and enhance respite care services to family members;
- Improve the statewide dissemination and coordination of respite care; and
- Provide, supplement, or improve access and quality of respite care services to family caregivers, thereby reducing family caregiver strain.

The Lifespan Respite Care Program, together with the National Family Caregiver Support program and the Alzheimer's Disease Supportive Services Program, provides AoA with another vehicle to address the needs of caregivers. The Lifespan Respite Care program will build upon the existing infrastructure of multi-faceted caregiver services that these two earlier programs now provide to leverage training for caregivers, enhance the provision of information about available respite and other supportive services, and to further assist caregivers in accessing all services available to them, including respite, from across the spectrum of caregiver support. With the addition of the Lifespan Respite Care Program, AoA will have new opportunities to further elevate the importance of caregiving by supporting the central role of caregivers in the health and long-term care delivery system with coordinated, accessible and high quality respite services.

Output Table:

Lifespan Respite Care Output

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output AE: Increase the number of people served as a result of Lifespan Respite Care (Output)	N/A	N/A	TBD	N/A

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Protection of Vulnerable Adults

Summary of Request

As the population of older Americans age 60 and older 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.[57] 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.[58] Together, these data suggest that a minimum of 2.5 million elders are abused, neglected, and/or exploited annually.

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.[59] 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.[60]

Protection of Vulnerable Adults programs address this problem through a full array of services designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. The FY 2012 request for these programs is $60,233,000 (including $3,312,000 in mandatory funding for Healthcare Fraud and Abuse Control), an increase of +$21,033,000 above the FY 2010 enacted level. The increase includes funding to support AoA's enhanced focus on elder rights and elder justice, including $16.5 million for Adult Protective Services State Demonstrations authorized under the Elder Justice Act and the Older Americans Act. Funding will be used to support States in improving their APS programs through evaluating interventions designed to detect and prevent elder abuse, including financial exploitation, and building the knowledge base about how to best implement these important activities. In addition to these APS improvements, the budget provides resources to improve resident advocacy to elders who live in long-term care settings through increased support to the Long-Term Care Ombudsman Program.

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[57] 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

[58] 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

[59] 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.

[60] 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.

PROTECTION OF VULNERABLE OLDER ADULTS – SUMMARY OF REQUEST

The enhanced focus on elder rights and elder justice will allow AoA's Protection of Vulnerable Adults 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.

Adult Protective Services State Demonstrations

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012 +/- FY 2010
Adult Protective Services State Demonstrations	--	--	$16,500,000	+$16,500,000
FTE	--	--	2	+2

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

FY 2012 Social Security Act Authorization..... $25,000,000

Allocation Method ..... Competitive Grants and Contracts

Program Description:

Adult Protective Services (APS) State Demonstrations, as established in Sections 6701-6703 of the Affordable Care Act, provide competitive grants to States to test and evaluate innovative approaches to preventing, detecting, and responding to elder abuse, neglect, and exploitation. Current State and local APS programs provide a range of services designed to ensure the safety and well-being of elders who are in danger of being mistreated or neglected, are unable to take care of themselves or to protect themselves from harm, and who have no one to assist them. These services include, but are not limited to, the following:

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

As the frequency of elder abuse, neglect, and exploitation continues to rise, the combination of shrinking State and local APS budgets and the increasing complexity of elder and adult abuse cases has greatly limited the ability of APS programs to effectively meet the growing demand for services. [61] APS State Demonstrations will improve the effectiveness and efficiency of State and local APS programs by providing funding to test and evaluate innovative approaches to service delivery. A number of obstacles have prevented APS programs from evaluating their services, including a lack of resources, the increasing number and complexity of abuse cases, and the

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

absence or inadequacy of consistent data systems and uniform reporting requirements needed to conduct meaningful program evaluations. Many of these same challenges have limited efforts to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation. APS State Demonstrations will provide competitive grant funding to APS programs to test new or previously unevaluated approaches and evaluate their effectiveness.

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

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

Funding History:

FY 2012 would be the first year of funding for this newly authorized program.

Budget Request and Anticipated Accomplishments:

The FY 2012 request for Adult Protective Services State Demonstrations is $16,500,000. The request includes funding to support 2 FTE for these activities.

As the size of the aging population continues to grow, so too has the demand for Adult Protective Services (APS). However, the ability of State and local APS programs to provide adequate assistance has not been able to keep up. This challenge has become even greater as the economic downturn has resulted in cuts to State and local APS budgets.

The FY 2012 request for $16.5 million includes approximately $13 million to fund competitive grants to test promising approaches to meeting the growing challenges that State and local APS programs face. Abuse, neglect, and exploitation present complex problems that require multidisciplinary solutions that employ the most effective and efficient interventions available. These competitive grants allow State and local APS programs to develop innovative approaches, evaluate promising approaches, and identify best practices that can then be disseminated to APS programs nationwide.

Additionally, $1.5 million will support research and demonstration programs for effectively preventing and addressing elder abuse within Tribal nations. Tribes will continue to define who qualifies as an elder within their community.

The remaining $2 million will support contracts to evaluate the demonstration's design and related activities, as well as the development of the initial phase of data collection and reporting requirements associated with the state-level demonstration grants. An effective evaluation of APS will depend upon the quality of work produced at the evaluation design stage. Recent AoA experiences with the design phase of program evaluations indicate that developing a rigorous design requires adequate funding. This is especially true of an evaluation of a program in which significant programmatic variation exists, particularly with regard to the differences in how States define elder abuse and the manner in which they conduct their APS programs.

Additionally, a portion of the $2 million allocated for the evaluation and administration of APS State Demonstrations will be used to provide adequate AoA staff resources to support the grants management, technical assistance, coordination, and the development and dissemination of best practices that are essential to the success of the these demonstration projects. The +2 FTE will allow AoA to maximize the value of APS Demonstrations by ensuring the integrity and consistency of each project while providing the project coordination necessary to carry out the dissemination of best practices and lessons learned from the demonstrations to APS programs throughout the nation.

Lastly, the budget request is consistent with the findings of the recent HHS report to Congress assessing the feasibility of establishing uniform standards for data collection, reporting, and dissemination of best practices regarding Elder Abuse. This report to Congress included a detailed analysis of the significant level of effort required to address the data collection and reporting requirements for APS. Taken together, the evaluation and the demonstration grants will complement each other, and will advance efforts to develop innovative approaches and best practices that can then be disseminated to APS programs nationwide.

Output Table:

Adult Protective Services Output

Indicator	Most Recent Result	FY 2011 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output AP.1: Design Adult Protective Service evaluation to develop and test appropriate methods of addressing elder abuse, neglect and exploitation.	N/A	N/A	Baseline	N/A

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Long-Term Care Ombudsman Program

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012 +/- FY 2010
Long-Term Care Ombudsman Program.....	$16,825,000	$16,827,000	$21,825,000	+$5,000,000

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

FY 2012 Older Americans Act Authorization..... Expired

Allocation Method .....Formula Grants and Competitive Grants

Program Description and Accomplishments:

The Long-Term Care Ombudsman program is a consumer advocacy program that improves the quality of care for the estimated 2.5 million residents of over 66,000 long-term care facilities.[62] Formula grants to States and Territories based on the number of seniors age 60 and older provide funding for the training, travel, and other operating costs of nearly 10,000 ombudsman staff and certified volunteer ombudsmen, who resolve complaints on behalf of residents and routinely monitor the condition of long-term care facilities.

Ombudsmen advocate on behalf of residents to ensure the protection of their rights and to ensure their welfare 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. The program enables States and communities to investigate and resolve complaints from residents and their caregivers related to improper action, inaction, or decisions which may have an adverse affect on the health, safety, welfare, or rights of long-term care facility residents.

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. In FY 2009, the number of ombudsmen consultations increased by six percent despite an increase in the number of nursing home beds per ombudsman FTEs (Outputs R and AH). 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 these issues – there was a ratio of seven volunteers to one paid staff (FTE) in FY 2009 for this program (the most recent year for which this data is available). The percentage of the complaints processed by ombudsmen that were fully or partially resolved to the satisfaction of the resident has consistently remained above 75 percent, demonstrating both the efficiency of the program and its ability to produce positive outcomes for seniors (Output Q),

[62] 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. http://www.nhpf.org/library/details.cfm/2767

LONG-TERM CARE OMBUDSMAN PROGRAM

FY 2009 output data for the Long-Term Care Ombudsman Program highlights the accomplishments achieved by this program and the important role that ombudsmen play in ensuring that the rights of long-term care facility residents are respected:

- Over 1,200 staff and 8,600 certified volunteer ombudsmen regularly visited residents in over 37,000 facilities, more than 80 percent of all nursing home facilities and nearly 50 percent of all licensed board and care facilities (Output S). At least another 2,000 volunteers support these paid staff and certified volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 233,025 complaints (Output Q).

- Ombudsmen provided over 483,000 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 2007	$15,010,000
FY 2008	$15,577,000
FY 2009	$16,327,511
FY 2010	$16,825,000
FY 2011 CR	$16,827,000

Budget Request:

The FY 2012 request for the Long-Term Care Ombudsman program is $21,825,000, an increase of +$5,000,000 above the FY 2010 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 will increase greatly. From 1990-2002 the number of licensed residential care and nursing home beds increased by 104 percent and continues to rise.[63] The resulting need for consumer advocates to protect residents' rights and to ensure the quality of residential long-term care will only increase.

[63] Harrington, *et al. Trends in the Supply of Long-Term Care Facilities.* Journal of Applied Gerontology, Vol. 24, No. 4, 265-282 (2005).

LONG-TERM CARE OMBUDSMAN PROGRAM

In order to ensure the continued safety and quality of residential long-term care, the FY 2012 request of $21,825,000 includes an additional $5,000,000 to provide the additional support that the Ombudsman program needs to continue its essential consumer advocacy efforts. The FY 2012 request represents an important element of AoA's enhanced 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. The proposed increase of $5,000,000 would be distributed through formula grants, consistent with the Older Americans Act, to fund interventions which would proactively address potentially problematic conditions before they occur, resulting in a projected decrease in the number of complaints per long-term care facility to 3.2 (Outcome 2.12); an increase in the capacity of Ombudsman programs to provide a projected 500,000 consultations (Output R); and an increased ombudsman presence in long-term facilities by increasing the total number of facilities visited regularly to 37,000 (Output S). These improvements would occur despite the anticipated challenge of operating during a period of State and local budget cuts.

As the complete performance summary demonstrates, State and local budget cuts resulting from the economic downturn have had an impact on the overall outcome and output measures of the Ombudsman program. Despite these setbacks, the Ombudsman program continues to provide the effective resident advocacy that older Americans need to live safe, high-quality lives in long-term care facilities.

Outcomes and Outputs Table:

Long-Term Care Ombudsman Program Outcomes and Outputs

Measure	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2010
2.12: Decrease the average number of complaints per LTC facility *(Outcome)*	FY 2009: 3.4	3.9	3.2	-.70
2.13: Decrease the percentage of complaints for abuse, gross neglect, and exploitation in nursing homes *(Outcome)*	FY 2009: 20.44%	19.5%	18.5%	-1.0%

Indicator	Most Recent Result	FY 2011 Projection	FY 2012 Projection	FY 2012 +/- FY 2010
Output Q: Decrease the Number of Complaints *(Output)*	FY 2009: 233,025	230,000	225,000	-5,000
Output R: Number of Ombudsman Consultations *(Output)*	FY 2009: 483,306	490,000	500,000	+10,000
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2009: 37,202	35,000	37,000	+2,000
Output AH: Decrease the number of nursing home beds per Ombudsman FTE *(Output)* [64]	FY 2009: 1,444	1,588	1,588	--

[64] This measure was previously incorrectly worded as "Increase the number of Ombudsman FTE per bed." The corrected language more accurately describes the measure.

Grant Awards Table:

Long-Term Care Ombudsman Program Grant Awards

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Request
Number of Awards	56	56	56
Average Award	$299,811	$297,477	$385,835
Range of Awards	$10,439 - $1,703,142	$10,412 - $1,684,326	$13,504 - $2,184,608

LONG-TERM CARE OMBUDSMAN PROGRAM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Request	Difference +/-FY 2010
Alabama	264,292	260,816	338,284	77,468
Alaska	83,947	83,294	108,034	24,740
Arizona	352,186	346,250	449,093	102,843
Arkansas	167,058	164,724	213,650	48,926
California	1,703,142	1,684,326	2,184,608	500,282
Colorado	222,532	226,039	239,178	67,139
Connecticut	197,313	195,462	253,518	58,056
Delaware	83,947	83,294	108,034	24,740
District of Columbia	83,947	83,294	108,034	24,740
Florida	1,249,006	1,219,737	1,582,027	362,290
Georgia	426,175	427,420	554,373	126,953
Hawaii	83,947	83,294	108,034	24,740
Idaho	83,947	83,294	108,034	24,740
Illinois	647,031	639,974	830,061	190,087
Indiana	335,450	333,095	432,032	98,937
Iowa	177,244	173,073	224,480	51,407
Kansas	149,063	146,207	189,634	43,427
Kentucky	235,478	231,947	300,840	68,893
Louisiana	225,227	224,924	291,732	66,808
Maine	83,947	83,294	108,034	24,740
Maryland	286,666	285,884	370,798	+84,914
Massachusetts	358,952	359,762	466,620	106,858
Michigan	541,752	541,407	702,217	160,810
Minnesota	268,281	268,872	348,734	79,862
Mississippi	153,463	151,078	195,951	44,873
Missouri	330,143	327,994	425,416	97,422
Montana	83,947	83,294	108,034	24,740
Nebraska	96,755	94,728	122,864	28,136
Nevada	128,482	128,083	166,127	38,044
New Hampshire	83,947	83,294	108,034	24,740

LONG-TERM CARE OMBUDSMAN PROGRAM

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

State/Territory	FY 2010 Actual	FY 2011 Continuing Resolution	FY 2012 Request	Difference +/-FY 2011
New Jersey	473,225	468,527	607,691	139,164
New Mexico	105,123	103,990	134,878	30,888
New York	1,069,764	1,052,277	1,364,828	312,551
North Carolina	482,691	487,368	632,127	144,759
North Dakota	83,947	83,294	108,034	24,740
Ohio	641,831	640,872	831,226	190,354
Oklahoma	201,454	197,849	256,615	58,766
Oregon	212,847	212,735	275,922	63,187
Pennsylvania	766,140	760,281	986,102	225,821
Rhode Island	83,947	83,294	108,034	24,740
South Carolina	252,516	254,737	330,400	75,663
South Dakota	83,947	83,294	108,034	24,740
Tennessee	343,717	342,367	444,058	101,691
Texas	1,045,289	1,043,148	1,352,987	309,839
Utah	102,099	101,393	131,509	30,116
Vermont	83,947	83,294	108,034	24,740
Virginia	397,554	395,088	512,439	117,351
Washington	335,165	335,722	435,439	99,717
West Virginia	116,871	115,329	149,584	34,255
Wisconsin	306,821	304,000	394,295	90,295
Wyoming	83,947	83,294	108,034	24,740
Subtotal, States	16,460,109	16,330,307	21,180,779	4,850,472
American Samoa	10,493	10,412	13,504	3,092
Guam	41,974	41,647	54,017	12,370
Northern Mariana Islands	10,493	10,412	13,504	3,092
Puerto Rico	224,389	224,305	290,929	66,624
Virgin Islands	41,974	41,647	54,017	12,370
Subtotal, States and Territories	16,789,432	16,658,730	21,606,750	4,817,318
Undistributed 65/	35,568	168,270	218,250	182,682
TOTAL	**16,825,000**	**16,827,000**	**21,825,000**	**5,000,000**

65/ Funds held for statutory related requirements are reflected in the undistributed line.

Prevention of Elder Abuse and Neglect

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012 +/- FY 2010
Prevention of Elder Abuse and Neglect	$5,055,000	$5,056,000	$5,055,000	--

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

FY 2012 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Prevention of Elder Abuse and Neglect program provides State formula grants for training and education, promoting public awareness of elder abuse, and supports State and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of AoA's enhanced focus in FY 2012 on 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, including Social Services Block Grant and State General Funds. In FY 2009 over $35 million of the Elder Abuse Prevention services expenditures came from non-OAA funds, a ratio of approximately $7 of non-OAA funds for every $1 investment of AoA funds.

Examples of State elder abuse prevention activities include:

- In Kentucky, the statewide network of Local Coordinating Councils on Elder Abuse has developed "Visor Cards" for law enforcement officers, which contain contact information and resource information to assist victims of elder abuse. Kentucky also produced "Fraud Fighter" forms that were distributed to thousands of seniors to help in the prevention of exploitation and scam artists. Other public awareness activities included renting billboards with elder abuse awareness messages and the State reporting number, hosting community trainings on the various forms of elder abuse, as well as other events and items to raise awareness in communities.

- Lifespan, out of Rochester, New York, used OAA funding to support training of non-traditional reporters, such as hairdressers, store clerks, and others who have frequent contact with the elderly, on what to look for and how to report suspected cases of elder abuse. Additionally, a series of television ads were developed and aired, which have resulted in an increased awareness of the problem of elder abuse.

- The Wisconsin Bureau of Aging and Disability Resources developed, in collaboration with the National Clearinghouse on Later Life, information designed to raise awareness of caregivers who have experienced abuse in the family, as well as of the risks and signs of abuse in later life, or "domestic violence grown old." The information was distributed statewide and is available at http://dhfs.wisconsin.gov/aps/Publications/publications.htm.

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 2007	$5,146,000
FY 2008	$5,056,000
FY 2009	$5,056,000
FY 2010	$5,055,000
FY 2011 CR	$5,056,000

Budget Request and Anticipated Accomplishments:

The FY 2012 request for the Prevention of Elder Abuse and Neglect program is $5,055,000, the same as the FY 2010 enacted amount. This funding will be distributed to the states as formula grants, consistent with the Older Americans Act.

The FY 2012 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 enhanced focus in FY 2012 on 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

Output Table:

Prevention of Elder Abuse and Neglect Output

Indicator	Most Recent Result	FY 2010 Projection	FY 2012 Projection	FY 2012 +/- FY 2011
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, results in thousands)*	FY 2009: $19,365	$17,992	$20,000	+$2,008

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Request
Number of Awards	56	56	56
Average Award	$89,383	$97,356	$115,034
Range of Awards	$3,128 - $501,013	$3,407 - $553,052	$4,026 - $653,479

PREVENTION OF ELDER ABUSE AND NEGLECT

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2012 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM: Prevention of Elder Abuse, Neglect, and Exploitation (CFDA 93.041)

State/Territory	FY 2010 Actual	FY 2011 Estimate	FY 2012 Request	Difference +/-FY 2010
Alabama	78,707	77,249	77,222	(1,485)
Alaska	25,224	25,027	25,022	(202)
Arizona	104,883	102,553	102,518	(2,365)
Arkansas	49,751	48,788	48,771	(980)
California	507,205	498,865	498,694	(8,511)
Colorado	66,271	66,949	66,926	655
Connecticut	59,907	59,907	59,907	--
Delaware	25,224	25,027	25,022	(202)
District of Columbia	25,224	25,027	25,022	(202)
Florida	371,960	361,264	361,140	(10,820)
Georgia	126,917	126,594	126,551	(366)
Hawaii	25,224	25,027	25,022	(202)
Idaho	25,224	25,027	25,022	(202)
Illinois	197,384	197,384	197,384	--
Indiana	99,899	98,657	98,623	(1,276)
Iowa	55,927	55,927	55,927	--
Kansas	45,843	45,843	45,843	--
Kentucky	70,126	68,698	68,675	(1,451)
Louisiana	68,518	68,518	68,518	--
Maine	25,224	25,027	25,022	(202)
Maryland	85,371	84,674	84,645	(726)
Massachusetts	109,606	109,606	109,606	--
Michigan	161,337	160,862	160,862	(475)
Minnesota	79,895	79,635	79,608	(287)
Mississippi	45,702	45,198	45,198	(504)
Missouri	98,318	97,643	97,643	(675)
Montana	25,224	25,027	25,022	(202)
Nebraska	29,770	29,770	29,770	--
Nevada	38,263	37,936	37,923	(340)
New Hampshire	25,224	25,027	25,022	(202)

PREVENTION OF ELDER ABUSE AND NEGLECT

PROGRAM: Prevention of Elder Abuse, Neglect, and Exploitation (CFDA 93.041)

State/Territory	FY 2010 Estimate	FY 2011 Estimate	FY 2012 Request	Difference +/-FY 2010
New Jersey	143,950	143,950	143,950	--
New Mexico	31,306	30,800	30,790	(516)
New York	318,581	318,066	318,066	(515)
North Carolina	143,748	144,349	144,300	552
North Dakota	25,224	25,027	25,022	(202)
Ohio	197,185	197,185	197,185	--
Oklahoma	60,208	60,208	60,208	--
Oregon	63,387	63,008	62,987	(400)
Pennsylvania	242,944	242,944	242,944	--
Rhode Island	25,224	25,027	25,022	(202)
South Carolina	75,200	75,448	75,423	223
South Dakota	25,224	25,027	25,022	(202)
Tennessee	102,361	101,403	101,368	(993)
Texas	311,293	308,961	308,855	(2,438)
Utah	30,406	30,030	30,020	(386)
Vermont	25,224	25,027	25,022	(202)
Virginia	118,394	117,018	116,978	(1,416)
Washington	99,814	99,435	99,401	(413)
West Virginia	36,736	36,736	36,736	--
Wisconsin	91,373	90,309	90,309	(1,064)
Wyoming	25,224	25,027	25,022	(202)
Subtotal, States	4,908,148	5,344,991	6,315,572	(39,598)
American Samoa	3,153	3,128	3,128	(25)
Guam	12,612	12,514	12,511	(101)
Northern Mariana Islands	3,153	3,128	3,128	(25)
Puerto Rico	66,824	66,435	66,412	(412)
Virgin Islands	12,612	12,514	12,511	(101)
Subtotal, States and Territories	5,044,712	5,005,440	5,004,450	(40,262)
Undistributed 66/	10,540	50,560	50,550	+40,010
TOTAL	**5,055,252**	**5,056,000**	**5,055,000**	**(252)**

66/ Funds held for statutory related requirements are reflected in the undistributed line.

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Senior Medicare Patrol Program

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012 +/- FY 2010
Senior Medicare Patrol Program.....	$13,217,000	$12,751,000	$12,750,000	-$467,000
*Healthcare Fraud and Abuse Campaign (non-add)).....	*$3,779,000*	*$3,312,000*	*$3,312,000*	*-$467,000*
FTE*.....	7	8	8	+1

*FTE are funded out of HCFAC funds.

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

FY 2012 Authorization..... Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Senior Medicare Patrol (SMP) program provides competitive grants to 54 States and Territories to support a national volunteer-based network for the purposes of preventing and identifying healthcare fraud and abuse. As a program of growing importance to the Department's ongoing fraud prevention activities in conjunction with the Patient Protection and Affordable Care Act (P.L. 111-148), AoA is proposing a FY 2012 budget requests that strengthens the Senior Medicare Patrol program by converting it to a formula-based grant program that will provide a dedicated source of funding while expanding the number of States and Territories in which the program operates.

The SMP program serves a unique role in the Department's fight to identify and prevent healthcare fraud in the Medicare and Medicaid programs. Projects use the skills of retired professionals as volunteers to conduct community outreach and education and provide toolkits that empower beneficiaries and their families to recognize and report suspected cases of Medicare and Medicaid fraud. Activities are carried out in partnership with the Centers for Medicare & Medicaid Services, the Office of Inspector General (OIG), healthcare providers, and other aging and elder rights professionals from around the country.

OIG collects performance data from the SMP projects semiannually. The most recent report, dated May 19, 2010, documented the following program outputs and outcomes for the calendar year 2009. Data show SMP projects:

- Maintained 4,444 active volunteers who worked over 122,000 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 217,227 beneficiaries in 7,177 group education sessions and held 33,855 one-on-one counseling sessions;

- Conducted 5,684 community outreach education events;

- Received 60,242 inquiries for information or assistance from beneficiaries and resolved over 99 percent;

- Resolved or referred for further investigation over 4,000 complaints of potential fraud, error, or abuse from beneficiaries, their families, or caregivers as a result of educational efforts; and

In addition, the OIG reports that since the program's inception 12 years ago, SMP projects have:

- Educated 2.8 million beneficiaries in 74,668 group education sessions and 1,042,098 one-on-one sessions;

- Conducted 68,831 community outreach education events; and

- Documented over $105.94 million in savings, including Medicare and Medicaid funds recovered, beneficiary savings, and other savings as directly attributable to the project as a result of beneficiary complaints. This does not attempt to quantify the savings that may occur as a result of SMP program's impact on fraud deterrence, which are believed to be substantial.

Healthcare Fraud and Abuse Control (HCFAC) Funds:

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created the Health Care Fraud and Abuse Control (HCFAC) Program to combat fraud and abuse in health care. Under HIPAA, recoveries from health care investigations are set aside in the Medicare Trust Fund and distributed at the joint discretion of the Secretary and Attorney General to finance anti-fraud activities. The SMP program historically has been supported by about $3.2 million in HCFAC funding for infrastructure, technical assistance, and other SMP program support and capacity-building activities designed to enhance program effectiveness. This includes support for project training and technical assistance provided by AoA's National Consumer Technical Resource Center (Center). The Center's website is maintained as a comprehensive "one stop" resource that contains information including current fraud alerts and consumer information, an SMP program locator, and the latest best practices information.

In the past year, the critically important role of the SMP program was recognized by partners in Medicare fraud prevention in the private and public sectors. First, the Centers for Medicare & Medicaid Services (CMS) announced the award of $9 million in grants to help more than 50 Senior Medicare Patrol (SMP) programs fight Medicare fraud. This action by CMS is in support of President Obama's mandate to educate seniors and other Medicare beneficiaries about how to prevent fraud in Medicare.

More recently, in November 2010, AoA received a national level commendation for the SMP program. The National Health Care Anti-Fraud Association (NHCAA), considered the leading national organization focused exclusively on the fight against health care fraud, bestowed this honor upon AoA and the SMP program. 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. This award is given annually by the NHCAA to 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 Administration on Aging's (AoA) Senior Medicare Patrol (SMP) 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:

Comparable funding for the Senior Medicare Patrol Program is as follows:

FY 2007 ..... $12,718,000
FY 2008 ..... $12,718,000
FY 2009 ..... $12,718,000
FY 2010 ..... $13,217,000
FY 2011 CR $12,751,000

All years include discretionary appropriations as well as mandatory HCFAC funds.

Budget Request and Anticipated Accomplishments:

The FY 2012 request for the Senior Medicare Patrol (SMP) program is $12,750,000, a reduction of -$467,000 from the FY 2010 enacted level. This includes mandatory HCFAC funds in the amount of $3,312,000, for a total discretionary request of $9,438,000, the same as in FY 2010. This amount will enable AoA to continue the proven fraud prevention activities of the SMP program at a time when the Department's fraud prevention and healthcare program integrity efforts have become essential components of the implementation of the Affordable Care Act.

The SMP program continues to demonstrate its effectiveness even as State and local funding cuts have resulted in 5 percent fewer program volunteers in 2009. Despite these challenges, the total savings to Medicare, Medicaid, beneficiaries, and others were over three times higher in 2009 than 2008.[67]

Since the program's inception, SMP projects have educated over 3.84 million beneficiaries and received over 170,000 complex issues (complaints) from beneficiaries who have detected billing

[67] May 2010 Performance Report for the Senior Medicare Patrol Projects, OEI-02-10-00100. http://www.oig.hhs.gov/oei/reports/oei-02-10-00100.pdf

or other discrepancies based on that information. While SMPs make numerous referrals of potential fraud to CMS program integrity contractors, there is no mechanism for tracking the actions (investigation, prosecution, collection) required to realize actual savings to the government as a result of these referrals. Therefore, it is not possible to directly track the outcome of most of the cases reported and dollars recovered as a result of SMP program activities. Moreover, the impact of the SMP program's primary activities - education of beneficiaries to prevent health care fraud - is difficult to measure and nearly impossible to quantify in dollars and cents. As the OIG indicated in the May 2010 report:

> "We continue to emphasize that the number of beneficiaries who have learned from the Senior Medicare Patrol Projects to detect fraud, waste, and abuse and who subsequently call the OIG fraud hotline or other contacts cannot be tracked….In addition, the projects are unable to track substantial savings derived from a sentinel effect, whereby fraud and errors are reduced in light of Medicare beneficiaries scrutiny of their bills."

Despite these evaluation challenges, the SMP program has documented nearly $106 million in savings to Medicare, Medicaid, program beneficiaries, and others since its inception in 1997, excluding any deterrent effect. During that same period, the program has educated over 2.8 million beneficiaries through the work of 19,467 volunteers who contributed a combined 543,805 hours of their time to preventing, detecting and reporting suspected incidents of fraud and educating and training community members about fraud prevention.

The FY 2012 request of $12,717,000 will improve the ability of the SMP program to prevent, detect, and report incidents of fraud and thereby increase the total dollar amount of fraud that is reported to the authorities for further action. The FY 2012 request will provide a projected increase of $1 million dollars in fraud reported for further action despite an anticipated overall decrease in total program funding resulting from State and local budget cuts.

Outcome Table:

Senior Medicare Patrol Outcome

Indicator	Most Recent Result	FY 2011 Target	FY 2012 Target	FY 2012 +/- FY 2010
1.5: SMP project will increase the total dollar amount referred for further action *(Outcome)*	FY 2009: $3.76 million (Target Exceeded)	$4 million	$5 million	+$1 million

Elder Rights Support Activities

	FY 2010 Appropriation	FY 2011 Continuing Resolution	FY 2012 Budget Request	FY 2012 +/- FY 2010
Elder Rights Support Activities.....	$4,103,000	$4,104,000	$4,103,000	--

Authorizing Legislation: Sections 201, 202, and 411 of the Older Americans Act of 1965, as amended, and Section 6703 of the Affordable Care Act, Subtitle B, Section 2042

FY 2012 Older Americans Act Authorization..... Expired

FY 2012 Affordable Care Act Authorization ..... Such Sums

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

Program Description and Accomplishments:

Elder Rights Support Activities consists of a combination of programs and resource centers that provide the necessary information, training, and technical assistance support that AoA and States need to fulfill their shared mission to maintain the health and independence of older Americans by preventing, detecting, and responding 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 to ensure their rights and financial security, and to enhance their choice and independence. By ensuring strong leadership at the State level, Model Approaches projects create linkages within the existing legal assistance community and services providers and professionals in the broader community-based aging and elder rights networks, including AAAs, 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.

ELDER RIGHTS SUPPORT ACTIVITIES

National Legal Assistance and Support Projects
National Legal Assistance and Support grants fund a comprehensive national legal assistance support system serving professionals and advocates working in legal and aging services networks. These grants form the National Legal Resource Center which supports the leadership, knowledge, and systems capacity of legal and aging provider organizations in order to enhance the quality, cost effectiveness, and accessibility of legal assistance and elder rights protections available to older persons with social or economic needs. AoA is funding four projects which provide core support functions for aging and legal networks including case consultation, training, technical assistance/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 and provides technical assistance and training to States and community-based organizations. The NCEA makes available news and resources; collaborates on research; provides consultation, education, and training; 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 FY 2009, the NCEA:

- Continued its outreach by serving over 1,700 subscribers to its newsletter and over 1,600 members to the Elder Abuse Listserv.

- Responded to over 1,000 individual public inquiries and requests for information.

- Effectively utilized technology to provide cost-effective trainings to over 1,177 professionals though live Webcast forums on issues relevant to elder rights and consumer protection, and maintained the NCEA training library with over 230 resources.

- Supported systems change in 12 local communities by providing funding, training, and technical assistance to new elder justice community coalitions to leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation.

National Long-Term Care Ombudsmen Resource Center
The National Long-Term Care Ombudsman Resource Center 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.

Among other accomplishments, the Center's FY 2009 outcomes included publication and distribution of *Equipping Long-Term Care Ombudsmen for Effective Advocacy: A Basic*

Curriculum; Self-Evaluation and Continuous Quality Improvement Tools for both State and local ombudsman programs; State and local ombudsman training at two national conferences and via web-based teleconferences; and continued high utilization (over 40,000 monthly visits) to the Center's website by ombudsmen, consumers, and agencies.

Funding History:

Comparable funding for Elder Rights Support Activities is as follows:

FY 2007	$3,560,877
FY 2008	$3,498,790
FY 2009	$4,104,000
FY 2010	$4,103,000
FY 2011 CR	$4,104,000

Budget Request and Anticipated Accomplishments:

The FY 2012 request for Elder Rights Support Activities is $4,103,000, the same as the FY 2010 enacted amount. This request reflects the need to continue the current level of support services to support AoA's enhanced focus on elder rights and elder justice, 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.

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

Elder Rights Support Activities includes funding for the following projects:

Activity	FY 2010 Enacted	FY 2011 CR	FY 2012 Request
Elder Rights Support Activities:			
Model Approaches to Statewide Legal Assistance	$ 1,999,569	$ 2,000,000	$ 2,000,000
National Legal Assistance and Support Projects	745,839	746,000	745,000
National Center on Elder Abuse	811,000	811,000	811,000
National Long-Term Care Ombudsman Resource Center	547,000	547,000	547,000
Total, Elder Rights Support Activities	**$ 4,103,408**	**$ 4,104,000**	**$ 4,103,000**

Consumer Information, Access, and Outreach

Summary of Request

Older Americans and Americans with disabilities today 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 opportunities available to assist them grows, so too does the complexity of navigating these programs and choosing among them so as to determine which best suit the needs of individuals.

A key part of AoA's emphasis on community living is providing consumers with the information they need to make decisions about their independence and in connecting consumers with the right services. Aging and Disability Resource Centers and the State Health Insurance Assistance Programs help to address this need by providing information, outreach, and assistance to seniors and those with disabilities, in order that they receive the services necessary for their independence. ADRCs serve as community-level "one stop shop" entry points into long-term care for people of all ages who have chronic conditions and disabilities. SHIPs provide one-on-one counseling to help aging and disabled beneficiaries and coming-of-agers navigate complex health and long-term care-related topics.

The FY 2012 request for these programs is $60,394,000, a reduction of $10,250,000 from the FY 2010 enacted levels.[68] This request includes $13,434,000 ($10 million mandatory as per the Affordable Care Act) for Aging and Disability Resource Centers and $46,960,000 for the SHIPs.

In order to further streamline their functionality and increase efficiency, the FY 2012 proposes to bring SHIPs (currently administered by the Centers for Medicare & Medicaid Services) under AoA. The strong synergies created by the single administration of these often co-located programs will create greater efficiency in service delivery while providing more consistent information for consumers. The SHIPs program fits naturally within AoA's mission of promoting community living, and will benefit from deeper connection to the aging services network from within AoA.

[68] This does not include the $30,000,000 transfer of mandatory funds from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for benefits outreach to low-income seniors per section 3306 of P.L. 111-148 (Affordable Care Act).

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Aging and Disability Resource Centers

	FY 2010 Enacted	FY 2011 Continuing Resolution	FY 2012 Request	FY 2012 +/- FY 2010
BA	$13,684,000	$13,684,000	$3,434,000	-$10,000,000
Affordable Care Act	$10,000,000	$10,000,000	$10,000,000	--
Total, Program Level	$23,684,000	$23,684,000	$13,434,000	-$10,000,000
Total, FTE	3	3	3	--

Authorizing Legislation: Section 202b of the Older Americans Act of 1965, as amended

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

FY 2012 Older Americans Act 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 consumer information and integrated access by creating "one-stop shop" entry points into long-term care at the community-level, ranging from in-home services to institutional care. ADRCs help States make better use of taxpayer dollars by streamlining access to public services, diverting individuals from more costly services and supports, and helping to overcome duplication and fragmentation in the long-term care system.

ADRCs are a key component in transforming States' long-term supports and services programs. Since 2003 AoA and CMS have provided grants to states to develop a foundational infrastructure for delivering person-centered systems of information, counseling, and access that make it easier for individuals to learn about and access their health and long-term services and support options. ADRCs grew out of best practice innovations known as "No Wrong Door"[69] and "Single Points of Entry" Programs, where people of all ages or disability may turn for objective information on their long-term services and support options.

ADRCs serve as integrated access point and "No Wrong Door – Single Entry Point" system for individuals of all ages for information and access to the long-term services and support options they need. ADRCs provide services including:

[69] 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).

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

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

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

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

- integrated access-point to care transition and diversion support to veterans served through the AoA and Veterans Administration (VA) Veterans Directed Home and Community Based Services Program partnership.

Effective ADRCs are able to build upon the foundational infrastructure they have developed and perform the following five key operational functions:

- *Information, Referral and Awareness*: ADRCs serve as a highly visible and trusted place that people know they can turn to for objective information on the full range of long term service and support options. ADRCs promote awareness of the various options, including Medicare benefits, that are available in the community, especially among underserved, hard-to-reach and private paying populations, as well as options individuals can use to "plan ahead" for their long-term care. ADRCs have the capacity to link consumers with needed services and supports – both public and private – through appropriate referrals to other agencies and organizations.

- *Options Counseling and Assistance*: ADRCs provide counseling and decision support to consumers and their family members and/or caregivers by identifying and understanding the needs of the clients and assisting them in making informed decisions about appropriate long term service and support choices – including their Medicare options – in the context of their personal needs, preferences, values and individual circumstances.

- *Streamlined Eligibility Determinations for Public Programs*: ADRCs serve as a single point of entry to publicly-funded long-term supports, including those funded by Medicaid, the Older Americans Act (OAA), and other State and Federal programs and services. ADRCs must have the necessary protocols and procedures in place to facilitate integrated and/or fully coordinated access (i.e., consumer intake, needs assessment, service or care planning, eligibility determination, and ensuring that people get the services they need) to publicly supported long-term services and supports – both community-based and institutional. The goal is to create a process that is seamless for consumers regardless of which service they choose.

- *Person-Centered Care Transitions*: ADRCs create formal collaborations between and among the major pathways that are used in health care and long-term services and supports, including preadmission screening programs for nursing home services, hospital discharge planning, physician services, and various community agencies and organizations. These linkages ensure that people with chronic conditions and disabilities have the information they need to make informed decisions about their service and support options as they pass through critical transition points in the health and long-term services and support systems that cut across all payers and settings. These critical activities can help individuals break the cycle of readmission to the hospital and live longer in the community.

- Quality Assurance and Continuous Improvement: ADRC must ensure that they are person centered and adhere to the highest standard of service in all areas. ADRCs should continually monitor the quality of their services and evaluate their own impact on consumers' lives, system efficiencies and public costs.

AoA and the Centers for Medicare & Medicaid Services (CMS) have invested over $100 million in the ADRC program since 2003. As a result of these investments:

- 300 ADRC sites have been established across 50 states, 3 territories, and Washington, DC, often by expanding existing infrastructure in the aging services network such as AAAs, etc. Together these ADRC sites can reach roughly 51 percent of the U.S. population.

- 13 States and Territories are achieving statewide coverage and an additional 13 states are achieving 50 percent or more statewide coverage.

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

- Standards have been established to provide guidance to States on the desired end result of how an ADRC should perform. For example, the standards require that each ADRC has a plan for reducing the average time from initial contact to determination of their eligibility for public services.

- In FY 2011, AoA, in partnership with CMS, will continue to support the 49 existing ADRC grants that are helping States continue to develop programs that reflect the five key operational functions specified above and implement plans to reach statewide coverage. AoA and CMS also plan to support the 16 existing grants funded in FY 2010 to help states further expand and enhance their ADRCs Person Centered Care Transitions function. Finally, utilizing the $10 million appropriated for FY 2011 in the Affordable Care Act, AoA expects to award new competitive grants to 20 to 25 states to further expand and enhance their ADRC's Options Counseling and Assistance function, which will include activities to jointly develop with AoA and its

technical assistance partners minimum national standards for options counseling. AoA will also fund a technical assistance resource center to support these activities.

- As a result of these investments, in 2011 it is estimated that ADRCs will respond to over three million contacts to help individuals make better informed decisions about their health and long-term care options, with the vast majority of these decisions resulting in referrals for community-based services.

Funding History:

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

FY 2007	$4,516,000	0 FTE
FY 2008	$2,250,000	0 FTE
FY 2009	$13,577,000	3 FTE
FY 2010	$13,684,000	3 FTE
FY 2011 CR	$13,684,000	3 FTE

Note: Discretionary funding for ADRC activities was provided under Aging Network Support Activities in FY 2009 and FY 2010 and requested under Health and Long-term Care Programs in FY 2011.

Budget Request and Anticipated Accomplishments:

The FY 2012 discretionary budget request for Aging and Disability Resource Centers is $3,684,000, a reduction of -$10,000,000 from the FY 2010 enacted level. Offsetting this reduction, an additional $10,000,000 was appropriated to AoA in the Affordable Care Act (section 2405 of P.L. 111-148) for each year from FY 2010 to 2014 for ADRC activities.

Beginning in FY 2012, funding for ADRCs is requested under a separate budget line, reflecting redistribution of the Health and Long-term Care Programs line in the FY 2012 request. With ADRCs established in every State and increasingly statewide with their reach, AoA believes ADRCs represent a mature, scalable program.

Funding under this request will help ADRCs to build the infrastructure needed to support ongoing operations and create greater integration with the medical system

In FY 2012, AoA plans to make available competitive grants to all States and Territories to further develop ADRC programs to reach statewide coverage and ensure the five key operational functions of programs are at a fully-functional level. The two Territories that have not received ADRC grant funding to date (American Samoa and Virgin Islands) will have the opportunity to compete for funding to develop all five key operational functions of an ADRC. All other States and Territories will have the opportunity to compete for funding to further bolster their capacity in the areas of Options Counseling and Assistance, Streamlined Eligibility Determinations for Public Programs, and Person Centered Care Transitions as well as to continue roll-out of their plans to achieve statewide coverage (all states who received FY 2009 ADRC grants were required to develop 5-year plans starting no later than March 2011).

Funds will also help continue to support AoA's partnership with the Department of Veterans Affairs. In FY 2008, the Veterans Administration and AoA began working together to develop the Veterans Directed Home and Community Based Services Program (VDHCBS), which is designed to serve veterans of any age who are at risk of admission to a nursing home by providing them the opportunity to self-direct their care and access services to help them remain in the community. Rather than build a separate infrastructure to serve veterans, the Veterans Administration made a strategic decision to use the aging services network infrastructure – including using the ADRC as the integrated access point to empower the veterans to set-up their own service plan for long-term supports and services – as a delivery vehicle for VDHCBS. In FY 2009 the Veterans Administration invested an additional $10 million in the implementation of VDHCBS and plans for continued funding in FY 2010. In FY 2009 and FY 2010, the implementation of VDHCBS is expected to expand to at least another 10 states, bringing the total number of states implementing VDHCBS to at least 20. AoA and the VA envision further expansion of the VDHCBS program in FY 2011, FY 2012, and into the future.

Evaluation

With ADRCs in place for nearly a decade, AoA believes it is appropriate to gather new information about the impact of ADRCs. AoA is partnering with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to rigorously evaluate the effectiveness of ADRCs. In FY 2009, AoA initiated a design contract for the evaluation. In FY 2010, AoA began a roughly $2.1 million evaluation based on recommendations from the design contract. Completion of the evaluation may require the use of funds already requested in FY 2011, though currently AoA does not anticipate requiring FY 2012 funds for the evaluation. The results of this evaluation will influence future performance measures and indicators.

Outcome and Outputs Table:

Aging and Disability Resource Centers Outcome and Outputs

Measure	Most Recent Result	FY 2012 Target	FY 2012 +/- FY 2010
LTC.2: Percent of individuals who indicate ADRC information and counseling contribute to informed decision making *(Outcome)*	N/A	TBD	N/A

Indicator	Most Recent Result	FY 2012 Projection	FY 2012 +/- FY 2010
Output AF: Total number of ADRC contacts *(Output)*	FY 2010: 2,857,387	3.25 M	+392,613
Output AG: Increase in the number of ADRC pilot programs *(Output)*	FY 2010: 300	300	Maintain

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.

State Health Insurance Assistance Programs

	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Request	FY 2012 +/- FY 2010
State Health Insurance Assistance Programs (SHIPs).....	$46,960,000	$46,960,000	$46,960,000	--
FTE.....	--	--	5	+5

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

FY 2012 Authorization..... Expired

Allocation Method ..... Formula and Competitive Grants/Contracts

Program Description and Accomplishments:

State Health Insurance Assistance Programs (SHIPs) provide one-on-one counseling to help aging and disabled beneficiaries and coming-of-agers navigate complex health and long-term care-related topics. SHIP grants to States provide 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 to strengthen their capacity to support a community-based network of State and local programs. 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 prescription drug benefits, Medicaid, and preventive benefits.

The budget request proposes to transfer the SHIP program from the Centers for Medicare & Medicaid Services to the Administration on Aging. This transfer reflects the natural synergies between the SHIP programs and the aging services network. Of the 54 SHIP grant programs, about two-thirds are administered by state units on aging established by the Older Americans Act. Most of the remaining programs are 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 administered by AoA.

SHIP activities align with the AoA mission to develop a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals maintain their health and independence in their homes and communities. AoA has been a long-time collaborator with CMS in planning and coordinating SHIP activities. In 2007, bimonthly meetings between CMS and AoA to coordinate SHIP, SMP and ADRC were also initiated. Streamlining the SHIP program into AoA would be a natural extension of 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.

Funding History:

Comparable funding for the State Health Insurance Assistance Program is as follows:

FY 2007	$34,187,538
FY 2008	$54,300,000
FY 2009	$52,500,000
FY 2010	$46,960,000
FY 2011 CR	$46,960,000

The following legislative action has taken place since FY 2008 which provided additional mandatory funding for the SHIPs:

- The Medicare, Medicaid, and SCHIP Extension Act of FY 2007 (MMSEA) provided the SHIPs with an additional $15.0 million in FY 2008.

- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided the SHIPs with an additional $7.5 million in FY 2009.

- The Affordable Care Act provides a total of $15 million to be distributed to states via formula grants in FY 2010 – FY 2012.

Budget Request and Anticipated Accomplishments:

The total SHIP budget request for FY 2012 is $46,960,000, the same as the FY 2010 enacted level. This includes funding for 5 FTE to administer the program. 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:

- Increasing the number of community outreach in public forums to include disabled, elderly, and pre-retirees to raise awareness of long-term care related topics.

- Increasing 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

- Increasing the number of local and field counselors (paid and unpaid)

- Increasing the number of individual personalized counseling sessions.

Due to AoA's unique connections to the aging services network as well as the greater efficiencies leveraged by a single point of management of these locations which are often co-located with ADRCs, these increases are anticipated despite the lack of increased funding. Funds will also be used to provide administrative support for the SHIPs program.

The SHIP grant year runs from April 1 through March 31 each year.

Outcomes and Outputs:

In grant year 2006, the total number of clients reached by SHIPs was 3.4 million. In grant year 2007, the number was 4.2 million. In grant year 2008, the number was 5.2 million. As part of the proposed reassignment to AoA, further performance measures will be established and reported in future submissions.

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Program Innovations

	FY 2010 Enacted	FY 2011 CR	FY 2012 Request	FY 2012 +/- FY 2010
Program Innovations.....	$27,874,000	$27,879,000	$11,509,000	-$16,395,000
Health & Long-term Care Programs (non-add)	*$16,905,000*	*$16,905,000*	--	--

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

FY 2012 Authorization..... Expired

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

Program Description and Accomplishments:

Program Innovations is intended to provide a source of funding for AoA to use as a catalyst for tapping new approaches, translating cutting-edge research and evaluation results into practice, and demonstrating techniques and best practices that can be replicated across the States and communities in the network. It also provides funds to address key AoA priorities to help seniors stay healthy, active, independent, and living in their own homes and communities.

These funds provide AoA with the flexibility to innovate and demonstrate practical methods that can then be more widely replicated by States and local communities to help strengthen and transform OAA core programs. Generally, these innovations are modeled after best practices developed within the aging services network that need further support, modeling, and evaluation before enabling widespread replication and adoption. This flexibility, for instance, provided the seed money for developing Aging and Disability Resource Centers and Evidence-Based Disease Prevention projects that are now being successfully implemented in locations across the nation.

Program Innovation grants also provide a vehicle for the exploration of emerging opportunities or risks facing seniors and caregivers where the aging services network has limited expertise. In these cases, universities, consumer-focused organizations, and other entities may be brought collaboratively into the aging network as technical assistance partners to assist with these emerging challenges.

PROGRAM INNOVATIONS

Funding History:

Comparable funding for Program Innovations during the past five years is as follows:

FY 2007	$16,533,998
FY 2008	$23,464,781
FY 2009	$19,546,000
FY 2010	$27,874,000
FY 2011 CR	$27,879,000

Budget Request:

The FY 2012 request for Program Innovations is $11,509,000, a decrease of -$11,365,000 from the FY 2010 appropriation.

In recent years, AoA's program innovations funds have been absorbed to fund ongoing health and long-term care programs and lacked the flexibility to address other new priorities. House and Senate appropriations committee reports and feedback in Older Americans Act reauthorization sessions have consistently called for AoA to fund several initiatives and activities that are not presently able to be supported due to the established commitments on these funds and standing directions on how they are to be used. [70] For example, the FY 2012 Senate appropriations committee report again encourages AoA to focus on innovations in older adults and mental health and section 416 of the Older Americans Act regarding transportation.

With discontinuation of the Community Living Program (CLP) and the creation of a stand-alone budget line for Aging and Disability Resource Centers (ADRCs) and Chronic Disease Self Management Programs (CDMSP) in the FY 2012 request, AoA needs to rededicate funds to new areas of innovation intended to strengthen our core programs. As a result, the Health and Long-term Care Programs line has been eliminated with some of the funding that had previously been in this line redirected to elder rights and elder justice, new areas of innovations, and administrative needs.

These changes will allow $11 million in funds that previously supported the demonstration of the Health and Long-term Care Programs to now be dedicated to Program Innovations for exploration of the next series of innovation activities. Among the issues that AoA is interested in exploring are:

- Best practices that address serious and growing problems of mental health, depression, and suicide among seniors. This will begin to address the Senate's preferences for

70 Program Innovations funding has historically supported a number of ongoing projects of national significance, including resource centers and other projects that are national in scope that have provided demonstrated benefits to elderly Americans. In FY 2009 to FY 2010, the totality of appropriated Program Innovations funding was devoted to these latter types of projects and the FY 2011 Senate mark continues this trend. In FY 2012, AoA has moved all of the projects of national significance, except for Community Innovations for Aging in Place, to either Elder Justice Support Activities or Aging Network Support Activities, consistent with their established nature of support to the aging services network. Those projects of national significance are comparatively funded in this budget.

innovations in mental health for older adults. Seniors face a disproportionate risk of suffering from mental illness or committing suicide, but this serious problem often does not receive the attention it urgently deserves. We anticipate that the aging services network likely has proven best practices for referrals to mental health clinics and other care programs for seniors that have not been studied, explored, or replicated.

- Helping seniors to navigate the increasingly complex marketplace of new assistive technologies that address safety and/or health. A variety of devices have been developed and are being developed that claim to allow caregivers or others to monitor seniors' health, location, or other needs and provide feedback or warnings in the event of an emergency. However, there is often limited information about how well such technology works, what works best, and what could be improved. Funding would support grants to study, collect, and disseminate information throughout the national aging services network about how and under what conditions currently marketed assistive technologies provide the best value for seniors and their caregivers. This information will better empower seniors and their caregivers to make informed decisions for their circumstances.

In addition, Community Innovations for Aging in Place has previously been funded at $5 million in FY 2010 and FY 2011 in Program Innovations. This new arrangement provides the Assistant Secretary with flexibility to fund this activity at a different level in FY 2012.

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Program Administration

Summary of Request

Program Administration funds provide the necessary resources for the operation of AoA programs. For the first time in FY 2012, AoA has two distinct Program Administration requests, totaling $144,543,000. These requests reflect the increased responsibility taken on by the organization, and the resulting need for administrative resources to implement these new programs effectively.

- *Aging Services Administration*: Funds the direction of programs established under the Older Americans Act (OAA), the Alzheimer's Disease Supportive Services program, and the Lifespan Respite program. The FY 2012 request for Aging Services Administration is $24,543,000, an increase of +$4,567,000 over the FY 2010 enacted level. This does not include resources necessary to carry out new programs, such as SHIPS or SCSEP. These resources are requested separately as part of the overall funding being requested for these programs.

- *Community Living Assistance Services and Supports Administration*: This request will continue to fund the implementation of the CLASS program, a new, voluntary insurance program created under Title VIII of the Affordable Care Act. The FY 2012 request for CLASS Administration is $120,000,000. This will be the first year that CLASS receives a discretionary appropriation. The Affordable Care Act anticipates CLASS' administrative activities being funded from premiums paid by participants, however, CLASS requires funds from a discretionary appropriation in FY 2012 to bridge the period between FY 2011 and the point at which funding can be drawn statutorily from premiums received.

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Aging Services Program Administration

	FY 2010 Appropriation	FY 2011 CR	FY 2012 Budget Request	FY 2012 + / - FY 2010
Program Administration……	$19,976,000	$19,979,000	$24,543,000	+4,567,000
FTE……....	100	111	121	+21

Note: Neither the dollar nor the FTE request includes resources to carry out new programs to be implemented in AoA by FY 2012. Resources for these programs are requested separately in the relevant narratives within this document.

Authorizing Legislation: Section 205 of the Older Americans Act of 1965, as amended

FY 2012 Older Americans Act Authorization..... Expired

Allocation Method ..... Direct Federal/Contract

Program Description and Accomplishments:

Program Administration funds the direction of AoA programs established under the Older Americans Act (OAA), as well as the Alzheimer's Disease Supportive Services program and the Lifespan Respite Care program authorized respectively by Section 398 and Title XIX of the Public Health Services Act (PHSA). In addition, Program Administration funds are used to support oversight and implementation of activities originally funded under the American Recovery and Reinvestment Act (ARRA) of 2009, and the Affordable Care Act of 2010.

Program Administration funding does not include resources necessary to carry out new programs that are proposed to come to AoA by FY 2012. Resources necessary to carry out these programs are requested separately as part of the overall funding being requested for these programs. In the case of programs being transferred to AoA, this is consistent with the authorizing statutes or appropriations language for these activities prior to their transfer. These include the State Health Insurance Assistance Program that will be transferred to AoA from the Centers for Medicare and Medicaid Services, the Senior Community Service Employment Program, that will be transferred from the Department of Labor, the Adult Protective Services Demonstration program, and the Community Living Assistance Services and Supports program that was embedded in AoA by the Secretary on January 5, 2011.

AoA's mission, as embodied in the OAA, is to develop a comprehensive and cost-effective system of services that helps elderly individuals to maintain their health and independence in their homes and communities. AoA does this by overseeing the development of coordinated systems of community-based care in States and localities that are responsive to the needs and preferences of older people and their family caregivers.

AGING SERVICES PROGRAM ADMINISTRATION

AoA is an agency whose finite administrative resources have failed to keep up with its growing responsibilities. In the last two years alone, AoA has received new funding under both the Affordable Care Act and the American Reinvestment and Recovery Act as well as funding under its regular appropriation for new and expanded activities including the implementation of new programs such as Lifespan Respite Care; the national implementation and rigorous evaluation of programs for reforming health and long-term care, including evidence-based programs such as the Chronic Disease Self Management Program (CDSMP) and Aging and Disability Resource Centers (ADRCs); and outreach activities to seniors and persons with disabilities to assist them in accessing Medicare benefits under the Low-Income Subsidy, Medicare Savings Program, and Medicare Part D. While these new mandates' dramatically expanded program responsibilities, AoA has been unable to add additional staff to keep pace; and has in fact seen staffing levels decline in the majority of the last eight years.

Additionally, AoA staff are increasingly being asked to develop and manage funding partnerships across multiple agencies, Departments and private philanthropies that support health and long-term care reforms related to seniors at the State and local level. These funding partnerships include initiatives involving AHRQ, CMS, CDC, HRSA and other Federal agencies, including the Departments of Veterans Affairs, Housing and Urban Development, Transportation, Agriculture, and the Corporation for National and Community Service, as well as a range of private philanthropies. While holding significant promise for improving service delivery and quality for seniors and persons with disabilities, insufficient administrative resources have made it difficult for staff to devote the time and attention needed to realize the full potential of these opportunities while still managing their other responsibilities.

For the agency as a whole, staffing has shrunk to 100 FTE in 2010 compared to 120 FTE in 2002. Of greater concern, staffing in AoA regional offices has fallen by more than 20 percent since 2002 to 31 FTE. AoA is no longer able to maintain a Regional Office in two of the ten regions and only maintains a single staff person in a third Region. Yet these are the Offices that going forward will be critical to insuring that the national aging services network is prepared to address the needs of the coming wave of seniors, and their desire to continue to live within their communities. Similarly, these are the Offices that AoA needs to be able to rely on to provide the network and through it, millions of seniors, with information about the implementation of enhancements to health care and human service programs that affect older individuals. Perhaps most importantly, regional offices are the primary points of contact for grantees and States with technical assistance questions and oversight issues. These offices are the primary method by which AoA interfaces with grantees to ensure program integrity.

AoA cannot successfully carry out its mission, and address the range of new responsibilities the agency is taking on, without these resources. To move forward, AoA needs to invest in regional staff, human capital development, information technology modernization, and other activities that have been delayed but are critically needed to effectively reach out to citizens, promote efficiency and innovation, and provide transparency and accountability.

AGING SERVICES PROGRAM ADMINISTRATION

Funding History:

Comparable funding for Program Administration during the past five years is as follows:

FY 2007	$18,379,000	112 FTE
FY 2008	$18,064,000	106 FTE
FY 2009	$18,696,000	103 FTE
FY 2010	$19,976,000	100 FTE
FY 2011 CR	$19,979,000	111 FTE*

*Includes 3 FTE funded from the mandatory ADRC appropriation.

Budget Request:

The FY 2012 request for Program Administration is $24,543,000, an increase of +$4,567,000 and +21 FTE over the FY 2010 enacted level. Sufficient resources are already expected to be available in FY 2011 to support +11 of these FTE. The FY 2012 request, therefore, includes funding to pay for the remaining +10 FTE, which will allow AoA to increase its regional staff by +7 FTE, to begin to bring all regional offices to levels that will allow AoA to meet the increasing range of responsibilities that it currently faces. The remaining +3 FTE will be used to address other needs related to AoA's growing responsibilities and enhanced partnerships to promote community living.

Of the additional +$4,567,000 that is in the request over the FY 2010 enacted level:

- $1,399,000 will be used to fund +10 new FTE to help AoA to meet the increased workload related to its expanding partnerships and increasing responsibilities;

- $1,025,000 will be used for higher costs of external services, taps and for accounting systems upgrades;

- $1,243,000 will be used to pay the General Services Administration for costs that it will need to incur to relocate AoA's Headquarters office to a new location.

- $900,000 will be used for tenant improvement/build-out costs related to the expiration of AoA's Headquarters lease in 2012.

The first priority for additional staffing resources requested for FY 2012 will be to make critical investments in the regions. Regional staffing is rapidly approaching the point where the regional offices as a whole will be unable to function effectively even as the services they provide will be most needed. Today regional staff levels stand at 31 FTE and are continuing to drop. There has been no regional office in Region III (Philadelphia) since the mid 1990's; no regional presence in Region VII (Kansas City) since 2008, and only a single staff person holding down the regional presence in Region X (Seattle). Most of the remaining regions are staffed at levels of three to four FTE each. These levels are barely adequate to manage existing regional business, and

wholly inadequate to address the level of responsibilities that the regions will face as AoA implements an increasing range of programs to enhance community living for older individuals and people with disabilities.

Lack of staff in the AoA Regional Offices has resulted in a number of serious issues relating to program administration at the State and Tribal levels. These issues include limitations on the ability of regional staff to work proactively with States and Tribes in program development, provide training of newly hired State and Tribal staff, and respond to daily customer service requests for technical assistance.

Turnover at the State and Tribal level can be extensive, from State and tribal fiscal staff on up to newly hired State Unit Directors. As staff turnover, there is a critical need for regional staff to orient, train and work with the new State and Tribal hires. Regional fiscal staff, for example, play a critical role in working with States and Tribes to complete audit closeouts, especially as increased OIG audit staff from the Department's Health Care Fraud and Abuse Campaign are identifying and working toward necessary systems corrections. While Regional Office staff can take a much needed active role to help States and Tribes enhance existing State systems and assist them in becoming more efficient, they currently lack the resources to do so. Other areas of work that have not been improved sufficiently over time because of a lack of regional staff include providing additional technical assistance in State Plan Development, continuous quality improvement efforts, and consistent and accurate data collection.

Today's emphasis in the regions is one of putting out fires, rather than preventing them. Regional staff also have been unable to devote adequate time at the State and Tribal levels to advancing new administration policy directions, and to assisting in the program implementation of new innovations coming out of the Central Office. Implementation of ADRCs offers one example where greater staff involvement at the regional level could have helped to advance the initial rollout of this program by helping ensure that these activities were well coordinated with AoA's core programs.

Not only are more staff needed in existing regional offices, AoA eventually needs to have a physical presence in all ten of the HHS regions. The absence of a regional office compromises AoA's ability to work in conjunction with the HHS Regional Directors as part of the larger regional team, as envisioned by HHS's *Regions Together* Initiative. Lack of physical presence also restricts AoA's ability to work on a range of common issues, including ADRC implementation, Chronic Disease Self-Management and implementation of enhancements to health care and human services programs that affect seniors with comparable regional staff from sister agencies including CMS and CDC.

AoA Headquarters Lease Renewal Process

The ten year lease on AoA's Central Office space is scheduled to end in October, 2012. AoA has been meeting with HHS Facilities staff regarding next steps. First and foremost, AoA will need to provide GSA with upfront good faith money, as required by law.. GSA requires an amount based on the number of FTE currently on board multiplied by a per capita cost of between $15,000 and $25,000. Using this rule of thumb, AoA estimated it would need $2.4 million in funding; half of this

amount has already been requested in a previous budget. Under either option, there are likely to be additional tenant improvement costs that would not be covered under the funding previously requested that will go to GSA. In particular, these include tenant improvement and build out/renovation costs. AoA continues to work closely with ASFR facilities staff to insure that adequate funds have been included in its request.

Performance Measures

Improving program efficiency, improving client outcomes, and effective targeting of services to vulnerable elders are the three performance measures used to assess the performance of the AoA's Aging Services programs as a whole. Program Administration is not directly measured by AoA's performance indicators, nor by specific outcomes, and it does not have specific output measures. Rather, the program provides the administrative resources that enable AoA to carry out its programmatic activities and achieve its performance goals.

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Community Living Assistance Services and Supports

	FY 2010 Enacted	FY 2011 Enacted	FY 2012 Request	FY 2012 +/- FY 2010
Community Living Assistance Services and Supports	--	--	$120,000,000	+$120,000,000
FTE	--	--	40	+40

Note: Funding for FY 2010 and FY 2011 is provided under Section 1005 of P.L. 111-152. 22 FTE are anticipated to be hired in FY 2011 using these funds. FY 2012 is a discretionary appropriations request.

Authorizing Legislation: Title XXXII of the Public Health Service Act

Allocation Method ..... Direct Federal/Contract

Program Description and Accomplishments:

The Community Living Assistance Services and Supports (CLASS) is a new self-funded, voluntary insurance program created under Title VIII of the Affordable Care Act (P.L. 111-148). Participating adults who meet eligibility requirements and have paid premiums for at least five years will receive a cash benefit to purchase long-term services and supports to help them remain independent. Under the law, benefits may only be paid from the CLASS Independence Fund, a trust fund established to manage and invest participants' premiums.

About 14 million people spend more than $230 billion a year on long-term services and supports to assist them with daily living.[71] About 56 million rely solely on unpaid care provided by family and friends.[72] Medicare only covers 100 days of skilled nursing care and only after hospitalization and its coverage of home health care is limited. While Medicaid is the largest public payer of these services, it is only available for people with very limited resources, often leading to middle class families spending their hard-earned resources until they qualify. The CLASS program represents a significant new opportunity for working adults to prepare financially to remain as independent as possible under a variety of future health circumstances.

To start enrollment, the CLASS program must achieve several objectives: 1) designate an actuarially-sound benefit plan by October 1, 2012; 2) increase public awareness and ensure public confidence in the benefit; and 3) develop an information technology (IT) and operations system capable of enrolling interested, eligible individuals. The CLASS program will develop robust, actuarially-sound models that the Secretary can use in the designation of the benefit plan to ensure that a fiscally-solvent program is established.

[71] Gleckman, Howard. 2010. "Long-Term Care Financing Reform: Lessons from the U.S. and Abroad." Washington, D.C.: Urban Institute.

[72] Johnson, Richard, Desmond Toohey and Joshua Weiner. 2007. "Meeting the Long-Term Care Needs of the Baby Boomers: How Changing Families Will Affect Paid Helpers and Institutions." Washington, D.C.: Urban Institute.

The CLASS program is making strides in all of these areas in FY 2011. AoA anticipates approximately 30 staff, for a total of 22 full time equivalents or FTEs, will be hired in FY 2011 using funds available from the Affordable Care Act. The staff will focus on the actuarial modeling, the design of the benefit, public awareness, IT development, and programmatic regulations.

In FY 2011, AoA anticipates achieving the following milestones:

- Begin developing a robust public information campaign;
- Seek public comment through the publication of a Notice of Proposed Rulemaking in the *Federal Register* on CLASS enrollment and eligibility criteria;
- Design and award contracts for an information technology system that will protect personally identifiable information and make it easy and efficient for the public to enroll in the program. The IT system design will follow the latest guidance from the Office of Management and Budget regarding IT modernization, including cloud computing solutions; and
- Convene the CLASS Independence Advisory Council to solicit input from experts and the public about the program.

Funding History:

Discretionary funding for CLASS during the past five years is as follows:

FY 2007 ..... $0
FY 2008 ..... $0
FY 2009 ..... $0
FY 2010 ..... [73]
FY 2011 Continuing Resolution ..... [74]

Budget Request:

The FY 2012 President's Budget request for CLASS is $120 million. This will be the first year CLASS will receive a discretionary appropriation. Created under the Affordable Care Act, in previous years this program had received funding through Section 1005 of P.L. 111-152, which provided funding to implement provisions of the Affordable Care Act.

The statute anticipates CLASS primarily funding its administrative operations through the CLASS Independence Fund. However, CLASS requires funds from a discretionary appropriation in FY 2012 to bridge the period between FY 2011 when funding is covered under Section 1005 of P.L. 111-152 and the point at which administrative funding can be drawn statutorily from premiums received. The information that follows describes the activities that will be necessary to designate a benefit plan by the statutory deadline of October 1, 2012 and begin enrollment.

[73] Funding in FY 2010 and FY 2011 is provided under Section 1005 of P.L. 111-152.

Information Technology ($13.4 million)
A robust information technology system is critical to ensuring the public enrolls smoothly and has confidence in the program. In addition, a quality information technology (IT) system should be fully integrated with other HHS IT infrastructure and reduce long-term costs by automating processes, allowing for fewer staff and minimizing the pressure on the administrative expenses authorized under the law. In FY 2011 the contracting process will begin and in FY 2012 the development contracts will continue and operations and maintenance contracts will be established to ensure an IT system is in place to begin enrollment.

Information and Education ($93.5 million)
The program's financial solvency and viability will depend on the enrollment of large numbers of participants. Employers and individuals will need to have access to information about the need for long-term services and supports and the benefits of the program. It will be crucial to educate employers about how to enroll their employees and to inform individuals about how to enroll directly in the program. A significant education initiative will help ensure that an adequate number of individuals will enroll to ensure program solvency. Recent Federal efforts have been similar in scope and funds. For example, the Census promotional efforts exceeded $350 million over two years. The CLASS effort necessitates a similar investment.

Board of Trustees & Advisory Committees ($2 million)
The CLASS statute authorizes two public advisory councils and a Board of Trustees. The CLASS Independence advisory council will serve as the policy and programmatic advisory council to the CLASS program, and has a short-term statutory charge to review at least three plan options and recommend a benefit plan to the Secretary that ensures financial solvency. As such, it will be a vital, transparent partner in engaging the public in FY 2012 and building public confidence in the program. The Personal Care Attendants Workforce advisory council has an intensive responsibility to focus on direct (i.e. "paid" personal care attendants) caregiving capacity across the country. The Board of Trustees will meet to ensure the solvency of the program. This request anticipates quarterly meetings for the CLASS Independence and the Personal Care Attendants Workforce advisory committees and at least one annual meeting of the Board of Trustees.

Staffing and Administrative Overhead ($11.1 million)
The CLASS program anticipates growing from a team of approximately 30 individuals (approximately 22 FTE) in FY 2011 to an estimated staff of 50 (approximately 40 FTE) in FY 2012. The CLASS program will hire experienced professionals in fields including long-term care insurance, education and outreach, information technology, actuarial science, and regulation management. The additional staff in FY 2012 is necessary to ensure a successful launch of the program. This request also covers overhead associated with staff, such as facilities, travel, and related support costs.

Output Table:

CLASS Program Output

Measure	Most Recent Result	FY 2012 Target	FY 2015 Target
CL 1: Increase the number of individuals enrolled in CLASS to 7.7 million by 2015 *(Output)*	N/A	Baseline	7.7 million

The output target is derived from the Congressional Budget Office's estimates prior to passage of the Affordable Care Act. This measure is subject to change based on the actuarial projection that accompanies the benefit plan designated by the Secretary.

Administration on Aging

Budget Authority by Object Class
(Dollars in thousands)

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	10,767	15,339	4,572
Other than full-time permanent (11.3)	414	609	195
Other personnel compensation (11.5)	188	277	89
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**11,369**	**16,225**	**4,857**
Civilian benefits (12.1)	2,795	5,587	2,792
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**14,163**	**21,812**	**7,649**
Travel and transportation of persons (21.0)	548	660	112
Transportation of things (22.0)	8	11	3
Rental payments to GSA (23.1)	2,180	2,870	690
Communication, utilities, and misc. charges (23.3)	155	228	73
Printing and reproduction (24.0)	27	40	13
Other Contractual Services:			
Advisory and assistance services (25.1)	22,099	133,936	111,837
Other services (25.2)	39	57	18
Purchase of goods and services from government accounts (25.3)	5,830	17,936	12,106
Operation and maintenance of facilities (25.4)	1	1	0
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	65	96	31
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**28,034**	**152,026**	**123,991**
Supplies and materials (26.0)	73	107	34
Equipment (31.0)	76	112	36
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0)	-	-	-
Grants, subsidies, and contributions (41.0)	2,343,193	2,060,078	(283,115)
Interest and dividends (43.0)	-	-	-
Refunds (44.0)	-	-	-
Total Non-Pay Costs	**2,374,294**	**2,216,132**	**(158,162)**
Total Budget Authority by Object Class	**2,388,457**	**2,237,944**	**(150,513)**

Administration on Aging

Salaries and Expenses
(Dollars in thousands)

	2010 Estimate	2012 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	10,767	15,339	4,572
Other than full-time permanent (11.3)	414	609	195
Other personnel compensation (11.5)	188	277	89
Military personnel (11.7)	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation	**11,369**	**16,225**	**4,856**
Civilian benefits (12.1)	2,795	5,587	2,792
Military benefits (12.2)	-	-	-
Benefits to former personnel (13.0)	-	-	-
Total Pay Costs	**14,163**	**21,812**	**7,649**
Travel and transportation of persons (21.0)	548	660	112
Transportation of things (22.0)	8	11	4
Rental payments to Others (23.2)	-	-	-
Communication, utilities, and misc. charges (23.3)	155	228	73
Printing and reproduction (24.0)	27	40	13
Other Contractual Services:			
Advisory and assistance services (25.1)	22,099	133,936	111,837
Other services (25.2)	39	57	18
Purchase of goods and services from government accounts (25.3)	5,830	17,936	- 12,106
Operation and maintenance of facilities (25.4)	1	1	0
Research and Development Contracts (25.5)	-	-	-
Medical care (25.6)	-	-	-
Operation and maintenance of equipment (25.7)	65	96	31
Subsistence and support of persons (25.8)	-	-	-
Subtotal Other Contractual Services	**28,034**	**152,026**	**123,992**
Supplies and materials (26.0)	73	107	34
Total Non-Pay Costs	**28,845**	**153,072**	**124,227**
Total Salary and Expense	**43,009**	**174,884**	**131,875**
Direct FTE	93	191	98

Administration on Aging

Detail of Full-Time Equivalent Employment (FTE)

	2010 Actual Civilian 1/	2010 Actual Military	2010 Actual Total	2011 Est. Civilian 1/	2011 Est. Military	2011 Est. Total	2012 Est. Civilian 2/	2012 Est. Military	2012 Est. Total
Immediate Office of the Assistant Secretary									
Direct:	8		8	10		10	10		10
Reimbursable:			0			0			0
Total:	8	0	8	10	0	10	10	0	10
Center for Management and Budget									
Direct:	17		17	22		22	24		24
Reimbursable:			0			0			0
Total:	17	0	17	22	0	22	24	0	24
Center for Policy, Planning and Evaluation									
Direct:	22		22	25		25	25		25
Reimbursable:			0			0			0
Total:	22	0	22	25	0	25	25	0	25
Center for Program Operations									
Direct:	22		22	20		20	28		28
Reimbursable:	2		2	3		3	3		3
Total:	24	0	24	23	0	23	31	0	31
Office of Community Living Assistance, Services and Supports									
Direct:	0		0			0	40		40
Reimbursable:	0		0			0			0
Total:	0	0	0	0	0	0	40	0	40
Office of Regional Operations									
Direct:	24		24	26		26	41		41
Reimbursable:	5		5	5		5	5		5
Total:	29	0	29	31	0	31	46	0	46
OPDIV FTE Total	**100**	**0**	**100**	**111**	**0**	**111**	**176**	**0**	**176**

Average GS Grade

FY 2007	12.5
FY 2008	12.9
FY 2009	13.0
FY 2010	12.8
FY 2011	12.8

1/ FY 2010 and FY 2011 do not include FTE for either the State Health Insurance Assistance Program (SHIPs) or the Senior Community Service Employment Program (SCSEP) which are proposed for transfer to AoA. These figures are not currently available as regional staff work on these and multiple other programs. FTE are also not included in these years for the CLASS program since they are funded in these years from the $1 billion Health Care Implementation fund and accounted for directly against those dollars.

2/ In FY 2012, FTE for SHIPs and for SCSEP have been annualized, as is standard, to reflect the fact that not all of these staff will be on board at the beginning of the year. As a result, while AoA anticipates filling 10 positions for SHIPs and 16 positions for SCSEP in FY 2012, only 5 FTE and 8 FTE respectively are included in the FTE breakdown above. Similarly, 20 new hires are anticipated over those on board in FY 2011 for CLASS, hired over the couse of FY 2012, and these are reflected above as 10 annualized FTE.

Administration on Aging

Detail of Positions

	2010 Actual 1/	2011 CR 1/	2012 Estimate
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 2/	$195,200	$195,200	$195,200
ES-0 4/	3	3	7
Subtotal	3	3	7
Total - ES Salary 2/ 3/	$571,000	$603,400	$1,485,100
GS-15	20	22	27
GS-14	18	19	36
GS-13	39	39	84
GS-12	9	12	19
GS-11	7	7	10
GS-10	1	2	2
GS-9	9	8	10
GS-8	0	0	0
GS-7	1	2	2
GS-6	1	1	1
GS-5	0	0	0
GS-4	0	0	0
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal	105	112	191
Total - GS Salary			
Average ES level	0	0	0
Average ES salary	$190,333	$201,133	$212,157
Average GS grade	12.8	12.8	12.9
Average GS salary	126,560	124,224	117,960

1/ Comparable numbers are not available in FY 2010 and FY 2011 for the Community Living Assistance for Services and Supports (CLASS) Program, or for the two programs proposed for transfer to AoA in FY 2012, the State Health Insurance Assistance Program (SHIPs) or the Senior Community Service Employment Program (SCSEP).

2/ Includes Salary and Benefits.

3/ The SES level for FY 2010 is stated at the actual lower level due to the position being vacant for part of the year.

4/ 7 SES in FY 2012 include 2 Senior Level (SL) Staff.

Administration on Aging

Programs Proposed for Elimination

No programs are proposed for elimination in FY 2012.

SIGNIFICANT ITEMS IN HOUSE AND SENATE APPROPRIATIONS COMMITTEE REPORTS

FY 2012 Senate Appropriations Committee Report Language (Senate Report 111-243)

Item

Civic Engagement - The Committee is aware of new research suggesting that interventions designed to promote health and function in seniors through everyday activity may improve the brain's plasticity, or the ability to bounce back, in key regions that support executive function. The Committee urges AoA to continue its work in advancing the field of civic engagement for older Americans by partnering with organizations with proven experience in creating robust, innovative opportunities for baby boomers and other older Americans to serve their communities while helping them to maintain and improve their health.

Action taken or to be taken

The Administration on Aging continues to support a grant to the National Council on the Aging to identify and provide technical assistance and other support to local programs that can become national multi-generational and civic engagement models for utilizing older volunteers in meaningful direct services. This grant, extended through 2011, focuses on three target populations: 1) older relatives caring for grandchildren; 2) families caring for children with special needs; and 3) caregivers of frail elderly. As reported in 2009, nineteen local grants were awarded. Preliminary evaluation shows that use of the criteria provides an accurate assessment of program effectiveness, impact, sustainability and replicability.

Next steps include synthesis and dissemination of best practices and setting the stage for widespread replication of the most promising models, using strategies and on-line tools grounded in diffusion of innovations theory and practice. This will be most helpful to the aging services network, which is heavily dependent on volunteers in providing its services.

In 2010, AoA announced a grant competition to fund a National Aging Civic Engagement Technical Center (the Center). The National Association of Area Agencies on Aging was awarded the grant. The Center will help AoA and the Aging Network use volunteers, especially Boomers, more effectively; develop AoA's and the Aging Network's leadership in civic engagement; and expand the Aging Network's existing use of volunteers. The Center, working together with the AARP Foundation, the National Association of State Units on Aging and Disabilities and Senior Service America Incorporated, will 1) conduct a systematic inquiry on civic engagement; 2) recommend an Action Plan in civic engagement for AoA and the Aging Network; 3) develop a national communication and outreach strategy; 4) provide training and technical assistance; 5) identify effective practices, develop and promote models; and 6) create a continuous quality improvement strategy. Outcomes include measurable change in Network's ability to meet needs and preferences of volunteers. Products include Action Plans, volunteer management toolkits, model practice fact sheets, conferences, website widgets, and a final report.

In addition to the above, AoA continues its relationship and coordination with the Corporation for National and Community Service. We expect to work closely with the Corporation as we expand our civic engagement efforts.

Item

Older Adults and Mental Health - The Committee notes that approximately 20 to 25 percent of older adults have a mental or behavioral health problem. Older white males (age 85 and over) currently have the highest rates of suicide of any group in the United States. The Committee acknowledges the importance of addressing the mental and behavioral health needs of older adults and encourages AoA to implement the Older Americans Act provisions related to mental and behavioral health. Specifically, the Committee urges AoA to designate an officer to administer the mental health services authorized under the act, work to improve the delivery of mental health screening and treatment services for older individuals, and increase public awareness and reduce the stigma associated with mental disorders in older individuals

Action taken or to be taken

The Administration on Aging is an active partner with the Substance Abuse and Mental Health Services Administration (SAMHSA) on a variety of initiatives. Through the SAMHSA Mental Health Transformation (MHT) initiative, AoA participates in the Federal Executive Steering Committee, the Federal Partner Senior Workgroup, and the Rural Mental Health Workgroup, as well as serving in an advisory capacity on a study to examine sustainability among SAMSHA MHT grantees. AoA also participates in the HHS Behavioral Health Coordinating Committee, as well as its Prescription Drug Abuse sub-committee. In addition, AoA also sits on a SAMSHA-convened workgroup currently developing a Model State Plan to assist State Agencies on Aging and State Mental Health Departments in enhancing their partnerships around older adult activities.

Through its health programs, AoA has also encouraged States and Area Agencies on Aging to use evidence-based programs designed to reduce reduce/prevent depression and improve quality of life in older adults including Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) and PEARLS (Program to Encourage Rewarding Lives for Seniors. State plan guidance developed by AoA for FY 2011, similar to past guidance, will direct States and Area Agencies on Aging to implement the provisions related to mental and behavioral health that were signed into law as part of the Older Americans Act Amendments of 2006.

Item

Transportation - The Committee is aware of the rapidly growing need for transportation services for older Americans. In order to expand resources to meet this need, the Committee encourages AoA to fund section 416 of the Older Americans Act. Such funding could support successful, entrepreneurial models of economically sustainable transportation that supplement publicly funded services by accessing private resources and voluntary local community support, and that do not rely on Federal or other public financial assistance after 5 years.

Action taken or to be taken
While section 416 of the Older Americans Act was not funded in FY 2010, the Administration on Aging recognizes the importance of supporting and fostering innovation in serving older consumers and their caregivers. Since 2004, AoA has been a key partner in the United We Ride initiative, to promote the participation of the aging services network in the coordination of transportation services at the Federal, State and local levels. AoA has provided guidance to State Units on Aging in the development of their State plans on aging and have encouraged their describing coordination activities and discussions with State and local transportation entities.

AoA continues to be involved in United We Ride, chairing the Health, Wellness, and Transportation workgroup. This workgroup focuses on ensuring that 1) transportation is not a barrier for transportation-disadvantaged populations seeking to access their health care, general health, and wellness needs (i.e. preventive care, hospitals, nutritional resources, and exercise) and 2) transportation options provide these populations the mobility that keeps them active and healthier, and therefore out of expensive nursing home care and acute treatment. To support our collaboration, maximize flexibility of funding and enhance services to older adults, Older Americans Act grantees have the option to use Title III B funds to meet the match requirements for programs administered by the Federal Transit Administration.

AoA has issued guidance allowing OAA Title III-B funds be used as match for FTA programs. AoA continues to be involved in the development and ongoing operation of the National Center on Senior Transportation (NCST) (http://www.seniortransportation.net), a Technical Assistance center funded by the Federal Transit Administration and administered by Easter Seals Project Action and the National Association of Area Agencies on Aging. AoA is an active member of NCST's National Steering Committee. One of the major activities of the NCST has been the funding of demonstration grants to promote innovations in the coordination and delivery of transportation services to older adults and their caregivers.

Item
Aging Network Support Activities - The Committee believes that AoA should use the funds previously allocated to ADRCs to focus on other programs that will help seniors remain healthy and live independently in their own communities. Specifically the Committee directs AoA to prioritize evidence-based disease prevention activities, such as the chronic disease self-management program (CDSMP). The Committee notes that Recovery Act funding provided to AoA for the CDSMP will end this year, and encourages AoA to use fiscal year 2011 funding to continue this program, which has been proven to reduce the effects of chronic conditions, improve health status and reduce unnecessary healthcare use among seniors.

Action taken or to be taken
The Aging and Disability Resource Center (ADRC) grant program is a critical vehicle for achieving streamlined, integrated access to State systems of long-term services and supports. ADRCs have been funded jointly by the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS). These grants provide infrastructure support to implement ADRC programs.

Funding for chronic disease self-management programs (CDSMP) for FY 2010 is sufficient to carry AoA CDSMP programs through FY 2011. In FY 2012, $10 million in new funding is requested for CDSMP. Therefore, there is no need for AoA to prioritize evidence-based disease prevention activities, such as the chronic disease self-management program (CDSMP) and fund these instead of ADRC activities.

Item

Alzheimer's Disease Demonstration Grants to States - The Committee recommends a funding level of $11,464,000 for Alzheimer's disease demonstration grants to States. This amount is the same as the administration request. The comparable funding level for fiscal year 2010 is $11,462,000. This program provides competitively awarded matching grants to States to encourage program innovation and coordination of public and private services for individuals with Alzheimer's disease and their families. The Committee urges the AoA to continue this program's focus on expanding services to people in the early stages of dementia and providing chronic care management.

Action taken or to be taken

The Administration on Aging continues to expand the availability of coordinated supportive services for persons with Alzheimer's disease and their families. In FY 2010, 32 cooperative agreements were awarded to 22 states, the District of Columbia and Puerto Rico to deliver evidence-based and innovative care coordination for persons with Alzheimer's disease and their families through the aging services network, community-based organizations, and partnerships with institutions of higher education. In particular, AoA awarded innovation grants for supportive services that enable individuals with Alzheimer's disease to remain in the community longer, promote early intervention and chronic care management, and enhance the ability of state systems to provide effective and cost-efficient supportive services for persons with Alzheimer's disease and their families. A key focus of the evaluation criteria for awarding Alzheimer's disease supportive services grants is reaching underserved and culturally-diverse populations.

In FY 2011, grants will expand the repertoire of evidence-based and innovative Alzheimer's disease interventions, particularly those that promote early intervention and chronic care management, and promote the embedding of successful interventions into State health and long-term services and supports systems across the country.

Item

Lifespan Respite Care - The Committee recommends $7,000,000 for the Lifespan Respite Care program. The administration requested $5,000,000 for this activity and the comparable fiscal year 2010 level is $2,500,000. The Lifespan Respite Care program provides grants to States to expand respite care services to family caregivers, improve the local coordination of respite care resources, and improve access and quality of respite care services, thereby reducing family caregiver strain. The Committee has provided additional funds to the Lifespan Respite Care program as part of the administration's Caregiver Initiative. In carrying out the program, the

Committee urges AoA to ensure that State agencies and ADRCs serve all age groups, chronic conditions and disability categories.

Action taken or to be taken

The Administration on Aging began implementation of the Lifespan Respite Care Program in FY 2009 and those activities continued into FY 2010. Throughout the program development process, AoA has carefully considered the requirements of the Lifespan Respite Care Act as well as Congressional intent as specified in the Committee Report accompanying the authorizing statute.

In 2009 and 2010, both the Statute and Committee Report were consulted during the development of the program announcements making competitive grant opportunities available to eligible state agencies. Further, AoA has worked closely with representatives of the National Lifespan Respite Taskforce to ensure that the needs of various age groups, disability categories and chronic conditions were understood and addressed by applicants.

To help ensure that State agencies and Aging and Disability Resource Centers use the funds to serve all age and disability groups, AoA employed the following strategies in FYs 2009 and 2010 and will continue to employ these strategies in future years:

First, applications from eligible State agencies are minimally required to:

1. Demonstrate the support and active involvement of a range of government and non-government, private, nonprofit and other organizations with a stake in serving all populations eligible to receive services under the Lifespan Respite Care Act;

2. Demonstrate thorough understanding of the population to be served, including knowledge of the family caregiver population for whom lifespan respite program services are to be provided, or for whom respite care workers and volunteers will be recruited and trained;

3. Demonstrate a meaningful and active inclusion of the state's Respite Coalition or organization to ensure statewide implementation of Lifespan Respite Programs across all age and disability categories; and

4. Demonstrate the broadest possible collaboration with relevant respite stakeholders from across the age and disability spectrum. Further, applicants must propose a program that immediately addresses the respite needs of all ages and special needs categories. No phase-in or preferences for age groups or disability categories are permitted.

Second, grantees are being monitored via semi-annual and annual reports as well as through ongoing communication with the AoA Program Officer to ensure the required elements outlined above are being fulfilled. Additionally, AoA facilitates regular email and telephone communications with the individual grantees and the group to share information and strategies related to program development and implementation.

Finally, AoA recognizes the necessity of providing technical assistance (TA) to the grantees as well as States yet to be funded under the Lifespan Respite Program. To that end, AoA has a Cooperative Agreement with the Family Caregiver Alliance in San Francisco with a sub-contract to the ARCH National Respite Network and Resource Center (ARCH) to design and disseminate training materials and TA on a range of issues associated with Lifespan Respite Care Program development and implementation.

During the first year of funded TA, ARCH assessed grantee training and TA needs, conducting individual consultations via phone, email and in person with each of the grantees to identify specific training needs and to address specific program development issues. Additionally, ARCH has developed and archived webinars on Lifespan Respite programs, the importance of collaboration, and working with faith-based communities to develop respite programs. ARCH has developed and/or updated numerous fact sheets and publications on a range of issues of interest to grantees as they develop their programs. These activities will continue in FY 2010 and FY 2011 in close collaboration with the AoA Program Officer.