DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year 2016

Administration for Community Living

Justification of Estimates for Appropriations Committees

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I am pleased to present the Administration for Community Living's (ACL) FY 2016 President's Budget request, totaling $2.1 billion, an increase of +$177 million, which focuses on two main goals. First it sustains the core ACL services that allow older adults and people of all ages with disabilities to remain independent. To this end, +$106 million would support investments in home and community based services (including nutrition programs) for seniors, Independent Living services for those with disabilities, and programs that support caregivers for older adults. Second, the request would add +$70 million to increase innovation and efficiency of ACL programs and to help them to modernize and be better positioned to meet future service needs.

I would like to highlight several of these initiatives. Our Family Support Initiative would direct $15 million to encourage the use of community assets and opportunities to help families to reduce stress, improve emotional well-being, develop support skills, and plan for the future. Over 80 percent of the long-term services and supports provided to older Americans come from family caregivers while over 75 percent of people with developmental disabilities in this country rely primarily on family members, often for most of their lives.

Second, ACL proposes to devote $20 million to modernize its older adult nutrition programs. These funds would support competitive grants to translate research into evidence-based models for delivering services at the community level. Nutrition services are particularly critical to keeping older Americans healthy and preventing the need for more costly medical interventions, and this effort would increase the knowledge base of nutrition providers, drive improved health outcomes for program recipients by promoting higher service quality, and increase program efficiency through innovative service delivery models.

ACL is also proposing to increase funding by $21 million to continue to develop a national Adult Protective Services data system, including grants to states to test and develop infrastructure, while also providing funding for key research. Research in the area of adult protective services is essential to the future development of evidence-based interventions that will effectively prevent, identify, report, and respond to abuse of adults of all ages.

The FY 2016 request also incorporates funds for programs transferred from the Department of Education by the Workforce Innovation and Opportunity Act. These programs—the National Institute on Disability, Independent Living, and Rehabilitation Research; Independent Living; and Assistive Technology—help further ACL's vision that all people, regardless of age and disability, live with dignity, make their own choices, and participate fully in society.

The three years since ACL's creation have been a time of growth, learning, and a rededication of our efforts to ensure that all Americans, regardless of age or disability, can live and thrive in their communities. This budget will allow us to continue serving our populations and position us for greater successes on their behalf.

Kathy Greenlee
Administrator and Assistant Secretary for Aging

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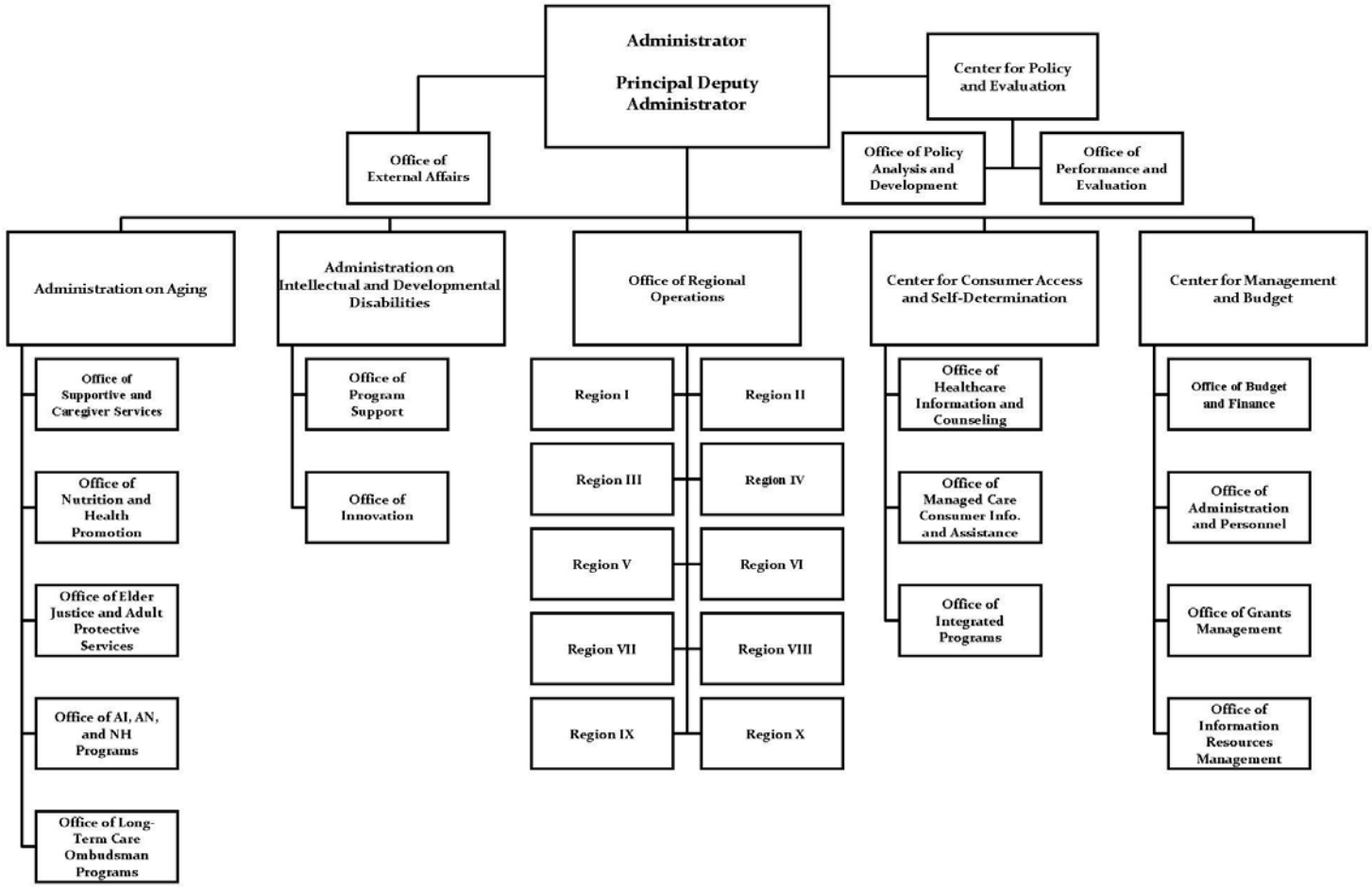
ADMINISTRATION FOR COMMUNITY LIVING ORGANIZATIONAL CHART



This Organization Chart reflects the ACL structure as established in the Statement of Organization, Functions, and Delegations of Authority published in the Federal Register on October 16, 2014. This structure does not incorporate future changes that will be made as a result of programs transferred to ACL by the Workforce Innovation and Opportunity Act.

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Introduction and Mission

The Administration for Community Living (ACL) is the single agency charged to work with States, localities, Tribal organizations, nonprofit organizations, businesses, and families to help older adults and people with disabilities live independently and fully participate in their communities. ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. Those with disabilities or functional limitations of any type, regardless of age, have a common interest: access to home and community-based supports and services that can help individuals to fully participate in all aspects of society, including having the option to live at home, which can be vital to an individual's well-being, instead of moving into an institutional setting. ACL works to improve this access through program lines that address the unique needs of each population.

Through its Administration on Aging (AoA), ACL works with and through its national aging services network to promote the development of comprehensive and coordinated systems of home and community-based services and supports that are responsive to the needs and preferences of older adults and their caregivers. The network is comprised of 56 State and Territorial Units on Aging (SUA), 618 Area Agencies on Aging (AAA), 264 Indian Tribal and Native Hawaiian organizations, nearly 20,000 direct service providers, and hundreds of thousands of volunteers. These services complement existing medical and health care systems, help prevent hospital readmissions, and support some of life's most basic functions, such as bathing or preparing meals. These programs also support family caregivers, address issues of exploitation, neglect and abuse of older adults, and adapt services to the needs of Native Americans.

Through its Administration on Intellectual and Developmental Disabilities (AIDD), ACL works through a network of States that includes, in each State and Territory, State Councils on Developmental Disabilities, State Protection and Advocacy systems, and University Centers for Excellence in Developmental Disabilities (UCEDDs) to address the needs of those with intellectual and developmental disabilities. AIDD programs fund capacity-building and systems change efforts to ensure that people with developmental disabilities and their families participate in the design of and have access to needed community services, individualized supports, and other forms of assistance that promote self-determination, independence, productivity, integration, and inclusion in all facets of community life. The transfer of the Independent Living programs and the National Institute on Disability, Independent Living and Rehabilitation Research from the Department of Education is a significant step in the evolution of ACL. These programs will allow ACL to further address the needs of individuals with disabilities, as well as enhance the agency's effort to support and implement disability research.

Finally, ACL promotes consistency and coordination in community living policy and seeks to better align the health, social, employment, family and community supports that are critical to both older adults and people with disabilities, through its Center for Policy and Evaluation (CPE) and Center for Consumer Access and Self-Determination (CCASD). These Centers support programs and activities that help provide both older Americans and people with disabilities information and access to long-term services and support, including the Assistive Technology program that was transferred by WIOA. Other programs transferred to ACL in recent years, such as the Limb Loss program, (transferred from the Centers for Disease Control in FY 2015), the Paralysis Resource Center (transferred from the Centers for Disease Control in FY 2014), and the State Health Insurance Assistance Program (transferred from the Centers for Medicare and Medicaid Services in FY 2014) also have expanded ACL's ability to fulfill this important objective.

Overview of Budget Request

The FY 2016 discretionary request for the Administration for Community Living (ACL) is $2,095,655,000, an increase of +$176,572,000 over the FY 2015 enacted level. The budget includes funding for three programs – Assistive Technology, Independent Living and the National Institute on Disability, Independent Living and Rehabilitation Research – transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act (WIOA).

In addition to ACL's discretionary increases discussed below, the FY 2016 program level includes $27,700,000 from the Prevention and Public Health Fund authorized by the Affordable Care Act. Of this, $8,000,000 would continue to fund Chronic Disease Self-Management Education programs, $5,000,000 would support senior falls prevention programs, and the remaining $14,700,000 would continue activities under the President's Alzheimer's Initiative, including an outreach campaign and the development of more dementia-capable long-term service and support systems designed to meet the needs of individuals with Alzheimer's Disease and their caregivers. The overall program level also includes an estimated $8,710,000 in mandatory funding for FY 2016 for Health Care Fraud and Abuse Control activities.

ACL's FY 2016 Request

ACL's FY 2016 request focuses first on sustaining the core ACL services that allow older adults and people of all ages with disabilities to remain independent and in their communities. To this end, an additional $105,950,000 would support investments in home and community based services (including nutrition programs) for seniors, Independent Living services for those with disabilities, and programs that support caregivers and families. Second, the request would target a total of $70,275,000 for initiatives that focus on increasing innovation and improving the efficiency of ACL programs with an eye towards modernizing and better positioning them to meet future service needs of the aging and disability populations. These dollars would target the following areas: nutrition, increasing support for families caring for older adults and/or supporting people with disabilities, continued development of Adult Protective Services systems, Aging and Disability Resources Centers, additional research by the National Institute on Disability, Independent Living and Rehabilitation Research, and an initiative to assist youth with developmental disabilities to transition from adolescence to productive adulthood. The remainder of the increase over FY 2015 would provide the additional resources needed to fully support the operations of the three programs transferred under WIOA and address costs related to the relocation of ACL's central office.

Supporting Services to Increase the Independence of Older Adults and People with Disabilities

Services provided through ACL's core service programs can be the difference between remaining independent and having to seek institutional care for many older adults and individuals with disabilities. Yet in recent years, flat or declining budgets at both the Federal and State level have resulted in declines in service levels even as the populations in need have grown. Recognizing these trends and importance of addressing the growing need for these services, ACL invests in three key areas:

- Home and Community-Based Services: ACL invests +$43,458,000 to strengthen home and community-based services, including +$38,458,000 for services for older adults (HCBSS), for a total of $386,182,000; and +$5,000,000 for Centers for Independent Living (CILs), for a total of $83,305,000. HCBSS for older adults include transportation, case management, personal care services, chore services, and physical fitness programs. In combination with state and local funding, the budget will support over 28 million hours of assistance to seniors unable to perform daily activities; more than 23 million rides for critical activities such as visiting the doctor, pharmacy, or grocery stores; and nearly 8 million hours of adult day services. CILs provide people with disabilities a variety of services, including information and referral, independent living skills training, peer counseling, transition services, and individual and systems advocacy. The additional funding will enable CILs to continue to provide these services and also begin to address the new core service requirements added by WIOA. ACL's home and community-based services are a critical part of state and local efforts to ensure that older adults and people with disabilities can live at home with the supports they need in the community, rather than turning to more expensive institutional care.

- Nutrition Services: ACL invests +$42,842,000 (+$39,900,000 for Congregate and Home-Delivered Meals and +$2,942,000 for Native American Nutrition and Supportive Services) for a total of $883,657,000. Nutrition Services are a vital support for older Americans nationwide, many of whom are low-income, as meals provided through home delivery or in senior centers allow many older Americans to remain independent and living at home for as long as possible, delaying or preventing the need for more costly institutional services. This increase in funding, leveraged further by state and local funding, will allow States to provide a total of 208 million meals to over 2 million older Americans nationwide, helping to halt recent declines in service levels.

- Caregiver Services— ACL invests an additional +$5,769,000 (+$5,000,000 for Family Caregiver Support Services and +$769,000 for Native American Caregiver Support) for a total of $157,386,000 in State and Native American caregiver support services for older adults. Increased support for caregivers is critical because it is often their

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

Modernizing and Positioning Services for the Future

This budget also includes investments to modernize ACL's core services by emphasizing greater innovation and efficiency. By utilizing evidence-based practices and promoting the adoption of proven models and practices across our aging and disability networks, ACL will help to ensure that services are able to address the evolving needs of the populations we serve and target resources to where they are most needed. ACL invests in the following areas:

- Family Support Initiative: Aligned with the President's effort on supporting middle-class families, ACL invests +$15,000,000 in a comprehensive and sustainable national effort to ensure the optimal deployment of public and private resources at the state and community level to assist family members caring for older adults and/or supporting people with disabilities across the lifespan. This initiative will incorporate evidence-based practices into existing public programs, will encourage innovation in local communities, and will leverage additional public and private resources to bolster the ability of families to support their loved ones to live self-determined and fulfilling lives, while still maintaining healthy, rewarding and economically viable balance for all family members. Over 80 percent of the long-term services and supports provided to older Americans come from family caregivers while over 75 percent of people with developmental disabilities in this country rely primarily on family members, often for most of their lives. The initiative will encourage use of community assets and opportunities to help families reduce stress, improve emotional well-being, develop support skills and knowledge, and plan for the future. Special attention will be given to efforts that assist families with balancing workforce participation and caregiving responsibilities, and those facing the dual demands of caring for older parents while raising children and/or supporting a family member with a disability, as well as approaches that reduce "caregiver burnout," a major contributor to out of home placement into residential care.

- Modernizing Senior Nutrition Programs: ACL invests +$20,000,000 to enhance and modernize its key nutrition programs. These funds would support competitive grants to translate research into evidence-based models for delivering services at the community level. Nutrition services are particularly critical to keeping older Americans healthy and preventing the need for more costly medical interventions, and this effort would increase the knowledge base of our nutrition providers, drive improved health outcomes for

program recipients by promoting higher service quality, and increase program efficiency through innovative service delivery models.

- National Adult Protective Services System: ACL's request includes an additional +$21,000,000 million, for a total of $25,000,000 in Elder Justice funding to continue to address the damaging impact of abuse, neglect, and exploitation on the health and independence of adults (including seniors and adults with disabilities) by making strategic investments in Adult Protective Services, research, and evaluation activities. With this funding, ACL will continue to develop a national Adult Protective Services data system, including grants to states to test and develop infrastructure, while also providing funding for key research. Research in the area of adult protective services is essential to the future development of evidence-based interventions that will effectively prevent, identify, report, and respond to abuse of adults of all ages.

- Streamlining Access to Community-Based Services: The Budget requests an additional +$13,881,000, for a total of $20,000,000, for the Aging and Disability Resource Center program, which has a proven track record of success in supporting state efforts to develop more efficient, cost-effective, and consumer-responsive systems of information, one-on-one person-centered counseling, and streamlined access to long-term services and supports at the community level. Aging and Disability Resource Centers make it easier for Americans nation-wide to learn about and obtain the long-term services and supports they need to remain living in their own homes and communities. At the same time, the budget would increases funding for the Lifespan Respite program by +$2,640,000, to $5,000,000, which funds grants to improve the quality and access to respite care for family caregivers of children or adults of any age with support needs. The budget also includes an additional $1,000,000 for the National Clearinghouse for Long-Term Care Information, which increases awareness of the need to plan ahead for long-term supports and services.

- Youth Transitions and Other Services for Individuals with Intellectual and Developmental Disabilities: The Budget provides +$5,000,000 within ACL's Projects of National Significance as part of a broader HHS effort to help young Americans with disabilities in the midst of difficult transitions and provides them with the tools and supports they need to enter adulthood. This initiative will help youth with intellectual or developmental disabilities transition successfully from adolescence and the supportive environment of school into an adulthood that offers them post-secondary education and work opportunities, ultimately reducing the likelihood that they become solely dependent on Social Security, Medicaid, or other similar benefits. In addition, +$643,000 more would be provided for Projects of National Significance to support the needs of people

with intellectual or developmental disabilities, and +$945,000 would be provided for University Centers for Excellence in Developmental Disabilities (UCEDDs).

- Conducting Innovative Disability Research: The request also includes +$4,030,000 to bring the budget for the National Institute on Disability, Independent Living, and Rehabilitation Research to $108,000,000. NIDILRR generates knowledge and promotes its use to assist people with disabilities in performing activities of their choice in the community, while also seeking to expand society's capacity to provide full opportunities and accommodations for people with disabilities. This program focuses on research in areas such as employment, health and function, technology for access and function, independent living and community integration, and other associated disability research areas for individuals with disabilities of all ages.

Funding for core ACL programs under the Older Americans Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Assistive Technology Act, the Rehabilitation Act, and other legislation would otherwise be maintained in this request. ACL's programs provide community-based services and supports to a growing segment of the population, which in turn can reduce costs to other public programs such as Medicaid. The U.S. population over age 60 is projected to increase by 20 percent between 2014 and 2020, from 64.8 million to 77.6 million.[1] The 2010 census puts the total number of Americans with disabilities at 56.7 million people, of which over 12 million required assistance with activities of daily living or instrumental activities of daily living.[2] Studies indicate that individuals with developmental disabilities currently comprise between 1.2 and 1.65 percent of the U.S. population, or between 3.7 and 5.2 million individuals.[3] The number of seniors age 65 and older with severe disabilities – defined as 3 or more limitations in activities of daily living – that are at greatest risk of nursing home admission, is projected to increase by more than 20 percent by the year 2020.[4] Meeting the long-term support needs of these populations can place tremendous strain on families, and if families become overwhelmed by the challenges of caregiving, the costs of providing this care will fall on other, more costly, government resources. For example, a 2014 Rand Corporation study found that the care provided by informal (family and friend) caregivers of elderly adults has an

[1] U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.

[2] U.S. Census Bureau, "Americans With Disabilities: 2010," http://www.census.gov/prod/2012pubs/p70-131.pdf, Issued July 2012, Accessed 21 August 2014.

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

[4] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

estimated economic value of $522 billion.[5] Maintaining funding for community-based services and supports, including supports for family caregivers, is therefore critical to delaying, reducing, or eliminating reliance upon institutional residential services, a more expensive and less preferable option.

ACL's request also includes $40,063,000 for Program Administration, an increase of +$2,354,000 over the FY 2015 enacted level to support an estimated 198 FTEs of the 221 total FTEs for the agency. This amount includes administrative costs for the implementation of programs transferring from the Department of Education as a result of the Workforce Innovation and Opportunity Act. It also provides funds for the higher rent costs projected as a result of ACL's headquarters move in CY 2015 to the Switzer building.

[5] *The Opportunity Costs of Informal Elder-Care in the United States.* Rand Corporation. http://www.rand.org/pubs/external_publications/EP66196.html.

Overview of Performance

ACL's mission is to maximize the independence, well-being, and health of older adults, people with disabilities across the lifespan, and their families and caregivers. ACL facilitates achievement of that mission through improvements in the analysis and availability of performance information while also enhancing the rigor of program evaluations. ACL's focus on performance management, transparency and use of evidence will carry through as we integrate ACL's newest programs that serve the aging and disability communities (e.g. State Health Insurance Assistance Program (SHIP), Assistive Technology Program, National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), etc.). Below, an overview of performance is organized around programs devoted to older adults and their caregivers and programs that serve the disability community along with a discussion of evaluation, data collection and dissemination activities; and performance management.

Overview of Performance: Aging Programs

ACL program activities that support older adults and their caregivers have a fundamental common purpose: to develop a comprehensive, coordinated and cost-effective system of home and community-based services that help elderly individuals maintain their health and independence in their homes and communities (Older Americans Act Section 301). This purpose led ACL to focus on three performance measures: 1) improving client outcomes; 2) effectively targeting services to vulnerable populations; and 3) improving efficiency. Each measure is representative of activities across the Aging Services Program budget and progress toward achievement is tracked using a number of indicators. Taken together, the three measures and their corresponding performance indicators are designed to reflect ACL's goals and objectives and in turn measure success in accomplishing ACL's mission.

Performance Highlights

An analysis of ACL's performance trends shows that through FY 2013 most outcome indicators have been maintained or steadily improved. While most service counts are declining due to flat funding and inflationary factors, ACL outcome indicators demonstrate that services are continuing to be effective. Following are some key successes that are indicative of the potential of ACL and the Aging Network to meet demographic and fiscal challenges.

ACL programs help older Americans remain independent and in the community: Older adults that have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home entry. Measures of the Aging Network's success at serving this vulnerable population is a proxy for nursing home delay and diversion. In FY 2005, one-third of home-delivered nutrition clients lived with three or more ADL impairments and by FY 2013 the proportion grew to 43.5%, a 30% increase.

The FY 2016 performance budget includes eleven core performance indicators supporting ACL's commitment to improving client outcomes and four indicators for effective targeting, capturing success with regards to increasing services to family caregivers and the most economically and socially vulnerable. While some indicators experience year-to-year variation, all indicators have trended in the desired direction and the vast majority meet or exceed targets annually.

These performance indicators support ACL's overall mission and its strategic plan Goal 3, "Work with older adults and people with disabilities as they fully engage and participate in their communities, make informed decisions, and exercise self-determination and control about their independence, well-being, and health" and Goal 4, "Enable people with disability and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports to family caregivers." They are strongly tied to HHS Goal 3, "Advance the Health, Safety and Well-being of the American People" and specifically Objectives 3.B (Promote economic and social well-being for individuals, families, and communities), 3.C (Improve the accessibility and quality of supportive services for people with disabilities and older adults), and 3.D (Promote prevention and wellness across the lifespan).

ACL aging 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. ACL has significantly increased the number of clients served per million dollars of Older Americans Act (OAA) Title III funding over the last decade. In FY 2013 The Aging Network served 9,753 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, ACL and the Aging Network have met or exceeded efficiency targets. For FY 2016, there are two efficiency indicators for older adult program activities, both consistently meet or exceed targets.

Improvements in program efficiency support ACL's mission and Goal 5 of ACL's Strategic Plan, "Implement management and workforce practices that support the integrity and efficient operations of programs serving people with disabilities and older adults and ensure stewardship of taxpayers' dollars." These indicators are linked to HHS's Strategic Plan Goal 4, "Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs" and specifically Objective 4.A (Strengthen program integrity and responsible stewardship by reducing improper payments, fighting fraud and integrating financial, performance, and risk management). Through optimal utilization of resources, improvements in program efficiency ensure that affordable and accessible community-based long-term care is available to promote the well-being of seniors and their family caregivers.

ACL programs are high quality: OAA clients' report that services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these

services. In 2013, over 94 percent of transportation clients and caregivers rated services good to excellent. To help ensure the continuation of these trends, AoA uses discretionary funding to test innovative service delivery models for state and local program entities that show promise for generating measurable improvements in program activities. Quality indicators are consistently high and are expected to meet or exceed targets in FY2016.

Performance indicators of the quality of ACL programs and services support the agency's overall mission and Goal 4 of its strategic plan, "Enable people with disability and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports to family caregivers." These indicators support the HHS Goal 3, "Advance the Health, Safety and Well-being of the American People" and specifically Objective 3.C (Improve the accessibility and quality of supportive services for people with disabilities and older adults).

Overview of Performance: Disability Programs

The ACL works with disability partners in every state and territory to facilitate achievement of the ACL mission and the goals embodied in the Rehabilitation Act and Developmental Disabilities Assistance and Bill of Rights Act (DD Act). The ACL disability programs' performance measurement strategy focuses on four measures that address outcomes related to the purpose of the DD Act: to assist people with intellectual and developmental disabilities to become independent and integrated into their community, protect their legal and human rights, and improve the quality of services and supports. These measures support ACL Goals 2, 3 and 4: "Protect and enhance the rights; and prevent the abuse, neglect, and exploitation of older adults and people with disabilities", "Work with older adults and people with disabilities as they fully engage and participate in their communities, make informed decisions, and exercise self-determination and control about their independence, well-being, and health" and "Enable people with disabilities and older adults to live in the community through the availability of and access to high-quality long-term services and supports, including supports for families and caregivers." ACL's disability programs performance measures are most strongly linked with HHS Strategic Plan Goal 3, "Advance the Health, Safety and Well-Being of the American People" and specifically Objectives 3.B (Promote economic and social well-being for individuals, families, and communities) and 3.C (Improve the accessibility and quality of supportive services for people with disabilities and older adults). The following section highlights the DD Network's accomplishments in three outcome focus areas plus efforts to improve program efficiency.

State Councils on Developmental Disabilities

State Councils on Developmental Disabilities work to promote the development of a comprehensive, person-centered and family-centered system that provides a coordinated array of culturally-competent services and other forms of assistance for people with developmental

disabilities and their families. A key activity for many State Councils is leadership training to individuals with developmental disabilities and their family members to enhance civic engagement for creating more effective policy solutions. Many participants go on to leadership positions on State Councils and other disability focused organizations and engage in systems change efforts. ACL measures the success of these activities in terms of the percent of people reached by State Councils who are independent, self-sufficient and integrated into the community. The results have consistently trended up and have met or exceeded performance targets since FY 2008 and are expected to continue to do so in FY 2016.

Given limited resources and economic pressures that create barriers to systems change and capacity building, the efficient use of federal funds is paramount. ACL illustrates the Network's efficiency tied to outcomes through measuring the number of individuals reached who are independent, self-sufficient and integrated into the community per $1000 of federal funding. This measure has shown an increasing trend since FY 2008. Targets have been reached or exceeded for the previous five years.

Developmental Disabilities Protection and Advocacy Program

The Developmental Disabilities Protection and Advocacy program (PADD) establishes and maintains a system to protect the legal and human rights of all persons with developmental disabilities. PADD grantees are highly successful at meeting the needs of complainants: The annual performance measure of the percentage of individuals who have their complaint of abuse, neglect, discrimination, or other human or civil rights corrected compared to the total assisted demonstrates the rate of successful benefits accruing from the program. The rate of success has been consistently over 80 percent and trended upward since FY 2011.

University Centers for Excellence in Developmental Disabilities

UCEDDs are interdisciplinary academic centers that engage in interdisciplinary pre-service training, community services, research, and information dissemination activities. One of the unique contributions UCEDDs make to the intellectual and developmental disabilities community is the provision of interdisciplinary training to students from a wide array of professional backgrounds to improve the quality of services and supports for people with developmental disabilities. Pre-service training is a mechanism through which UCEDDs advance practice, scholarship and policy that impact the lives of people with developmental disabilities and their families. UCEDDs performance in this area is measured as the percentage of individuals with developmental disabilities receiving the benefit of services through activities in which UCEDD trained professionals were involved. The result for FY 2013 exceeded the target at forty percent. Since FY 2009 this measure has steadily increased.

As the programs transferred from the Department of Education (National Institute on Disability, Independent Living, and Rehabilitation Research; Independent Living Programs; and Assistive

Technology Programs) become fully integrated into ACL, program performance will be reviewed and a set of meaningful measures will be adopted to manage performance of these activities. The integration of these programs' performance management activities will add to ACL's and the disability networks already robust program and advocacy work.

ACL's Commitment to Transparency, Accountability and Evaluation

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

- Supported increased access to program data and performance information. ACL continues to enhance the data portal (www.agid.acl.gov) which provides data visualization tools, downloadable data files, and data analysis tools which enables the development of benchmarks and trend analyses at the national and at the state level. Grantee reporting tools now include 5-year trend analysis and improved tools for identifying missing data. ACL recently launched new webpages that provide access to a wider array of Census and grantee performance data in easily accessible and 508 compliant formats. ACL also supports efforts to facilitate developer use of federal data sets through http://www.data.gov/ and http://www.healthdata.gov/.

- Enhanced support of efforts to measure Long-Term Services and Supports including service quality. ACL continues to partner with the National Institute on Disability, Independent Living and Rehabilitation Research (now a component of ACL) and others to advance data collection efforts to measure state progress with regards to competitive employment, housing choice, self-determination and service quality. ACL supports The National Core Indicators, Aging and Disability project that is working with states to develop a suite of surveys for states to use to measure LTSS system performance and quality across all ages, disabilities and payers.

- Supported an on-going effort to enhance data collection and information dissemination to better understand and promote effective supports for families and for individuals who direct their own support. The intention of the six-year grant (Data Collection for Supporting Families) includes: generation of a standard set of key state indicators that can be used to benchmark progress; implementation of annual data collection effort that produces reliable, accurate national and state-by-state data about family supports that is comparable across states; production of an interactive website with an online data dashboard that can be used to track, compare and contrast progress made on achieving outcomes at the national and state levels; and design of a plan to develop an electronic, web-based data distribution system that will be easily accessible to families and people

with intellectual or developmental disabilities. The grantee's project website can be accessed here: https://fisp.umn.edu/.

In additional to robust performance measurement strategies, ACL employs rigorous program evaluation methods including longitudinal data collection and matched comparison groups. ACL is engaged in multiple program research and evaluation efforts that include nutrition and caregiver programs as well as efforts regarding employment systems change. New efforts are also underway to conduct evaluability assessments of selected programs as a precursor to formal evaluation designs. A key accomplishment in FY2014 was finalizing OMB PRA clearance to allow the collection of social security number (SSN) as part of the Title III-C Elderly Nutrition Services Program (ENSP) evaluation. This will allow ACL to link program recipients, and members of a matched comparison group, with their Medicare records for the purpose of analyzing the effects of the Title III-C ENSP on the health of recipients. While ACL is highly committed to all evaluation activities, a key priority in FY2015 and 2016 will be dissemination of data from completed evaluations to the field and developing programmatic recommendations that can help ACL to improve programs. Following are brief descriptions of the array of evaluation activities underway at ACL.

- The OAA Title III-C Elderly Nutrition Services program evaluation employs a complex design that includes three major components and several subcomponents. The major components include a process study that covers a large array of topics; a cost study that measures the actual cost of providing a meal by cost category; and an individual outcome study. The individual outcome study will measure the program's success at meeting the legislative intent of the program (reduce hunger and social isolation while improving health and well-being of consumers). In addition, ACL/AoA and Centers for Medicare & Medicaid Services (CMS) are entering into an Inter-Agency Agreement that will enhance this evaluation to include prospective analysis of healthcare utilization and cost. Data collection for the process study is ongoing with 100% of State Units on Aging and 80% of AAAs completing both parts of their data request (92% responded to the survey and 83% responded to a separate data form).

- The evaluation of the Title III-E National Family Caregiver Support Program (NFCSP) will be the first for this OAA program. It is designed as a longitudinal study with a comparison group so that the effects of the five service categories can be measured over time. The evaluation seeks to assess the impact of the program at the individual, program, and long-term care (LTC) policy/home and community-based service (HCBS) system levels. The evaluation will also examine how the program meets its goals and the extent to which the program has contributed to long-term care system efficiency. The process evaluation phase of the study is scheduled to begin data collection in early 2015. The outcome evaluation phase, to be completed in 2017, will gather information from a

sample of caregivers receiving NFCSP services and from a comparable group of caregivers not receiving NFCSP services.

- An evaluability assessment of the OAA Title VI Tribal Grant Program is underway to provide ACL with a description of the program models in the field, an assessment of how well defined the programs/program services are, and information about what Federal and Tribal stakeholders want to get from an evaluation and how the evaluation data findings would be used. ACL will use this information to identify the most promising program components and sites for a future evaluation.

- The evaluation of the Aging and Disability Resource Centers (ADRC) was completed in November 2014. Process data collection was completed during the fall of 2013 (preliminary results: http://www.aoa.acl.gov/Program_Results/docs/ADRC.pdf), and consumer-level data collection concluded in March 2014. The evaluation includes a process evaluation examining populations served, services provided, and organizational characteristics including funding levels and partnerships. The evaluation also an outcome study that collected information, from approximately 600 consumers at 33 sites, about their experience with an ADRC. A final report was completed in November 2014 and is expected to be posted on the ACL website in January 2105.

- The Administration on Intellectual and Developmental Disabilities awarded a six-year contract in 2011 to evaluate the eight Partnerships in Employment Systems Change projects. The evaluation of the eight employment projects will inform ACL and its partners how to best work to support competitive, integrated employment systems for individuals with intellectual and developmental disabilities. A recent project update found that early grantee outcomes include: creation, modification or alignment of policies that promote employment such as, Alaska's passage in April 2014 of an Employment First Bill; removal of barriers to employment through agency and policy changes, such as, New York's pilot testing of a Job Readiness Curriculum; increased number of individuals with I/DD accessing early work experiences such as, California and Wisconsin reporting that more than half of the pilot site students are engaged in Integrated, Competitive Employment (ICE); and increased cross-system and cross-agency collaboration, such as, California, Iowa and Tennessee developing shared data systems.

ACL's Internal Performance Management Plan

ACL's programs provide grants to the Aging and Developmental Disability Networks. Since ACL is not directly involved in hands-on service provision, the Agency employs a program performance improvement strategy with multiple components (e.g. collaboration with other agencies and organizations, enhanced partnerships between Aging and DD Networks, technical

assistance, and senior leadership's involvement in performance management) that are expected to yield performance improvements. Examples of activity supporting the overall strategy follow:

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

Activities cited above are conducted directly by ACL's Central and Regional Office staff, as well as through discretionary grants and contracts.

In FY 2014, ACL initiated a formula grant monitoring framework for Older Americans Act Title III and VII state formula grants. The framework combines assessments of grantee's progress toward program goals and objectives with identification of risk or instances of fraud, waste and abuse. An integrated team from program staff, regional offices, Office of Performance and Evaluation and Office of Grants Management are developing monitoring tools, evaluating monitoring efforts and providing staff training on the process. The approach will involve the review of a wide variety of information such as state plans, financial reports, program data and performance measures. State monitoring reports will include findings, recommendations and corrective actions; grantee response with timelines for corrective actions; and grant conditions when necessary. The financial component of the new framework is being tested using two quarters of fiscal data with the goal to automate fiscal reports. Automated fiscal reporting will improve efficiency and provide the ability for more extensive reviews which are essential to a successful monitoring framework and the targeting of technical assistance and continuous quality improvements. Based on the success with OAA Title III and VII programs, ACL will develop customized monitoring frameworks for AIDD State Grant Programs, OAA Title VI (Tribal Formula Grants), and ACL discretionary grants.

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

ACL also monitors senior manager performance by including measurable performance targets in performance plans. These performance targets must support ACL's mission and are consistent with the Agency's performance measures. This and other performance information are used during the year to update ACL's Executive Leadership so that adjustments can be made as needed to ACL programs; it is also discussed and used as appropriate in ACL internal discussions as decisions are made each year regarding funding levels to propose to the Department and OMB.

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

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All Purpose Table

Administration for Community Living
(dollars in thousands)

Program	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Health & Independence for Older Adults				
Home & Community-Based Supportive Services	347,724	347,724	386,182	38,458
Nutrition Services	811,191	814,657	874,557	59,900
Preventive Health Services	19,848	19,848	19,848	--
Chronic Disease Self-Management Education [PPHF]	*8,000*	*8,000*	*8,000*	--
Falls Prevention [PPHF]	*5,000*	*5,000*	*5,000*	--
Native American Nutrition & Supportive Services	26,158	26,158	29,100	2,942
Aging Network Support Activities	7,406	9,961	9,961	--
Holocaust Survivor Assistance {non-add}	--	*2,500*	*2,500*	--
Subtotal, Health & Independence for Older Adults	1,225,327	1,231,348	1,332,648	101,300
Caregiver & Family Support Services				
Family Caregiver Support Services	145,586	145,586	150,586	5,000
Family Support	--	--	15,000	15,000
Native American Caregiver Support Services	6,031	6,031	6,800	769
Alzheimer's Disease Supportive Services Program	3,772	3,800	3,800	--
Alzheimer's Disease Initiative -- Services [PPHF]	*10,500*	*10,500*	*10,500*	--
Lifespan Respite Care	2,342	2,360	5,000	2,640
Subtotal, Caregiver & Family Support Services	168,231	168,277	191,686	23,409
Protection of Vulnerable Adults				
Long-Term Care Ombudsman Program	15,885	15,885	15,885	--
Prevention of Elder Abuse & Neglect	4,773	4,773	4,773	--
Senior Medicare Patrol Program	8,888	8,910	8,910	--
Health Care Fraud and Abuse Control [HCFAC] 1/	*6,591*	*8,710*	*8,710*	--
Elder Rights Support Activities	3,845	7,874	28,874	21,000
Elder Justice {non-add}	--	*4,000*	*25,000*	*21,000*
Subtotal, Protection of Vulnerable Adults	39,982	46,152	67,152	21,000
Disability Programs, Research & Services				
State Councils on Developmental Disabilities	70,692	71,692	71,692	--
Developmental Disabilities Protection and Advocacy	38,634	38,734	38,734	--
University Centers for Excellence in Developmental Disabilities	36,674	37,674	38,619	945
Projects of National Significance	8,821	8,857	14,500	5,643
Youth Transitions {non-add}	--	--	*5,000*	*5,000*
National Institute on Disability, Independent Living, and Rehabilitation Research 4/	103,970	103,970	108,000	4,030
Independent Living 4/	101,183	101,183	106,183	5,000
Subtotal, Disability Programs, Research & Services	359,974	362,110	377,728	15,618

Consumer Information, Access & Outreach				
Aging and Disability Resource Centers	15,347	6,119	20,000	13,881
Aging and Disability Resource Centers [Discretionary] {non-add}	*6,067*	*6,119*	*20,000*	*13,881*
Aging and Disability Resource Centers [Mandatory] 2/ {non-add}	*9,280*	--	--	--
State Health Insurance Assistance Program	52,115	52,115	52,115	--
Voting Access for People with Disabilities (HAVA)	4,963	4,963	4,963	--
Assistive Technology 4/	33,000	33,000	31,000	(2,000)
Alzheimer's Disease Initiative--Communications Campaign [PPHF]	*4,200*	*4,200*	*4,200*	--
National Clearinghouse for Long-Term Care Information	--	--	1,000	1,000
Limb Loss Resource Center 5/	2,810	2,800	2,810	10
Paralysis Resource Center	6,683	6,700	6,700	--
Medicare Improvements for Patients and Providers Act [TRA/BBA] 3/	*17,500*	*8,750*	--	*(8,750)*
Subtotal, Consumer Information, Access & Outreach	136,618	118,647	122,788	4,141
Program Administration 6/	37,476	37,709	40,063	2,354
Subtotal, Program Level	1,967,608	1,964,243	2,132,065	167,822
Less: Funds From Mandatory Sources				
HCFAC Wedge Funds 1/	(6,591)	(8,710)	(8,710)	--
ACA Direct Appropriations 2/	(9,280)	--	--	--
Prevention & Public Health Fund (ACA)	(27,700)	(27,700)	(27,700)	--
Medicare Improvements for Patients and Providers Act 3/	(17,500)	(8,750)	--	8,750
Total, Discretionary Budget Authority	1,906,537	1,919,083	2,095,655	176,572

1/ $8,710,146 is a placeholder amount in FY 2016. The Secretary and Attorney General will determine the final amount.

2/ Mandatory funding for ADRCs was provided under PL 111-148 in FY 2014. In FY 2016, all funding requested for this program is discretionary.

3/ Includes funding for ADRCs, AAAs, and the National Center for Benefits Outreach Enrollment. Funding for the SHIPs is appropriated to CMS and administered by ACL through an Intra-Departmental Delegation of Authority (IDDA).

4/ Funding for FY 2014 is displayed comparably. Funding for FY 2015 reflects the estimated annualized amount transferred to ACL, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting funding for these programs directly.

5/ Funding for FY 2014 is displayed comparably. Funding for this program was appropriated to ACL beginning in FY 2015.

6/ Funding for FY 2014 includes estimated comparable funding for programs transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act. Funding for FY 2015 includes the annualized amount transferred to ACL for program administration, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting these funds directly.

Appropriations Language

Administration for Community Living
Aging and Disability Services Programs
(including transfer of funds)

For carrying out, to the extent not otherwise provided, the **[OAA]** *Older Americans Act of 1965 ("OAA")*, titles III and XXIX of the PHS Act, section 119 of the Medicare Improvements for Patients and Providers Act of 2008, *section 6021(d) of the Deficit Reduction Act of 2005,* title XX–B of the Social Security Act, the Developmental Disabilities Assistance and Bill of Rights Act, parts 2 and 5 of subtitle D of title II of the Help America Vote Act of 2002, *the Assistive Technology Act of 1998, titles II and VII (and section 14 with respect to such titles) of the Rehabilitation Act of 1973,* and for Department-wide coordination of policy and program activities that assist individuals with disabilities, **[$1,621,141,000]** *$2,043,540,000,* together with $52,115,000 to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to carry out section 4360 of the Omnibus Budget Reconciliation Act of 1990: *Provided*, That, amounts appropriated under this heading may be used for grants to States under section 361 of the OAA only for disease prevention and health promotion programs and activities which have been demonstrated through rigorous evaluation to be evidence-based and effective: *Provided further*, That, *notwithstanding section 206(g) of the OAA, up to one percent of amounts appropriated to carry out programs authorized under title III of such Act shall be available for conducting evaluations, training, and technical assistance:* **[none of the funds provided shall be used to carry out sections 1701 and 1703 of the PHS Act (with respect to chronic disease self-management activity grants), except that such funds may be used for necessary expenses associated with administering any such grants awarded prior to the date of the enactment of this Act:]** *Provided further*, That

notwithstanding any other provision of this Act, funds made available under this heading to carry out section 311 of the OAA may be transferred to the Secretary of Agriculture in accordance with such section.

Appropriations Language Analysis

Administration for Community Living

Language Provision	Explanation
…section 6021(d) of the Deficit Reduction Act of 2005…	Provides authorization for the National Clearinghouse for Long-Term Care Information
… the Assistive Technology Act of 1998, titles II and VII (and section 14 with respect to such titles) of the Rehabilitation Act of 1973…	Provides authorization for the Assistive Technology, Independent Living, and the National Institute on Disability, Independent Living, and Rehabilitation Research programs transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act
Provided further, That, notwithstanding section 206(g) of the OAA, up to one percent of amounts appropriated to carry out programs authorized under title III of such Act shall be available for conducting evaluations, training, and technical assistance:	Authorizes ACL to increase its set-aside from 0.5% to up to 1% of funding provided under Title III of the OAA to evaluate OAA programs and disseminate the results throughout the Aging Services Network

Amounts Available for Obligation

Administration for Community Living

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)	1,610,143,000	1,621,141,000	2,043,540,000
Across-the-board reductions (L/HHS)	--	--	--
Subtotal, Appropriation (L/HHS, Ag, or Interior)	1,610,143,000	1,621,141,000	2,043,540,000
Secretary's Transfer	-4,358,000	--	--
Subtotal, adjusted appropriation	1,605,785,000	1,621,141,000	2,043,540,000
Transfer of Funds to Department of Agriculture 1/	-2,391,605	-2,549,334	--
Comparable transfer from Centers for Disease Control 2/	2,810,000		--
Comparable transfer from Department of Education 3/	245,827,000	245,827,000	--
Subtotal, adjusted general fund discr. appropriation	1,852,030,395	1,864,418,666	2,043,540,000
Total, Discretionary Appropriation	**1,852,030,395**	**1,864,418,666**	**2,043,540,000**
Mandatory Appropriation:			
Appropriation (PPACA) ADRCs	9,280,000	--	--
Appropriation (PPACA) Prevention Funds	27,700,000	27,700,000	27,700,000
Appropriation (Taxpayer Relief Act) MIPPA	17,500,000	8,750,000	--
Subtotal, adjusted mandatory. appropriation	54,480,000	36,450,000	27,700,000
Offsetting collections from:			
Trust Funds: HCFAC	6,590,974	8,710,146	8,710,146
Trust Funds: SHIPs HI/SMI	52,115,000	52,115,000	52,115,000
Subtotal, spending authority from offsetting collections	58,705,974	60,825,146	60,825,146
Unobligated balance, lapsing	684,512	--	--
Total obligations	**1,965,900,881**	**1,961,693,812**	**2,132,065,146**

1/ Funding transferred to the Department of Agriculture is included within the Nutrition Services Incentive Program. Discretionary Appropriations on this table will therefore differ by this amount from amounts listed on ACL's All Purpose Table.

2/ Funding shown includes comparable amounts appropriated to CDC for the Limb Loss Resource Center program transferred to ACL in FY 2015.

3/ Funding shown includes FY 2014 estimated comparable amounts and FY 2015 estimated annualized amounts appropriated to the Department of Education for programs transferred to ACL by the Workforce Innovation and Opportunity Act.

Summary of Changes

Administration for Community Living
(Dollars in thousands)

2015	
Total estimated budget authority	1,919,083
(Obligations)	
2016	
Total estimated budget authority	2,095,648
(Obligations)	
Net Change	176,565

	FY 2016 PB FTE	FY 2016 PB BA	FY 2016 +/- FY 2015 FTE	FY 2016 +/- FY 2015 BA
Increases:				
A. Program:				
1. Home & Community Based Supportive Services	--	386,182	--	38,458
2. Nutrition Services	--	874,557	--	59,900
3. Native American Nutrition & Supportive Services	--	29,100	--	2,942
4. Family Caregiver Support Services	--	150,586	--	5,000
5. Family Support	--	15,000	--	15,000
6. Native American Caregiver Support Services	--	6,800	--	769
7. Lifespan Respite Care	--	5,000	--	2,640
8. Elder Rights Support Activities	4	28,874	2	21,000
9. University Centers for Excellence in Developmental Disabilities	--	38,619	--	945
10. Projects of National Significance	--	14,500	--	5,643
11. National Institute on Disability, Independent Living, and Rehab Research	--	108,000	--	4,030
12. Independent Living	--	106,183	--	5,000
13. Aging and Disability Resource Centers	--	20,000	--	13,881
14. National Clearinghouse for Long-Term Care Information	--	1,000	--	1,000
15. Limb Loss Resource Center	--	2,810	--	10
16. Program Administration	198	40,063	7	2,354
Subtotal, Program Increases	202	1,827,274	9	178,572
Total Increases		1,827,274		178,572
Decreases:				
A. Program:				
1. Assistive Technology		31000		-2000
Subtotal, Program Decreases		31,000		2,000
Total Decreases				2,000
Net Change				176,572

Budget Authority by Activity

Administration for Community Living
(Dollars in Thousands)

	FY 2014 Actual	FY 2015 Enacted	FY 2016 President's Budget
Health & Independence for Older Adults			
Home & Community-Based Supportive Services	347,724	347,724	386,182
Nutrition Services	811,191	814,657	874,557
Preventive Health Services	19,848	19,848	19,848
Native American Nutrition & Supportive Services	26,158	26,158	29,100
Aging Network Support Activities	7,406	9,961	9,961
Subtotal, Health & Independence for Older Adults	1,212,327	1,218,348	1,319,648
Caregiver & Family Support Services			
Family Caregiver Support Services	145,586	145,586	150,586
Family Support	--	--	15,000
Native American Caregiver Support Services	6,031	6,031	6,800
Alzheimer's Disease Supportive Services Program	3,772	3,800	3,800
Lifespan Respite Care	2,342	2,360	5,000
Subtotal, Caregiver & Family Support Services	157,731	157,777	181,186
Protection of Vulnerable Adults			
Long-Term Care Ombudsman Program	15,885	15,885	15,885
Prevention of Elder Abuse & Neglect	4,773	4,773	4,773
Senior Medicare Patrol Program	8,888	8,910	8,910
Elder Rights Support Activities	3,845	7,874	28,874
Subtotal, Vulnerable Adults	33,391	37,442	58,442
Disability Programs, Research & Services			
State Councils on Developmental Disabilities	70,692	71,692	71,692
Protection and Advocacy	38,634	38,734	38,734
University Centers for Excellence in Developmental Disabilities	36,674	37,674	38,619
Projects of National Significance	8,821	8,857	14,500
National Institute on Disability, Independent Living, and Rehab. Research 4/	103,970	103,970	108,000
Independent Living 4/	101,183	101,183	106,183
Subtotal, Disability Programs, Research & Services	359,974	362,110	377,728

Consumer Information, Access & Outreach			
Aging and Disability Resource Centers [Discretionary]	6,067	6,119	20,000
State Health Insurance Assistance Program	52,115	52,115	52,115
Voting Access for People with Disabilities (HAVA)	4,963	4,963	4,963
Assistive Technology 4/	33,000	33,000	31,000
National Clearinghouse for Long-Term Care Information 3/	--	--	1,000
Limb Loss Resource Center 5/	2,810	2,800	2,810
Paralysis Resource Center	6,683	6,700	6,700
Subtotal, Consumer Information, Access & Outreach	105,638	105,697	118,588
Program Administration	37,476	37,709	40,056
Total, Discretionary Budget Authority	**1,906,537**	**1,919,083**	**2,095,648**
HCFAC Wedge Funds 1/	6,591	8,710	8,710
ACA Direct Appropriations	9,280	--	--
ADRC Mandatory Funding (ACA) {Non-Add} 2/	9,280	--	--
Prevention & Public Health Fund (ACA)	27,700	27,700	27,700
Chronic Disease Self-Management Education {Non-Add}	8,000	8,000	8,000
Falls Prevention {Non-Add}	5,000	5,000	5,000
Alzheimer's Disease Initiative - Services {Non-Add}	10,500	10,500	10,500
Alzheimer's Disease Initiative - Communications {Non-Add}	4,200	4,200	4,200
Taxpayer Relief Act/Bipartisan Budget Act 3/	17,500	8,750	--
Aging and Disability Resource Centers {Non-Add}	5,000	2,500	--
Area Agencies on Aging {Non-Add}	7,500	3,750	--
National Center for Benefits Outreach & Enrollment {Non-Add}	5,000	2,500	--
Total, Program Level	**1,967,608**	**1,964,243**	**2,132,058**

1/ $8,710,146 is a placeholder amount in FY 2016. The Secretary and Attorney General will determine the final amount.

2/ Mandatory funding for ADRCs was provided under PL 111-148 in FY 2014. In FY 2016, all funding requested for this program is discretionary.

3/ Includes funding for ADRCs, AAAs, and the National Center for Benefits Outreach Enrollment. Funding for the SHIPs is appropriated to CMS and administered by ACL through an Intra-Departmental Delegation of Authority (IDDA).

4/ Funding for FY 2014 is displayed comparably. Funding for FY 2015 reflects the estimated annualized amount transferred to ACL, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting funding for these programs directly.

5/ Funding for FY 2014 is displayed comparably. Funding for this program was transferred to ACL beginning in FY 2015.

6/ Funding for FY 2014 includes estimated comparable funding for programs transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act. Funding for FY 2015 includes the estimated annualized amount transferred to ACL for program administration, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting these funds directly.

Authorizing Legislation

Administration for Community Living

	FY 2015 Amount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Expired	347,724,000	Expired	386,182,000
2) Nutrition Services OAA Sections 311, 331, and 336 1/	Expired	814,657,000	Expired	874,557,000
3) Preventive Health Services: OAA Section 361	Expired	19,848,000	Expired	19,848,000
4) National Family Caregiver Support Program: OAA Section 371	Expired	145,586,000	Expired	150,586,000
5) Family Support: OAA Title IV, and Developmental Disabilities Assistance and Bill of Rights Act Section 163	Expired	0	Expired	15,000,000
6) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Expired	26,158,000	Expired	29,100,000
7) Native American Caregiver Support Program: OAA Section 631	Expired	6,031,000	Expired	6,800,000
8) Long-Term Care Ombudsman Program: OAA Section 712	Expired	15,885,000	Expired	15,885,000
9) Prevention of Elder Abuse and Neglect: OAA Section 721	Expired	4,773,000	Expired	4,773,000
10) Senior Medicare Patrol Program OAA Sections 201 and 202, as amended	Expired	8,910,000	Expired	8,910,000
11) Elder Rights Support Activities OAA Sections 201, 202, and 411, 751, and 752, as amended. Social Security Act, Title XX-B, Section 2042	Expired	7,874,000	Expired	28,874,000
12) Aging Network Support Activities: OAA Sections 202, 215 and 411	Expired	9,961,000	Expired	9,961,000
13) Alzheimer's Disease Demonstration Grants 1/ Public Health Services Act Section 398	Expired	3,800,000	Expired	3,800,000
14) Lifespan Respite Care 1/ Lifespan Respite Care Act of 2006 and Public Health Service Act Title XXIX	Expired	2,360,000	Expired	5,000,000
15) Program Administration: OAA Section 205	Expired	37,709,000	Expired	40,063,000

	FY 2015 Amount Authorized	FY 2015 Appropriations Act	FY 2016 Amount Authorized	FY 2016 President's Budget
16) Aging and Disability Resource Centers				
OAA Section 202b	Expired	6,119,000	Expired	20,000,000
17) State Health Insurance Assistance Program:				
Omnibus Budget Reconciliation Act of 1990 Section 4360	Expired	52,115,000	Expired	52,115,000
18) State Councils on Developmental Disabilities				
DD Act Section 129(a)	Expired	71,692,000	Expired	71,692,000
19) Protection and Advocacy				
DD Act Section 145	Expired	38,734,000	Expired	38,734,000
20) University Centers for Excellence in Developmental Disabilities				
DD Act Section 156	Expired	37,674,000	Expired	38,619,000
21) Projects of National Significance				
DD Act Section 163	Expired	8,857,000	Expired	14,500,000
22) Voting Assistance for People with Disabilities				
Help America Vote Act Section 291	Expired	4,963,000	Expired	4,963,000
23) Paralysis Resource Center 1/				
Public Health Services Act Sections 311 and 317(k)(2)	N/A	6,700,000	N/A	6,700,000
24) National Clearinghouse on Long-Term Care Information				
Deficit Reduction Act of 2005 Section 6021(d)	Expired	0	Expired	1,000,000
25) National Institute on Disability, Independent Living, and Rehabilitation Research 4/				
Rehabilitation Act of 1973, Title II	103,970,000	103,970,000	112,001,000	108,000,000
26) Independent Living 4/				
Rehabilitation Act of 1973, Title VII, Parts B, C, and Chapter 2				
Independent Living State Grants	22,878,000	22,878,000	24,645,000	22,878,000
Centers for Independent Living	78,305,000	78,305,000	84,353,000	83,305,000
27) Assistive Technology 4/				
Assistive Technology Act of 1998	Expired	33,000,000	Expired	31,000,000
28) Limb Loss Resource Center 5/				
Public Health Services Act, Title III	N/A	2,800,000	N/A	2,810,000
Total Request Level		$1,919,083,000		$2,095,655,000
Unfunded Authorizations:				
1) Legal Assistance:				
OAA Section 731	Such Sums	0	Such Sums	0

Appropriations History Table

Administration for Community Living

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
FY 2007	1,334,835,000	1,390,306,000	1,380,516,000	1,383,007,000
FY 2008 /1	1,335,146,000	1,417,189,000	1,451,585,000	1,438,567,000
FY 2008 Rescission	--	--	--	-25,131,765
FY 2009 /2	1,381,384,000	1,492,741,000	1,478,156,000	1,491,343,000
FY 2009 ARRA /4	--	--	--	100,000,000
FY 2010 /3	1,491,343,000	1,530,881,000	1,495,038,000	1,516,297,000
FY 2010 Transfer				-224,298
FY 2011	1,624,733,000	1,651,178,000	1,659,383,000	1,500,323,000
FY 2011 Rescission				-3,000,646
FY 2012 /5	2,237,944,000	1,471,324,000	1,534,701,000	1,473,703,000
FY 2012 Rescission				-2,785,299
FY 2013 /6	1,978,336,000	N/A	1,708,105,000	1,645,291,724
FY 2013 Rescission	--	--	--	-3,290,583
FY 2013 Sequestration	--	--	--	-82,768,046
FY 2013 Transfer	--	--	--	-6,133,066
FY 2014 /7	2,094,755,000	N/A	1,716,664,000	1,662,258,000
FY 2015 /8	2,062,279,000	N/A	1,676,152,000	1,673,256,000
FY 2016	2,095,655,000			

1/ Includes $2,659,000 in FY 2008 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
2/ Includes $2,681,000 in FY 2009 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
3/ American Recovery and Reinvestment Act of 2009, Public Law 111-5.
4/ Includes $2,544,103,000 in FY 2010 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursuant to Public Law 110-19.
5/ Includes $2,025,445 in FY 2012 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 112-74.
6/ Includes $2,542,042 in FY 2013 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 113-6
7/ Includes $2,391,605 in FY 2014 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 113-76.
8/ Includes $2,549,334 in FY 2015 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 113-235.

Appropriations Not Authorized by Law

Administration for Community Living

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2015
Alzheimer's Disease Suppoertive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$3,800,000
Older Americans Act	FY 2011	Such Sums	$1,927,486,000	$1,474,645,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,495,000	$2,360,000
State Health Insurance Assistance Programs: Omnibus Budget Reconciliation Act of 1990	FY 1996	$10,000,000	N/A	$52,115,000
Developmental Disabilities Assistance and Bill of Rights Act	FY 2007	Such Sums	$155,115,000	$156,957,000
National Clearinghouse for Long-Term Care: Deficit Reduction Act of 2005 section 6021(d)	FY 2010	$1,000,000	$3,000,000	$0
Elder Justice / Adult Protective Services: Social Security Act, Title XX-B	FY 2014	$129,000,000	$0	$4,000,000

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Health and Independence for Older Adults

Summary of Request

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

The U.S. population over age 60 is projected to increase by 20 percent in six years, between 2014 and 2020, from 64.8 million to 77.6 million.[6] In addition, the number of seniors age 65 and older with severe disabilities (defined as 3 or more limitations in activities of daily living), who are at greatest risk of nursing home admission, is projected to increase by more than 20 percent over the same period.[7] Health and Independence Programs are vital to helping seniors remain in their homes and communities for as long as possible. For example, 61 percent of congregate and 93 percent of home-delivered meal recipients reported that the meals allowed them to continue living in their own homes. Additionally, 52 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.[8]

ACL's FY 2016 funding request for Health and Independence services is $1,332,648,000; an increase of +$101,300,000 from the comparable FY 2015 enacted level. For FY 2016, specific program requests include:

- $386,182,000 for Home and Community-Based Supportive Services (HCBSS), an increase of +$38,458,000 above the FY 2015 enacted level. HCBSS provides grants to States to fund a broad array of services that enable seniors to remain in their homes for as long as possible, including adult day care, transportation, case management, personal care services, chore services, and physical fitness programs. These services also aid caregivers, who might otherwise have to be even more intensively relied upon to provide

[6] U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.

[7] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population Data from the 2012 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

[8] 2012 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

- care for their loved ones, taking more time away from their work and other family responsibilities.

- $874,557,000 for three Nutrition Services programs (Congregate Nutrition Services, Home-Delivered Nutrition Services and the Nutrition Services Incentives Program), and innovation dollars to modernize service delivery, an increase of +$59,900,000 above the FY 2015 enacted level. Nutrition Services help nearly 2.4 million older adults receive the meals they need to stay healthy and decrease their risk of disability. In FY 2016, these funds will support an estimated 208 million meals.

- $19,848,000 for Preventive Health Services, the same as the FY 2015 enacted level. These services support activities that educate older adults about the importance of healthy lifestyles and promote healthy behaviors that can help prevent, delay, or enable seniors to better cope with and manage chronic disease and disability, thereby reducing the need for more costly medical interventions. ACL is continuing to include appropriations language that requires States to use their Preventive Health Services funds for proven evidence-based prevention activities.

- $8,000,000 for Chronic Disease Self-Management Education (CDSME), requested again for FY 2016 from the Prevention and Public Health Fund (PPHF) authorized under the Affordable Care Act. This would continue funding at the same level proposed in the FY 2015 enacted level. CDSME programs have proven effective in helping people to better self-manage their chronic conditions and reduce their need for more costly medical interventions.

- $5,000,000 for Falls Prevention, requested again for FY 2016 from the Prevention and Public Health Fund (PPHF) authorized under the Affordable Care Act. This would continue funding at the same level proposed in the FY 2015 enacted level. Falls are the leading cause of both fatal and nonfatal injuries for those 65 and over. However, ACL's national infrastructure has enabled over 264,000 individuals throughout the country to participate in evidence-based chronic disease self-management education, falls prevention, diabetes self-management training, physical activity, nutrition education, and depression management programs.

- $29,100,000 for Native American Nutrition and Supportive Services, an increase of +$2,942,000 above the FY 2015 enacted level. These funds will provide approximately 5.4 million meals and 620,000 rides for Native American seniors to critical daily activities such as meal sites, medical appointments, and grocery stores.

- $9,961,000 for Aging Network Support Activities, the same as the FY 2015 enacted level. These funds support competitive grants and contracts for ongoing activities which help seniors and their families obtain information about their care options and benefits, and which assist States, Tribes, and community providers of aging services in carrying out their mission to help older people, including survivors of the Holocaust, remain independent and live in their own homes and communities.

Outcome Table:

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
2.10: Increase the likelihood that the most vulnerable people receiving Older Americans Act Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. (Outcome)	FY 2013: 64.2% Target: 63% (Target Exceeded)	62.5%	63.0%	+ 0.5
3.3: The % of Older American Act clients served who live in rural areas is at least 15% greater than the percent of all US elders who live in rural areas. (Outcome)	FY 2013: 35.9% Target: 26.2% (Target Exceeded)	26.2%	26.2%	Maintain
3.6: The percentage of OAA Clients served who live in poverty is at least 150% greater than the percent of all US elders who live below poverty.	FY 2013: 31.6% Target: 24.9% (Target Exceeded)	24.85%	24.75%	- 0.1

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Home and Community-Based Supportive Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Home and Community-Based Supportive Services	$347,724,000	$347,724,000	$386,182,000	$38,458,000

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

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

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

While age alone does not determine the need for these long-term care supports, statistics show that both disability rates and the use of long-term supports increase with advancing age. Among those aged 85 and older, 58 percent are unable to perform critical activities of daily living and require long-term support. Data also show that over 90 percent of seniors have at least one chronic condition and 75 percent have at least two.[9] Providing a variety of supportive services that meet the diverse needs of these older individuals is crucial to enabling them to remain healthy and independent in their homes and communities, and therefore avoiding unnecessary, expensive nursing home care.

[9] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [data tables 2.5a and 2.6a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

Services provided by the HCBSS program in FY 2013, the most recent available data, include:

- *Transportation Services* provided 24.2 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 30 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework) (Output D).

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

- *Case Management Services* provided 4 million hours of assistance in assessing needs, developing care plans, and arranging services for older persons or their caregivers (Output F).

Continuing ACL's commitment to provide services to those in most need, nearly 47 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.[10] 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:[11]

- 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

- 2 percent have Parkinson's disease.

[10] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[11] Id.

Of the transportation participants, 96 percent take daily medications, with over 12 percent taking 10 to 20 medications daily.[12] Data from ACL's National Surveys of OAA Participants show that services such as transportation are providing these seniors with the assistance and information they need to help them remain at home. For example, over half of seniors using transportation services rely on them for the majority of their transportation needs and would otherwise be homebound, while over 81 percent of clients receiving case management reported that as a result of the services arranged by the case manager that they were better able to care for themselves.[13] In addition, a study published in the Journal of Aging and Health shows that the services provided by the HCBSS program, what the article calls "personal care services," are the critical services that enable frail seniors to remain in their homes and out of nursing home care.[14]

Funding History:

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

FY 2006 .....$350,354,000
FY 2007 .....$350,595,000
FY 2008 .....$351,348,000
FY 2009 .....$361,348,000
FY 2010 .....$368,290,000
FY 2011 .....$367,611,000
FY 2012 .....$366,916,000
FY 2013 .....$347,724,297
FY 2014 .....$347,724,000
FY 2015 .....$347,724,000

Budget Request:

The FY 2016 request for Home and Community-Based Supportive Services is $386,182,000, an increase of +$38,458,000 above the FY 2015 enacted level. HCBSS funding remained flat and has not kept pace with demand in recent years, which has led to declining levels of service due to inflation and stable or declining State, and local funding for these programs. The FY 2016 request will allow ACL to increase services to the increasing number of the population in need,

[12] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[13] Id.

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

which can significantly reduce the risk of nursing home admission. At this level, the overall budget request will support nearly 8 million hours of adult day care for older adults; 23.5 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and 28.5 million hours of assistance to seniors who are unable to perform daily activities.

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

Core OAA formula grant programs like HCBSS currently reach nearly one in five seniors, serving over a half million seniors in their own communities who meet the disability criteria for nursing home admission and helping to keep them from joining the 1.9 million seniors who live in institutional settings.[15] Nationally, 25 percent of individuals 60 and older live alone[16], and in FY 2016 ACL projects 67.5 percent of the OAA transportation users will be individuals who live alone (Outcome 2.11). Living alone is a key predictor of nursing home admission, and HCBSS services are critical to their ability to remain at home, especially for those who do not have an informal caregiver to assist with their care. Recent research has also shown that childless seniors who live in a State with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[17]

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

Although transportation, adult day care, and chore services have had a downward trend in the provision of service units since at least 2007, the budget requested in FY 2016 would provide an

[15] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

[16] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2012), accessed January, 08, 2015.

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

increase in these service unit measures of performance for home and community-based services. Increases in outputs are projected despite inflation, which can often increase the cost per unit of service for these programs.

Outputs and Outcomes Table:

Home and Community-Based Supportive Services Outputs and Outcomes

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
2.9b: Maintain at 90% or higher the percentage of transportation clients who rate services good to excellent *(Outcome)*	FY 2013: 97% Target: 90% (Target Exceeded)	90%	90%	Maintain
2.10: Increase the likelihood that the most vulnerable people receiving Older Americans Act Home and Community-based and Caregiver Support Services will continue to live in their homes and communities. (Outcome)	FY 2013: 64.2% Target: 63% (Target Exceeded)	62.5%	63.0%	+ 0.5
2.11: Increase the percentage of transportation clients who live alone. *(Outcome)*	FY 2013: 68% Target: 70% (Target Not Met)	67%	67.5%	+ 0.5
3.3: The % of OAA clients served who live in rural areas is at least 15% greater than the percent of all US elders who live in rural areas. (Outcome)	FY 2013: 35.9% Target: 26.2% (Target Exceeded)	26.2%	26.2%	Maintain
3.6: The % of OAA clients served who live in poverty is at least 150% greater than the percent of all US elders who live below poverty.	FY 2013: 31.6% Target 24.85% (Target Exceeded)	24.85%	24.75%	- 0.1

Indicator	Most Recent Result	FY 2015 Projection	FY 2016 Projection	FY 2016 +/- FY 2015
Output C: Transportation Services units *(Output)*	FY 2013: 24.2 M	23.0 M	23.5 M	+ 0.5 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2013: 29.8 M	28.3 M	28.5 M	+ 0.2 M
Output E: Adult Day Care/Day Health units *(Output)*	FY 2013: 7.95 M	7.6 M	7.7 M	+ 0.1 M
Output F: Case Management Services units *(Output)*	FY 2013: 4.0 M	4.0 M	4.0 M	Maintain

Note: For presentation within the budget ACL 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 ACL'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 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$6,147,264	$6,147,264	$6,827,146
Range of Awards	$215,155 - $34,081,746	$215,155 - $34,081,746	$238,950 - $39,082,557

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	5,325,874	5,325,874	5,816,476	490,602
Alaska	1,721,234	1,721,234	1,911,601	190,367
Arizona	6,478,530	6,478,530	8,052,473	1,573,943
Arkansas	3,450,663	3,450,663	3,610,227	159,564
California	34,081,746	34,081,746	39,082,557	5,000,811
Colorado	4,095,054	4,095,054	5,464,852	1,369,798
Connecticut	4,341,017	4,341,017	4,404,337	63,320
Delaware	1,721,234	1,721,234	1,911,601	190,367
District of Columbia	1,721,234	1,721,234	1,911,601	190,367
Florida	24,898,663	24,898,663	27,855,262	2,956,599
Georgia	7,795,519	7,795,519	9,928,983	2,133,464
Hawaii	1,721,234	1,721,234	1,911,601	190,367
Idaho	1,721,234	1,721,234	1,911,601	190,367
Illinois	14,316,068	14,316,068	14,524,890	208,822
Indiana	6,827,801	6,827,801	7,456,124	628,323
Iowa	4,199,620	4,199,620	4,260,878	61,258
Kansas	3,383,554	3,383,554	3,432,908	49,354
Kentucky	4,673,107	4,673,107	5,181,336	508,229
Louisiana	4,726,948	4,726,948	5,049,599	322,651
Maine	1,721,234	1,721,234	1,911,601	190,367
Maryland	5,773,227	5,773,227	6,531,196	757,969
Massachusetts	8,091,074	8,091,074	8,209,095	118,021
Michigan	11,093,893	11,093,893	12,125,990	1,032,097
Minnesota	5,420,599	5,420,599	6,175,873	755,274
Mississippi	3,225,660	3,225,660	3,373,026	147,366
Missouri	7,016,089	7,016,089	7,285,919	269,830
Montana	1,721,234	1,721,234	1,911,601	190,367
Nebraska	2,261,944	2,261,944	2,294,938	32,994
Nevada	2,426,000	2,426,000	3,108,718	682,718
New Hampshire	1,721,234	1,721,234	1,911,601	190,367

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	10,115,423	10,115,423	10,289,663	174,240
New Mexico	2,036,483	2,036,483	2,451,822	415,339
New York	23,934,312	23,934,312	24,283,431	349,119
North Carolina	9,234,231	9,234,231	11,387,010	2,152,779
North Dakota	1,721,234	1,721,234	1,911,601	190,367
Ohio	13,618,168	13,618,168	14,196,928	578,760
Oklahoma	4,216,778	4,216,778	4,404,977	188,199
Oregon	4,074,931	4,074,931	4,991,148	916,217
Pennsylvania	17,622,920	17,622,920	17,879,977	257,057
Rhode Island	1,721,234	1,721,234	1,911,601	190,367
South Carolina	4,722,656	4,722,656	5,896,258	1,173,602
South Dakota	1,721,234	1,721,234	1,911,601	190,367
Tennessee	6,663,028	6,663,028	7,716,870	1,053,842
Texas	20,033,849	20,033,849	24,527,337	4,493,488
Utah	1,839,934	1,839,934	2,328,474	488,540
Vermont	1,721,234	1,721,234	1,911,601	190,367
Virginia	7,751,887	7,751,887	9,048,265	1,296,378
Washington	6,357,321	6,357,321	7,877,988	1,520,667
West Virginia	2,733,663	2,733,663	2,773,538	39,875
Wisconsin	6,298,516	6,298,516	6,913,857	615,341
Wyoming	1,721,234	1,721,234	1,911,601	190,367
Subtotal, States	337,532,792	337,532,792	375,044,013	37,511,221
American Samoa	465,527	465,527	472,317	6,790
Guam	860,617	860,617	955,800	95,183
Northern Mariana Islands	215,155	215,155	238,950	23,795
Puerto Rico	4,312,052	4,312,052	4,653,300	341,248
Virgin Islands	860,617	860,617	955,800	95,183
Subtotal, States and Territories	344,246,760	344,246,760	382,320,180	38,073,420
Undistributed 18/	3,477,240	3,477,240	3,861,820	384,580
TOTAL	**347,724,000**	**347,724,000**	**386,182,000**	**38,458,000**

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

Nutrition Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Congregate Nutrition…….	$438,191,000	$438,191,000	$458,091,000	$19,900,000
Home-Delivered Nutrition	$216,397,000	$216,397,000	$236,397,000	$20,000,000
Nutrition Services Incentive Program…….....	$156,603,000	$160,069,000	$160,069,000	--
Nutrition Innovation Demonstrations……..	--	--	$20,000,000	$20,000,000
Total…….....	$811,191,000	$814,657,000	$874,557,000	$59,900,000

Authorizing Legislation: Sections 311, 331, 336, and 411 of the Older Americans Act of 1965, as amended

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

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

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

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

- Nutrition Services Incentive Program (Title III-A): Provides additional funding to States, Territories, and eligible Tribal Organizations that is used exclusively to purchase food and cannot be used to pay for other nutrition-related services or for administrative costs. Funds are awarded to States, Territories, and eligible Tribal Organizations based on the number of meals served in the prior Federal fiscal year. Recipients have the option to purchase commodities directly from the U.S. Department of Agriculture (USDA) with any portion of their award if they determine that doing so will enable them to better meet the needs of seniors. Seven States and five Tribes elected to spend nearly $2.4 million on commodities, including $141,939 assessed by USDA as administrative expenses, in FY 2014.

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

Nutrition Services help approximately 2.4 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.[19] These nutrition programs help address their needs. Serving Elders at Risk, a national evaluation of ACL's nutrition program clients, found that nutrition services recipients are older, poorer, more likely to live alone, more likely to be minorities, in poorer health, in poorer nutritional status, more functionally impaired, and at higher nutritional risk than those in the general population. Nutrition Services provide an important opportunity for social interaction that helps to improve the general health status of participants, including homebound elders. A comparison of the number of social contacts of congregate and home-delivered meal participants showed that nutrition program clients had significantly more social contacts than older adults who did not participate in the program.

Multiple chronic diseases and conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals' health,

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

and contribute to increased hospitalizations and health care costs.[20] Many of the most common chronic conditions such as hypertension, heart disease, diabetes, and osteoporosis are related to nutrition as a primary prevention, risk reduction, or treatment modality. Data also show that Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. For example, the two-thirds of Medicare beneficiaries with two or more chronic conditions account for 93 percent of Medicare spending, and the one-third of Medicare beneficiaries with four or more chronic conditions account for almost three-fourths of Medicare spending.[21]

Because the prevalence of multiple chronic conditions is higher among congregate and home-delivered meal program participants than for the general Medicare population, the provision of healthy meals, access to lifestyle modification programs, and evidence-based advice such as nutrition education and counseling are important to helping these individuals avoid more serious medical care. Data from ACL's National Survey of OAA Participants indicate that about 57 percent of congregate and 72 percent of home-delivered participants have 5 or more illnesses and conditions. About 32 percent of congregate and 51 percent of home-delivered participants take over six medications per day and some take as many as 30 medications.[22] The congregate and home-delivered program participants are significantly less healthy than the general Medicare population and access to healthy meals is essential to their well-being.

Prevalence for malnutrition or risk for malnutrition across the community- and facility-based care settings has varied based on factors used to determine malnutrition. A study applying similar criteria found the lowest prevalence (38 percent) among older adults in the community, compared to 91 percent in rehabilitation facilities, 86 percent in hospitals, and 67 percent in nursing homes.[23] Data from the National Survey of OAA Participants indicate that about 21 percent of congregate and 37 percent of home-delivered program participants stayed overnight in the hospital or a nursing home in the past year and thus might be at risk of malnutrition.[24] Individuals transitioning between or among facility-based care settings and their homes are likely to be in poorer health and at higher risk for poor nutrition, and have an increased need for healthy home-delivered and congregate meals as well as nutrition education and counseling to aid recovery and decrease the risk of readmission.

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

[20] Lochner KA, Cox CS. Prevalence of Multiple Chronic Conditions among Medicare Beneficiaries, United States, 2010. Prev Chronic Dis 2013; 10:120137. DOI http://dix.doi.org/10.5888/pcd10.12037
[21] *Id.*
[22] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.
[23] Kaiser et al. JAGS 2010; 58: 1734-1738
[24] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

OAA Participants indicate that about 11 percent of congregate and over 40 percent of home-delivered participants indicate that they have 3 or more impairments in instrumental activities of daily living (IADLs), meaning that they may be unable to shop for groceries and prepare meals for themselves. The data also indicate that about 16 percent of congregate and 51 percent of home-delivered participants need help in getting outside the house, thus limiting their ability to shop for food themselves.[25] Although many of these older adults may rely on family and friends for assistance, about 46 percent of congregate and 52 percent of home-delivered participants live alone.[26] Living alone is a risk factor for social isolation, poorer health, and nursing home placement.

Data from ACL's National Survey of OAA Participants show that Nutrition Services are effectively helping older adults improve their nutritional intake and remain at home. For example, data indicate that 77 percent of congregate and 84 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 61 percent of congregate and 93 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[27] The extra support provided by these programs can help older adults avoid more costly institutional care. Using State Program Report data, made available on ACL's data portal (www.agid.acl.gov), independent research has found that states that invest more in delivering meals (both Federal, state, and all other sources of funding) to older adults' homes have lower rates of "low-care" seniors in nursing homes who have the functional capacity to live in a less care-intensive environment, after adjusting for several other factors.[28] For every $25 per year per older adult that states spend on home-delivered meals, they reduce their percentage of low-care nursing home residents compared to the national average by 1 percent.[29]

ACL's annual performance data further demonstrate that these programs are an efficient and effective means to help seniors remain healthy and independent in their homes and in the community. Eighty-nine percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the percentage of home-delivered meal recipients with severe disabilities (3+ ADL) was 43.5 percent in 2013 (Outcome 3.5). This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs, in combination with state and local funding for nutrition, are helping seniors remain healthy and independent in their homes include:

[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] Thomas, K & Mor, V. The Relationship between Older Americans Act Title III State Expenditures & Prevalence of Low-Care Nursing Home Residents. Health Services Research. 12.3.12. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12015/abstract
[29] *Id.*

- *Home-Delivered Nutrition Services* provided 136 million meals to over 830,000 individuals in FY 2013 (Output G).

- *Congregate Nutrition Services* provided over 83.4 million meals to 1.6 million seniors in a variety of community settings in FY 2013 (Output H).

Funding History:

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

FY 2006 .....$714,578,000
FY 2007 .....$735,070,000
FY 2008 .....$758,003,000
FY 2009 .....$809,743,000
FY 2009 (ARRA).....$97,000,000
FY 2010 .....$819,353,000
FY 2011 .....$817,835,000
FY 2012 .....$816,289,000
FY 2013 .....$768,310,870
FY 2014 .....$811,191,000
FY 2015 .....$814,657,000

Budget Request:

The FY 2016 request for Nutrition Services is $874,557,000, an increase of +$59,900,000 above the FY 2015 enacted level. This includes an additional $39,900,000 for congregate and home-delivered nutrition services. At this level, the budget request combined with state and local contributions will support approximately 208 million home-delivered and congregate meals to more than 2.3 million elderly individuals in a variety of community settings, which would allow ACL to maintain approximately the same level of meals as is currently projected in FY 2015, and halt the decline in service levels for the first time since 2009-2010 when these programs received a one-time funding increase due to the American Recovery and Reinvestment Act. This budget also provides $20,000,000 to enable ACL to fund evidence-based demonstration grants, aimed at enhancing the quality and effectiveness of our nutrition program services.

Nutrition Services must continue to be funded because they, like HCBSS, help to delay the need for much more expensive institutional services. Consistent with ACL's commitment to target services to those most in need to help them maintain their health and independence, approximately 66 percent of home-delivered meal recipients have annual incomes at or below

$20,000.[30] Meals are especially critical for the survival of the nearly 62 percent of recipients who report these meals as half or more of their food intake for the day and for the 45 percent of home-delivered meal recipients with severe disabilities who are projected to be served in FY 2016.[31] This population with severe disabilities is particularly important to serve since this level of disability is frequently an eligibility requirement for more costly nursing home admission.

Federal support for Nutrition Services is not expected to serve every older American in need. These programs have strong partnerships with State and local governments, philanthropic organizations, and private donors that contribute funding. In FY 2013, State and local funding comprised approximately 63 percent of all the funding for home-delivered meals and congregate meals. Though all programs funded through OAA rely on State and local funding in some part, funding for congregate and home-delivered meals leverages more State and local financial support than many other OAA services.

In FY 2016 these programs are expected to continue to provide home-delivered meals that clients rate as good to excellent (Outcome 2.9a), ensuring that clients continue to receive high quality services. However, as Federal funds do not keep up with inflation and State and local funding tightens, some providers may look at cost cutting measures such as reducing menu choices or the frequency of deliveries. This could affect client satisfaction with the quality of service.

While investments in nutrition services are clearly needed, it is also critical that ACL work with our state and local partners to modernize these services and ensure that every dollar is spent effectively. As noted above, research clearly shows that providing nutrition services improves the health of participants and reduces their need for more expensive medical interventions and institutional care. Translating the knowledge generated by this research into evidence-based models for delivering services at the community level is essential to ensuring the continued efficacy of these programs and improving their efficiency. This knowledge is also needed to help to prepare these programs to meet the changing demands of seniors as the baby boom generation ages – for example, serving clients who will be more accustomed to interacting with service providers over the web and via smartphone apps than only by phone.

Evidence-based innovation projects would focus on a number of priorities, including efforts to:

- Modernize the infrastructure and delivery mechanisms in use by the national aging network to insure that States and Tribal Organizations are able to maximize the return on investment in nutrition programs, both in terms of number of meals and seniors that they are able to serve and in terms of the impact that these programs have;

[30] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[31] Id

- Instill, increase, and then maintain consistent quality in meals and nutrition services through collaborative efforts among State Units on Aging, Area Agencies on Aging, Tribal organizations, and local nutrition service providers;

- Improve quality, service and effectiveness of providing meals and other nutrition services to meet the special nutrition needs of ethnically and culturally appropriate diets as well as religious needs of diverse communities;

- Utilize new food and food service technology and equipment as well as food service personnel (such as chefs) to reduce costs, improve service and delivery, and add value;

- Enhance communication through effective use of health IT and other techniques to improve business practices and establish quality feedback procedures to report outcomes to the entities at risk for meal recipients' health care costs; and

- Develop innovative ways to use existing nutrition sites for other health promotion activities that could receive sustainable funding outside the OAA, and likewise, develop innovative uses of existing nutrition sites as multi-purpose community sites and cafes for the broader populations and needs in the community.

Examples of innovative and promising practices that enhance the quality and effectiveness of our nutrition program include service products that appeal to caregivers (such as web-based ordering systems and carryout meals), increased involvement of volunteers (such as retired chefs), consideration of eating habits and choice (such as variable meal times, salad bars, or more fresh fruits and vegetables), new service models (testing variations and hybrid strategies) and other innovations to better serve the younger cohort of older adults whose needs and preferences may be different from those of older cohorts. Through this program, funds may be used to help develop and test additional models or to replicate models that have already been tested in other community-based settings.

ACL anticipates awarding approximately 20 grants of up to $1 million. As has been done with Preventive Health Services, ACL will provide guidance to potential grantees regarding acceptable evidence-based practices and interventions.

Outcomes and Outputs Table:

Nutrition Services Outcomes and Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
1.1: For Home and Community-Based Services including Nutrition Services, and Caregiver services increase the number of clients served per million dollars of ACL funding. *(Outcome)*	FY 2013: 9,753 Target: 9,300 (Target Exceeded)	9,250	8,700	- 550
2.9a: Maintain at 90% or higher the percentage of home-delivered meal clients who rate services good to excellent. *(Outcome)*	FY 2012: 89% Target: 90% (Target Not Met)	90%	90%	Maintain
3.5: Increase the percentage of older persons with severe disabilities who receive home-delivered meals. *(Outcome)*	FY 2012: 43.5% Target: Baseline	44.8%	45.0%	+0.2
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output G: Number of Home-Delivered meals served *(Output)*	FY 2013: 136 M	129 M	129 M	Maintain
Output H: Number of Congregate meals served *(Output)*	FY 2012: 83.4 M	79 M	79 M	Maintain
Outputs G& H: Total Number of Meals *(Outputs)*	FY 2012: 219.4 M	208 M	208 M	Maintain

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

Grant Awards Tables:

Congregate Nutrition Programs Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$7,746,591	$7,746,591	$8,098,394
Range of Awards	$271,131 - $43,228,051	$271,131 - $43,228,051	$283,444 - $46,294,011

Home-Delivered Nutrition Programs Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$3,825,590	$3,825,590	$4,179,161
Range of Awards	$133,896 - $22,048,734	$133,896 - $22,048,734	$146,271 - $24,229,113

Nutrition Services Incentive Program Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards[32]	319	319	319
Average Award[33]	$490,919	$496,766	$496,766
Range of Awards[34]	$762 - $15,927,625	$779 - $16,113,431	$779 - $16,113,431

[32] Number of awards includes 264 awards to Tribal organizations.

[33] If the 264 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,779,430 in FY 2014 and $2,881,242 in FY 2015 and FY 2016.

[34] If the 264 award to Tribal organizations are excluded from the "range of awards" calculation, the smallest award to States, DC, and the territories is $58,437 in FY 2014 and $59,119 in FY 2015 and FY 2016.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	6,511,955	6,511,955	6,889,723	377,768
Alaska	2,169,045	2,169,045	2,267,550	98,505
Arizona	8,895,789	8,895,789	9,538,304	642,515
Arkansas	4,163,564	4,163,564	4,276,380	112,816
California	43,228,051	43,228,051	46,294,011	3,065,960
Colorado	5,978,941	5,978,941	6,473,219	494,278
Connecticut	5,241,452	5,241,452	5,241,452	0
Delaware	2,169,045	2,169,045	2,267,550	98,505
District of Columbia	2,169,045	2,169,045	2,267,550	98,505
Florida	30,962,559	30,962,559	32,995,073	2,032,514
Georgia	10,973,199	10,973,199	11,761,064	787,865
Hawaii	2,169,045	2,169,045	2,267,550	98,505
Idaho	2,169,045	2,169,045	2,267,550	98,505
Illinois	17,286,541	17,286,541	17,286,541	0
Indiana	8,320,826	8,320,826	8,831,916	511,090
Iowa	5,081,501	5,081,501	5,081,501	0
Kansas	4,089,903	4,089,903	4,089,903	0
Kentucky	5,791,780	5,791,780	6,137,389	345,609
Louisiana	5,645,998	5,645,998	5,981,344	335,346
Maine	2,169,045	2,169,045	2,267,550	98,505
Maryland	7,244,786	7,244,786	7,736,322	491,536
Massachusetts	9,780,267	9,780,267	9,780,267	0
Michigan	13,524,083	13,524,083	14,363,460	839,377
Minnesota	6,834,789	6,834,789	7,315,435	480,646
Mississippi	3,891,114	3,891,114	3,995,412	104,298
Missouri	8,467,047	8,467,047	8,630,306	163,259
Montana	2,169,045	2,169,045	2,267,550	98,505
Nebraska	2,738,802	2,738,802	2,738,802	0
Nevada	3,420,814	3,420,814	3,682,334	261,520
New Hampshire	2,169,045	2,169,045	2,267,550	98,505

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	12,190,488	12,190,488	12,190,488	0
New Mexico	2,727,494	2,727,494	2,904,229	176,735
New York	28,963,855	28,963,855	28,963,855	0
North Carolina	12,616,135	12,616,135	13,488,124	871,989
North Dakota	2,169,045	2,169,045	2,267,550	98,505
Ohio	16,393,785	16,393,785	16,816,524	422,739
Oklahoma	5,080,736	5,080,736	5,217,776	137,040
Oregon	5,508,448	5,508,448	5,912,107	403,659
Pennsylvania	21,279,716	21,279,716	21,279,716	0
Rhode Island	2,169,045	2,169,045	2,267,550	98,505
South Carolina	6,522,158	6,522,158	6,984,227	462,069
South Dakota	2,169,045	2,169,045	2,267,550	98,505
Tennessee	8,608,241	8,608,241	9,140,776	532,535
Texas	27,060,605	27,060,605	29,053,084	1,992,479
Utah	2,556,342	2,556,342	2,758,120	201,778
Vermont	2,169,045	2,169,045	2,267,550	98,505
Virginia	10,058,787	10,058,787	10,717,837	659,050
Washington	8,686,777	8,686,777	9,331,623	644,846
West Virginia	3,305,947	3,305,947	3,305,947	0
Wisconsin	7,687,478	7,687,478	8,189,592	502,114
Wyoming	2,169,045	2,169,045	2,267,550	98,505
Subtotal, States	425,518,338	425,518,338	444,852,333	19,333,995
American Samoa	594,843	594,843	594,843	0
Guam	1,084,523	1,084,523	1,133,775	49,252
Northern Mariana Islands	271,131	271,131	283,444	12,313
Puerto Rico	5,255,732	5,255,732	5,511,920	256,188
Virgin Islands	1,084,523	1,084,523	1,133,775	49,252
Subtotal, States and Territories	433,809,090	433,809,090	453,510,090	19,701,000
Undistributed 35/	4,381,910	4,381,910	4,580,910	199,000
TOTAL	**438,191,000**	**438,191,000**	**458,091,000**	**19,900,000**

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ADMINISTRATION ON AGING

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	3,321,462	3,321,462	3,605,906	284,444
Alaska	1,071,165	1,071,165	1,170,165	99,000
Arizona	4,537,352	4,537,352	4,992,106	454,754
Arkansas	2,068,715	2,068,715	2,238,149	169,434
California	22,048,734	22,048,734	24,229,113	2,180,379
Colorado	3,049,595	3,049,595	3,387,918	338,323
Connecticut	2,498,252	2,498,252	2,706,223	207,971
Delaware	1,071,165	1,071,165	1,170,165	99,000
District of Columbia	1,071,165	1,071,165	1,170,165	99,000
Florida	15,792,643	15,792,643	17,268,784	1,476,141
Georgia	5,596,948	5,596,948	6,155,442	558,494
Hawaii	1,071,165	1,071,165	1,170,165	99,000
Idaho	1,071,165	1,071,165	1,170,165	99,000
Illinois	8,082,580	8,082,580	8,796,462	713,882
Indiana	4,244,089	4,244,089	4,622,401	378,312
Iowa	2,193,513	2,193,513	2,381,662	188,149
Kansas	1,863,836	1,863,836	2,027,917	164,081
Kentucky	2,954,133	2,954,133	3,212,153	258,020
Louisiana	2,872,528	2,872,528	3,130,483	257,955
Maine	1,081,160	1,081,160	1,182,503	101,343
Maryland	3,695,248	3,695,248	4,048,995	353,747
Massachusetts	4,540,013	4,540,013	4,944,825	404,812
Michigan	6,898,042	6,898,042	7,517,470	619,428
Minnesota	3,486,126	3,486,126	3,828,713	342,587
Mississippi	1,925,602	1,925,602	2,091,097	165,495
Missouri	4,155,738	4,155,738	4,516,883	361,145
Montana	1,071,165	1,071,165	1,170,165	99,000
Nebraska	1,217,228	1,217,228	1,323,940	106,712
Nevada	1,744,807	1,744,807	1,927,240	182,433
New Hampshire	1,071,165	1,071,165	1,170,165	99,000

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	5,884,229	5,884,229	6,379,045	494,816
New Mexico	1,391,175	1,391,175	1,519,999	128,824
New York	13,027,753	13,027,753	14,127,245	1,099,492
North Carolina	6,434,937	6,434,937	7,059,342	624,405
North Dakota	1,071,165	1,071,165	1,170,165	99,000
Ohio	8,110,984	8,110,984	8,801,342	690,358
Oklahoma	2,514,252	2,514,252	2,730,852	216,600
Oregon	2,809,618	2,809,618	3,094,247	284,629
Pennsylvania	9,517,980	9,517,980	10,315,516	797,536
Rhode Island	1,071,165	1,071,165	1,170,165	99,000
South Carolina	3,326,667	3,326,667	3,655,367	328,700
South Dakota	1,071,165	1,071,165	1,170,165	99,000
Tennessee	4,390,687	4,390,687	4,784,050	393,363
Texas	13,802,428	13,802,428	15,205,647	1,403,219
Utah	1,303,878	1,303,878	1,443,530	139,652
Vermont	1,071,165	1,071,165	1,170,165	99,000
Virginia	5,130,546	5,130,546	5,609,444	478,898
Washington	4,430,744	4,430,744	4,883,935	453,191
West Virginia	1,491,504	1,491,504	1,611,372	119,868
Wisconsin	3,921,045	3,921,045	4,286,225	365,180
Wyoming	1,071,165	1,071,165	1,170,165	99,000
Subtotal, States	210,210,751	210,210,751	229,685,523	19,474,772
American Samoa	136,498	136,498	146,271	9,773
Guam	535,583	535,583	585,083	49,500
Northern Mariana Islands	133,896	133,896	146,271	12,375
Puerto Rico	2,680,719	2,680,719	2,884,799	204,080
Virgin Islands	535,583	535,583	585,083	49,500
Subtotal, States and Territories	214,233,030	214,233,030	234,033,030	19,800,000
Undistributed 36/	2,163,970	2,163,970	2,363,970	200,000
TOTAL	**216,397,000**	**216,397,000**	**236,397,000**	**20,000,000**

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

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	3,053,645	3,089,267	3,089,267	--
Alaska	428,688	433,689	433,689	--
Arizona	1,856,152	1,877,804	1,877,804	--
Arkansas	2,642,603	2,673,429	2,673,429	--
California	12,554,022	12,700,468	12,700,468	--
Colorado	1,343,341	1,359,011	1,359,011	--
Connecticut	1,484,120	1,501,432	1,501,432	--
Delaware	677,792	685,699	685,699	--
District of Columbia	498,188	503,999	503,999	--
Florida	6,272,912	6,346,087	6,346,087	--
Georgia	2,786,158	2,818,659	2,818,659	--
Hawaii	395,577	400,191	400,191	--
Idaho	717,305	725,673	725,673	--
Illinois	6,096,331	6,167,446	6,167,446	--
Indiana	1,781,348	1,802,128	1,802,128	--
Iowa	1,940,863	1,963,504	1,963,504	--
Kansas	2,221,633	2,247,549	2,247,549	--
Kentucky	1,842,359	1,863,850	1,863,850	--
Louisiana	3,336,619	3,375,541	3,375,541	--
Maine	606,114	613,185	613,185	--
Maryland	1,571,488	1,589,819	1,589,819	--
Massachusetts	6,078,563	6,149,471	6,149,471	--
Michigan	7,478,670	7,565,910	7,565,910	--
Minnesota	1,947,407	1,970,124	1,970,124	--
Mississippi	1,633,374	1,652,428	1,652,428	--
Missouri	4,055,402	4,102,709	4,102,709	--
Montana	1,188,863	1,202,731	1,202,731	--
Nebraska	1,317,323	1,332,689	1,332,689	--
Nevada	1,140,975	1,154,285	1,154,285	--
New Hampshire	1,142,862	1,156,193	1,156,193	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	3,677,969	3,720,873	3,720,873	--
New Mexico	2,106,453	2,131,025	2,131,025	--
New York	15,927,625	16,113,431	16,113,431	--
North Carolina	3,383,189	3,422,655	3,422,655	--
North Dakota	809,432	818,874	818,874	--
Ohio	5,592,141	5,657,375	5,657,375	--
Oklahoma	2,155,059	2,180,198	2,180,198	--
Oregon	1,856,581	1,878,239	1,878,239	--
Pennsylvania	5,918,127	5,987,163	5,987,163	--
Rhode Island	426,360	431,333	431,333	--
South Carolina	1,418,082	1,434,625	1,434,625	--
South Dakota	895,460	905,906	905,906	--
Tennessee	1,578,163	1,596,573	1,596,573	--
Texas	11,785,324	11,922,802	11,922,802	--
Utah	1,379,023	1,395,109	1,395,109	--
Vermont	796,027	805,312	805,312	--
Virginia	2,081,156	2,105,433	2,105,433	--
Washington	2,143,449	2,168,453	2,168,453	--
West Virginia	1,687,663	1,707,350	1,707,350	--
Wisconsin	2,735,030	2,766,935	2,766,935	--
Wyoming	849,822	859,735	859,735	--
Subtotal, States	149,292,832	151,034,369	151,034,369	--
American Samoa	--	--	--	--
Guam	332,811	336,693	336,693	--
Northern Mariana Islands	58,437	59,119	59,119	--
Puerto Rico	2,998,055	3,033,028	3,033,028	--
Virgin Islands	186,505	188,681	188,681	--
Subtotal, States and Territories	152,868,640	154,651,890	154,651,890	--
Tribal Organizations	3,734,360	3,816,420	3,816,420	--
Undistributed 37/	--	1,600,690	1,600,690	--
TOTAL	**156,603,000**	**160,069,000**	**160,069,000**	--

[37] The undistributed line reflects the amount reserved from the NSIP appropriation for statutory related activities, including contingencies and for program support including information and systems, technical assistance, evaluation, monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States. This amount includes commodities that States elected to use instead of cash.

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Preventive Health Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Preventive Health Services	$19,848,000	$19,848,000	$19,848,000	--

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method.....Formula Grant

Program Description and Accomplishments:

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

Due in large part to advances in public health and medical care, Americans are leading longer and more active lives. Average life expectancy has increased from less than 50 years at the turn of the 20th century to over 78 years today. On average, an American turning age 65 today can expect to live an additional 19.2 years.[38] The population of older Americans is also growing, particularly the population age 85 and over, which is growing very rapidly, totaling 6.2 million in 2014 and projected to reach 9.1 million by the year 2030.[39] One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and depression, as well as the greater probability of injury from a fall, which quickly limits physical activity.

[38] National Center for Health Statistics. Health, United States, 2013: With Special Feature on Prescription Drugs. Hyattsville, MD. 2014. [Web update: Table 18 Life expectancy at birth, at age 65, and at age 75, by sex, race, and Hispanic origin: United States, selected years 1900–2011] *Updated data when available, Excel, PDF, and more data years: http://www.cdc.gov/nchs/hus/contents2013.htm#018*. Accessed 12 January 2015.

[39] U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.

In recent years, some States have increasingly shifted their funding to provide greater support to evidence-based approaches, especially to help individuals manage chronic diseases. In FY 2012, AoA requested and Congress enacted appropriations language requiring States to use their Preventive Health funds to support proven evidence-based models that enhance the wellness and fitness of the aging community. The same language has been included in each subsequent year's appropriation's language, and will also be included in the language proposed for FY 2016. Since evidence-based programs have demonstrated their effectiveness, ACL expects that States will be able to maximize the impact of these limited dollars. At the same time, if States wish to continue funding other health services, such as health screenings, they still have the flexibility to continue to use funds provided under the Home and Community-Based Supportive Services program for this purpose.

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

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

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

Funding History:

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

FY 2011 .....$20,984,000
FY 2012 .....$20,944,000
FY 2013 .....$19,848,825
FY 2014 .....$19,848,000
FY 2015 .....$19,848,000

Budget Request:

The FY 2016 budget request for Preventive Health Services is $19,848,000, the same as the FY 2015 enacted level. ACL continues to request appropriations language that was included by Congress since FY 2012, which requires States to use their Preventive Health Services funds to support proven evidence-based models that enhance the wellness and fitness of the aging community.

Recognizing that the development of evidence-based programs is ongoing, ACL has invested in an Aging and Disability Evidence-Based Program and Practices (ADEPP) review process that consists of a rigorous review of evidence-based interventions involving two panels of independent expert reviewers. One set of reviewers assess and rate the quality of research; the other reviewers rate the program on readiness for dissemination. Intervention summaries are made available on ACL's website at http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx and a link to the page is one resource on the Title IIID webpage. ADEPP is one way that ACL is working to improve access to information on evaluated interventions and reduce the lag time between the creation of scientific knowledge and its practical application in the field.

ACL will continue to provide guidance regarding what meets the evidence-based requirement. ACL uses a graduated or tiered set of criteria for defining evidence-based interventions implemented through the OAA. The OAA Title IIID webpage contains definitions of evidence-based interventions, frequently asked questions, and program examples.[40] Grantees can use the Title IIID Highest-Tier Criteria Evidence-Based Disease Prevention and Health Promotion Programs Cost Chart[41] on the site to search the 45+ highest-level criteria programs listed.

Underscoring the need for these programs, the 2014 National Survey of OAA Participants found that between 71 and 90 percent of clients across OAA services take three or more different

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

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

prescription medications every day. In addition, between 21 and 40 percent of clients across OAA services reported having stayed overnight in a hospital in the past 12 months. Preventive Health Services funding has enabled the Aging Services Network to help older adults control their medications and health through the implementation of evidence-based DPHP programs. Over 70% of clients across OAA services report learning how to take care of a chronic illness or medical condition during the past year. Six to thirteen percent of respondents, representing over 230,000 OAA clients, reported that they learned through a group class.[42]

Each of the evidence-based programs for which States could use these funds has been rigorously evaluated and found to be effective. By requiring States to use funding for one or more of these proven programs, ACL seeks to maximize the impact of this funding on providing benefits to individuals and on achieving savings due to reduced medical costs. At the same time, States would continue to have the flexibility to use funding provided under the Home and Community-Based Supportive Services program to fund related health services, such as health screenings and physical fitness programs that do not meet these evidence-based requirements.

Output Table:

Preventive Health Services Output

Indicator	Most Recent Result	FY 2015 Projection	FY 2016 Projection	FY 2016 +/- FY 2015
Output AB: The number of people served with health and disease prevention programs *(Output)*	FY 2013: 1,543,983	1.5 M	1.5 M	Maintain

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$350,884	$350,884	$350,884
Range of Awards	$12,281 - $1,992,449	$12,281 - $1,992,449	$12,281 - $1,992,449

[42] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	311,357	311,357	311,357	--
Alaska	98,248	98,248	98,248	--
Arizona	378,742	378,742	378,742	--
Arkansas	197,733	197,733	197,733	--
California	1,992,449	1,992,449	1,992,449	--
Colorado	239,401	239,401	239,401	--
Connecticut	244,076	244,076	244,076	--
Delaware	98,248	98,248	98,248	--
District of Columbia	98,248	98,248	98,248	--
Florida	1,455,604	1,455,604	1,455,604	--
Georgia	455,734	455,734	455,734	--
Hawaii	98,248	98,248	98,248	--
Idaho	98,248	98,248	98,248	--
Illinois	786,094	786,094	786,094	--
Indiana	399,161	399,161	399,161	--
Iowa	217,047	217,047	217,047	--
Kansas	179,147	179,147	179,147	--
Kentucky	273,195	273,195	273,195	--
Louisiana	276,343	276,343	276,343	--
Maine	98,437	98,437	98,437	--
Maryland	337,509	337,509	337,509	--
Massachusetts	434,993	434,993	434,993	--
Michigan	648,562	648,562	648,562	--
Minnesota	316,895	316,895	316,895	--
Mississippi	183,404	183,404	183,404	--
Missouri	395,543	395,543	395,543	--
Montana	98,248	98,248	98,248	--
Nebraska	116,724	116,724	116,724	--
Nevada	141,827	141,827	141,827	--
New Hampshire	98,248	98,248	98,248	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	580,295	580,295	580,295	--
New Mexico	119,055	119,055	119,055	--
New York	1,286,483	1,286,483	1,286,483	--
North Carolina	539,844	539,844	539,844	--
North Dakota	98,248	98,248	98,248	--
Ohio	781,158	781,158	781,158	--
Oklahoma	240,576	240,576	240,576	--
Oregon	238,225	238,225	238,225	--
Pennsylvania	951,872	951,872	951,872	--
Rhode Island	98,248	98,248	98,248	--
South Carolina	276,092	276,092	276,092	--
South Dakota	98,248	98,248	98,248	--
Tennessee	389,528	389,528	389,528	--
Texas	1,171,202	1,171,202	1,171,202	--
Utah	107,565	107,565	107,565	--
Vermont	98,248	98,248	98,248	--
Virginia	453,184	453,184	453,184	--
Washington	371,656	371,656	371,656	--
West Virginia	143,112	143,112	143,112	--
Wisconsin	365,822	365,822	365,822	--
Wyoming	98,248	98,248	98,248	--
Subtotal, States	19,274,622	19,274,622	19,274,622	--
American Samoa	12,281	12,281	12,281	--
Guam	49,124	49,124	49,124	--
Northern Mariana Islands	12,281	12,281	12,281	--
Puerto Rico	252,088	252,088	252,088	--
Virgin Islands	49,124	49,124	49,124	--
Subtotal, States and Territories	19,649,520	19,649,520	19,649,520	--
Undistributed[43]	198,480	198,480	198,480	--
TOTAL	19,848,000	19,848,000	19,848,000	--

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

Chronic Disease Self-Management Education

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
CDSME……..	$8,000,000	$8,000,000	$8,000,000	--

Note: Funding in FY 2014 and FY 2015 was provided from the Prevention and Public Health Fund, and FY 2016 funding is requested from the same source.

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

FY 2016 Public Health Service Act Authorization.....Expired

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

Program Description and Accomplishments:

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

In the United States, over 76 percent of older adults have multiple (2 or more) chronic conditions,[44] placing them at greater risk for premature death, poor functional status, unnecessary hospitalizations, adverse drug events, and nursing home placement. [45] Chronic

[44] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [Table 2.6a Self-Reported Health Conditions and Risk Factors of Non-institutionalized Medicare Beneficiaries, by Living Arrangement and Age, 2012]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

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

conditions also impact health care costs, as 93 percent of Medicare expenditures are for beneficiaries with chronic conditions. [46]

CDSME programs have been shown repeatedly, through multiple studies (including randomized control experiments, with both English and Spanish speaking populations), to be effective at helping participants adopt healthy behaviors, and improve their psychological and physical health status. [47] Some evidence suggests that CDSME programs may also significantly reduce the use of hospital care and physician services and reduce health care costs.[48]

CDSMEs emphasize an individual's role in managing his/her illness. The in-person programs consist of a series of workshops that are conducted once a week for two and a half hours over six to seven weeks in health care and community settings such as hospitals, churches, libraries, YW/MCAs, senior centers, public housing projects, community health centers, and cooperative extension programs. People with different chronic health problems attend together, and the workshops are facilitated by two trained leaders. One or both of the leaders are non-health professionals or lay people with chronic diseases themselves. Core topics covered include: techniques to deal with problems such as frustration, fatigue, pain and isolation; appropriate exercise for maintaining and improving strength, flexibility, and endurance; appropriate use of medications; communicating effectively with health professionals; and nutrition.

Funding for CDSME is awarded in the form of competitive grants to states. External experts review project proposals, and project awards are made for periods of up to three years. In FY 2010, AoA funded 47 state grants for CDSME programs for a two year project period, using funding provided under the Recovery Act. ACL also funded a Resource Center through a grant to the National Council on Aging. Competitive grants and contracts are also used to support evaluation, data, and related activities.

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

A new round of grants, funded in FY 2012 through the Prevention and Public Health Fund (PPHF), provided grants to 22 states to continue these activities. These three-year grants will

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

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

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

allow states to provide CDSME programs to approximately 80,000 adults to help them better manage chronic conditions. The funding is not only increasing access to CDSME programs, but also fostering the development of comprehensive, integrated delivery systems to embed and sustain these programs within the long-term supports and services and health care systems.

Funding History:

Funding for Chronic Disease Self-Management Education during the past five years is as follows:

FY 2011 .....$0
FY 2012 .....$10,000,000
FY 2013 .....$7,086,000
FY 2014 .....$8,000,000
FY 2015 .....$8,000,000

Budget Request:

ACL requests FY 2016 funding totaling $8,000,000 for CDSME from the Prevention and Public Health Fund, the same as the FY 2015 enacted level. The Prevention and Public Health Fund (ACA Section 4002) is designed to target resources to activities that invest in prevention and public health programs to improve our nation's health while also restraining the rate of growth in public and private sector health care costs. CDSME programs, by emphasizing an individual's role in managing his/her illness, help participants to reduce their pain and depression, improve mobility and exercise, increase energy, and boost confidence in their ability to manage their conditions.[49] A recent national study indicated that the program can also help participants achieve better care, better health, and lower health care costs. Participants reported significant improvements in aspects of their care (communication with their physicians, medication compliance, and health literacy), better health outcomes (self-assessed health, depression and quality of life), and reduced health care utilization (lower emergency room visits and hospitalizations), resulting in estimated potential cost savings.[50] This continued investment of resources will allow ACL, in coordination with its existing HHS partners and private philanthropy, to continue to build on past investments in CDSME and on ACL's existing service delivery infrastructure as it pursues its goal of taking CDSME to scale nationwide.

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

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

Older Americans are disproportionately affected by a vast array of chronic diseases and conditions. For example, nearly 11 million adults over the age of 65 have diabetes.[51] Minority elders – the fastest growing segment of the elderly population – are especially at risk of chronic illnesses and conditions. CDSME programs are having a significant reach and impact on these populations. In FY 2013 alone, over 29,000 individuals with chronic conditions completed the CDSME program through ACL's network (Output CD1). Nearly 61 percent of participants reporting relevant data indicate having multiple chronic conditions, with the most common conditions being hypertension (43.7 percent), arthritis (41.1 percent), and diabetes (31.2 percent). Over one-third of the participants are minority elders, including 23 percent African-Americans and over 16 percent Hispanics.

CDSME programs are also especially well-suited for delivery through ACL's network of community based organizations, including senior centers, congregate meal programs, faith-based organizations and senior housing projects. At the community level, aging services provider organizations work in collaboration with public health agencies and health care providers. Participant referrals to the CDSME program come from both clinical and community-based organizations. Clinical referrals come from community-health centers, physicians, hospitals, managed care organizations, and other health system components. Community referrals come from a variety of sources, including the Aging and Disability Resource Centers.

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

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

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

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
CD2: Increase the percentage of individuals who complete the CDSME program *(Outcome)*	FY 2013: 74% (Baseline)	75%	75%	Maintain
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output CD1: Total number of individuals with chronic conditions completing the CDSME program *(Output)*	FY 2013: 29,763	20,000	20,000	Maintain

Evaluation

In its initial evaluation design work, ACL partnered with the Agency for Healthcare Research and Quality and the Assistant Secretary for Planning and Evaluation to determine the most promising approach for rigorously evaluating the effectiveness of employing CDSME in the Aging Services Network. In FY 2010, ACL initiated a design contract through AHRQ for recommendations on how to best carry out an evaluation. The evaluation design recommendations were completed in the spring of 2011. Using the recommendations as a foundation, ACL awarded a contract in the fall of 2011 for an evaluation of how the CDSME program is being implemented through the aging network and its partners (i.e., a process evaluation) and a more detailed outcome evaluation design. The contract was modified in 2012 to eliminate the detailed outcome evaluation design as ACL is working with CMS to match CDSME participants with their Medicare records, and to identify a matched comparison group of similar Medicare recipients, in order to analyze changes in health care utilization between the two groups. The process evaluation was completed during the summer of 2013 and the final report is available on the ACL website.[52] A retrospective outcome study conducted by CMS was completed in the fall of 2013. A copy of the CMS report which includes CDSME outcomes is available on the CMS website.[53] CMS is currently conducting a prospective study to analyze beneficiary readiness to engage in community based wellness and prevention activities and to evaluate existing program impacts on both the health and wellbeing of participating beneficiaries.

[52] http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx

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

Grant Awards Table:

Chronic Disease Self-Management Education Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	23	11	11
Average Award	$329,517	$679,918	$679,918
Range of Awards	$152,000 - $1,000,000	$152,000 - $1,000,000	$152,000 - $1,000,000

Resource and Program Data:

Chronic Disease Self-Management Education
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	10	6,479	11	7,479
Continuations	23	7,579	1	1,000	--	--
Contracts	2	218	2	284	2	284
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		203		237		237
Total Resources		8,000		7,989		8,000

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

Falls Prevention

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Falls Prevention……..	$5,000,000	$5,000,000	$5,000,000	--

Note: Funding in FY 2014 and FY 2015 was provided from the Prevention and Public Health Fund, and FY 2016 funding is requested from the same source.

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

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

Program Description and Accomplishments:

Falls are the leading cause of both fatal and nonfatal injuries for those 65 and over.[54] One in three adults aged 65 and older falls each year.[55] In 2010, fall-related injuries resulted in 2.3 million emergency room visits, over 660,000 hospitalizations, about 21,700 deaths, and an estimated $30 billion in direct medical costs.[56] Of those who fall, 20 to 30 percent will experience serious injuries, such as brain trauma, broken bones, or hip fractures.[57] The average hospital stay for a hip fracture is one week, and about one-third of those with hip fractures stay in a nursing home for a year or more.[58] 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.[59] Many people limit their activity after a fall, which may reduce strength, physical fitness, and mobility.[60] The importance of preventing falls is underscored by the inclusion of falls prevention screening in the annual Medicare wellness visit.

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

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

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

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

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

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

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

Falls can result in significant loss of independence and often trigger the onset of a series of growing needs. For those over age 75, fallers are more than four times more likely to be admitted to a skilled nursing facility.[61] Even without a major injury, falls can cause an older adult to become fearful or depressed, making it difficult for them to stay active, which in turn increases the need for assistance.

Falls prevention programs help participants to achieve improved strength, balance, and mobility and provide education on how to avoid falls and reduce fall risk factors. These programs may also involve medication reviews and modifications; provide referrals for medical care management for selected fall risk factors; and provide home hazard assessments of ways to reduce environmental hazards. Since 2006, more than 27,000 older adults in 38 states have been served via ACL-supported Falls Prevention/Management programs, including A Matter of Balance, Stepping On, and Tai Chi: Moving for Better Balance.

Randomized controlled trials of several community-based Falls Prevention/Management programs have clearly demonstrated a reduction in falls. When compared with control groups, the risk of falling for participants in the Tai Chi: Moving for Better Balance intervention was decreased 55 percent;[62] and the Stepping On program reduction was 31 percent.[63] Matter of Balance is an evidence-based program designed to reduce the fear of falling and increase activity levels among older adults. Research has shown significant improvements for participants regarding their level of falls management (the degree of confidence participants perceive concerning their ability to manage the risk of falls and of actual falls); falls control (the degree to which participants perceive their ability to prevent falls); level of exercise; and social limitations with regard to concern about falling.[64] Matter of Balance participation has been associated with total medical cost savings, and cost savings in the unplanned inpatient, skilled nursing facility, and home health settings. Participation was associated with a -$938 decrease in total medical costs per year. This finding was driven by a -$517 reduction in unplanned hospitalization costs, a -$234 reduction in skilled nursing facility costs, and an -$81 reduction in home health costs.[65]

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

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

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

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

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

Funding History

Funding for Falls Prevention during the past five years is as follows:

FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$5,000,000
FY 2015 .....$5,000,000

Budget Request:

ACL is requesting $5,000,000 from the Prevention and Public Health Fund in FY 2016, the same as the FY 2015 enacted level. Falls Prevention activities received their first funding in FY 2014, and funded a national resource center and provided grants to States, Tribes, and/or other applicants to implement evidence-based falls prevention programs through ACL's network of community-based provider organizations that are sustained in community settings.

ACL's Falls Prevention program aligns with and complements funding received by the Centers for Disease Control and Prevention (CDC), which also carries out falls prevention efforts. CDC's falls prevention programs in the clinical/medical setting refer individuals at risk for falls to programs in the community, where ACL excels. ACL has a long-standing commitment to the translation of evidence-based prevention programs from the research setting into community practice, and funding to ACL leverages, rather than duplicates, what CDC has invested in provider training and program translation to improve access to evidence-based programs in local communities to prevent older adult falls. ACL's national infrastructure has enabled over 264,000 individuals throughout the country to participate in evidence-based chronic disease self-management education, falls prevention, diabetes self-management training, physical activity, nutrition education, and depression management programs.

Grants are used to:

- Promote and disseminate fall prevention tools, including education and evidence-based falls prevention material that can be delivered in community settings.

- Align with the Affordable Care Act, including the annual Medicare wellness visits that include screening for falls prevention and referrals to community-based interventions, as well as care transitions programs to reduce hospital readmissions due to falls.

- Utilize and expand the local evidence-based program infrastructure for falls prevention programs started in the ACL Evidence-Based Disease and Disability Prevention Program.

- Increase the number of older adults and adults with disabilities at risk for falls who attend an evidence-based falls prevention program in their communities.

- Gather and promote best practices for development, implementation, and sustainability of evidence-based falls prevention programs appropriate for a community setting, including innovative collaborations with integrated health care systems and large employer groups.

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

Grant Awards Table:

Falls Prevention Program Grant Awards

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	15	15	15
Average Award	$323,238	$317,968	$317,968
Range of Awards	$200,000 - $450,000	$200,000 - $450,000	$200,000 - $450,000

Resource and Program Data:

Falls Prevention
(Dollars in Thousands)

Mechanism	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	15	4,839	14	4,370	15	4,770
Continuations	--	--	1	400	--	--
Contracts	1	104	1	197	1	197
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		47		34		34
Total Resources		5,000		5,000		5,000

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

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Native American Nutrition and Supportive Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Native American Nutrition & Supportive Services…..	$26,158,000	$26,158,000	$29,100,000	$2,942,000

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

FY 2016 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. An estimated 591,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[66] Over 291,000 of those elders identify as Native American or Alaskan Native with no other racial group.[67]

Native American Nutrition and Supportive Services grants support a broad range of services to older Native Americans, including adult day care; transportation; congregate and home-delivered meals; information and referral; and personal care, chore, and other supportive services. Currently ACL's congregate meal program reaches 24 percent of eligible Native American seniors in participating Tribal organizations, home-delivered meals reach 12 percent of such persons, and supportive services reach 41 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.

[66] U.S. Census Bureau, 2012 American Community Survey. . S0201: Selected Population Profile In The United States. http://factfinder.census.gov. Accessed 12 January 2015. And 2010 Census Summary File 2. DP-1-Geography-United States POPGROUP-American Indian and Alaska Native alone or in combination with one or more other races (300, A01-Z99) & (100-299) or (300, A01-Z99) or (400-999): Profile of General Population and Housing Characteristics: 2010. Accessed 26 August 2013.

[67] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2012), accessed January, 08, 2015.

Services provided by this program in FY 2013, the most recent year for which data are available, include:

- *Transportation Services*, which provided 661,435 rides to meal sites, medical appointments, pharmacies, grocery stores, and other critical daily activities (Output L).

- *Home-Delivered Nutrition Services,* under which 2.6 million meals were provided to 25,192 homebound Native American elders. The program also provides critical social contacts that help to reduce the risk of depression and isolation experienced by many home-bound Native American elders (Output M).

- *Congregate Nutrition Services*, which provided 2.4 million meals to 52,137 Native American elders in community-based settings, as well as an opportunity for elders to socialize and participate in a variety of activities, including cultural and wellness programs (Output N).

- *Information, Referral and Outreach Services*, which provided 920,928 hours of outreach and information on services and programs to Native American elders and their families, thereby empowering them to make informed choices about their service and care needs (Output O).

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

Eligible Tribal organizations receive nutrition and supportive services formula grants based on their share of the American Indian, Alaskan Native, and Native Hawaiian population age 60 and over. Tribal organizations must represent at least 50 Native American elders age 60 and over to receive funding. There is no requirement for matching funds. In addition, Tribes may decide the age at which a member is considered an elder and thus eligible for services. In FY 2014, grants were awarded to 264 Tribal organizations (representing 400 Tribes), including one organization serving Native Hawaiian elders, with an average award of $96,886 and a range of grant awards from $63,900 to $1,505,000.

Funding History:

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

FY 2011 .....$27,653,000
FY 2012 .....$27,601,000
FY 2013 .....$26,157,052
FY 2014 .....$26,158,000
FY 2015 .....$26,158,000

Budget Request:

The FY 2016 request for Native American Nutrition and Supportive Services is $29,100,000, an increase of +$2,942,000 above the FY 2015 enacted level.

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

At the FY 2016 request level, these services will provide 620,000 rides (Output L), 2.9 million meals at home (Output M), and 2.5 million meals at congregate sites (Output N) to over 74,000 Native American seniors. Services will allow Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation for as long as they desire.

In FY 2016 the targeted number of units of service, such as home-delivered meals and transportation trips, provided to Native Americans per thousand dollars of ACL funding is projected at 304, a 38 percent increase over the FY 2002 base of 220 (Outcome 1.3). Over the past several years Native American services have generally met or exceeded their efficiency and output targets for meals and trips due in part to increased contributions from tribal organizations.

Outcome and Outputs Table:

Native American Nutrition & Supportive Services Outcome and Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Outcome 1.3: For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of ACL funding. *(Outcome)*	FY 2013: 303 Target: 300 (Target Exceeded)	300	304	+4
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output L: Transportation Services units *(Output)*	FY 2013: 661,435	590,000	620,000	+30,000
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2013: 2.6 M	2.6 M	2.9 M	+0.3 M
Output N: Congregate Nutrition meals *(Output)*	FY 2013: 2.4 M	2.3 M	2.5 M	+0.2 M
Output O: Information, Referral and Outreach units *(Output)*	FY 2013: 920,928	902,000	1.0 M	+88,000

Grant Awards Table:

Native American Nutrition & Supportive Services Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	265	265	265
Average Award	$97,086	$97,086	$107,951
Range of Awards	$63,900 - $1,505,000	$63,900 - $1,505,000	$71,780 - $1,505,000

Resource and Program Data:

Native American Nutrition and Supportive Services
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	264	25,578	264	25,580	264	28,457
New Discretionary	1	150	--	--	--	--
Continuations	--	--	1	150	1	150
Contracts	1	392	1	401	1	446
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		38		27		47
Total Resources		26,158		26,158		29,100

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

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Aging Network Support Activities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Aging Network Support Activities	$7,406,000	$9,961,000	$9,961,000	--

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

FY 2016 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

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

Competitive grants, cooperative agreements, and contracts for Aging Network Support Activities are awarded to eligible public or private agencies and organizations, States, and Area Agencies on Aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are required to provide a match equal to 25 percent of the project's total cost. Project proposals are reviewed by external experts and project awards are made for periods of one to five years. In FY 2014, Aging Network Support Activities funded 24 grants with an average award of $295,230.

National Eldercare Locator and Engagement

Older Americans and their caregivers face a complicated array of choices and decisions about health care, pensions, insurance, housing, financial management, and long-term care. The Eldercare Locator, created in 1991, helps seniors and their families navigate this complex environment by connecting those needing assistance with State and local agencies on aging that serve older adults and their caregivers. The Eldercare Locator can be accessed through a toll-free

nationwide telephone line (800-677-1116) or website (http://www.eldercare.gov). The phone line and website both connect those in need to providers in every zip code in the nation. The Eldercare Locator website continues to grow as a resource tool for older adults and their caregivers, serving 738,234 individuals in FY 2013.

ACL also supports civic engagement efforts that help connect older adults with volunteer opportunities in their communities. In FY 2011, ACL/AoA launched the *Aging Network's Volunteer Collaborative.* The Collaborative is a partnership of a number of aging organizations and the Corporation for National and Community Service. It has assessed needs and barriers to volunteering, offers technical assistance through workshops and webinars, developed a robust website, and awarded small incentive grants. In FY 2014, building on the work of the Collaborative, ACL funded a National Volunteer Resource Center that will assist in developing and sustaining the volunteer capacity within the aging network as well as provide cost saving services to organizations within the network.

National Alzheimer's Call Center

The National Alzheimer's Call Center is a national information and counseling service for persons with Alzheimer's disease, their family members, and informal caregivers. In the 12-month period ending January 31, 2013, the National Alzheimer's Call Center handled over 294,000 calls through its national and local partners, and its on-line message board community recorded over 5.2 million page views. The National Alzheimer's Call Center is available to people in all States, 24 hours a day, 7 days a week, 365 days a year to provide expert advice, care consultation, and information and referrals at the national and local levels regarding Alzheimer's disease. Trained professional customer service staff and Masters degree social workers are available at all times. The Call Center is accessible by telephone, website, or e-mail at no cost to the caller. Information provided may include basic information on caregiving, handling legal issues, resources for long-distance caregiving, and tips for working with the medical community. Local community-based organizations are directly involved to ensure local, on-the-ground capacity to respond to emergencies and on-going needs of Alzheimer's patients, their families, and informal caregivers. The Call Center has multilingual capacity and responds to inquiries in at least 140 languages through its own bilingual staff and with the use of a language interpretation service.

Pension Counseling and Retirement Information

The Pension Counseling program, first funded in 1993, assists older Americans in accessing information about their retirement benefits and helps them negotiate with former employers or pension plans for due compensation. Currently there are more than 700,000 private (as well as thousands of public) pension and retirement plans in the United States. Given that an employee may have worked for several employers, and these employers may have merged, sold their plans, or gone bankrupt, it is very difficult for the average person to know where to go to get help in

finding out whether he or she is receiving all of their pension benefits. ACL currently funds six regional counseling projects covering 29 States. Data for the program show that:

- Pension Counseling projects have successfully recovered over $175 million in client benefits, representing a return of more than eight dollars for every Federal dollar invested in the program.

- Projects have directly served over 50,000 individuals by providing hands-on assistance in pursuing claims through administrative appeals processes, helping seniors to locate pension plans "lost" as a result of mergers and acquisition, answering queries about complex plan provisions, and making targeted referrals to other professionals for assistance.

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

ACL also supports the National Education and Resource Center on Women and Retirement Planning, which provides access to a one-stop gateway that integrates financial information and resources on retirement planning for health and long-term care. This project has made user-friendly financial education and retirement planning tools available to traditionally hard-to-reach women, including low-income women, women of color, women with limited English speaking proficiency, rural, and other "underserved" women. Information is offered through financial and retirement planning programs, workshops tailored to meet women's special needs, and published in hard copy and Web-based formats. Since its establishment 1998, the Center has conducted approximately 200 workshops per year on strategies to access financial and retirement planning information for women. It has developed and published over 175 Fact Sheets tailored to the specific needs of hard-to-reach women and maintains an interactive web site.

National Resource Centers on Native American Elders

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

program planning and direction. This process has developed a database of information about American Indian, Alaska Native and Native Hawaiian Elders. The University of Hawaii Resource Center has focused on long term care needs of Native Hawaiian Elders. The University of Alaska Resource Center has focused on elder abuse and neglect issues within Native communities.

National Minority Aging Organizations Technical Assistance Centers

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

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

LGBT elders also face a number of unique challenges as they strive to maintain their independence. The LGBT Resource Center, established in 2010, strives to meet three primary objectives: to educate mainstream aging services organizations about the existence and special needs of LGBT elders, to sensitize LGBT organizations about the existence and special needs of older adults, and to educate LGBT individuals about the importance of planning ahead for future long-term care needs. The national resource center formally began services in September 2010 with the launching of a website including training curricula and social networking tools. In 2016, with the groundwork and tools now in place and available, a primary Resource Center focus will be on the provision of training and technical assistance for community providers across the country.

Holocaust Survivor Assistance

The United States is home to an estimated 130,000 victims of Nazi persecution, approximately 25 percent of whom are living in poverty. Because of the experiences they endured early on in

their lives, Holocaust survivors are likely to have greater and more complex physical and mental health needs as they age. The nonprofit social service agencies that serve this population have projected that the need for supportive services will continue to grow and intensify over the next five to ten years.

In FY 2015, ACL will develop a program to help provide supportive services for aging Holocaust survivors in the United States. The program will advance innovative approaches to help this population age with dignity and support in their homes and communities.

Program Performance and Technical Assistance

This activity supports cooperative efforts between ACL and selected States and AAAs to develop tools, performance measures, and best practices that can be used to effectively and efficiently identify the results produced through OAA programs on an ongoing basis. It also supports partnerships with National Aging Organizations to foster innovation and provide technical assistance to States, AAAs, and Tribal organizations in strategic planning, program development, and performance improvement.

Funding History:

Comparable funding for Aging Network Support Activities is as follows:

FY 2011 .....$8,184,000
FY 2012 .....$7,873,000
FY 2013 .....$7,431,864
FY 2014 .....$7,406,000
FY 2015 .....$9,961,000

Budget Request:

The FY 2016 request for Aging Network Support Activities is $9,961,000, the same as the FY 2015 enacted level. Within this budget, $2,500,000 is specifically for Holocaust Survivors, the same level of funding for this purpose provided in FY 2015. All programs funded by this request provide critical and ongoing support for the national aging services network and are needed to support the activities of ACL's core service delivery programs. Not only do they provide a variety of services, some of which – such as the National Alzheimer's Call Center and the National Eldercare Locator – are not the responsibility of any other government agency, these programs also considerably strengthen and streamline ACL's core services, and are critical to our continuing success.

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

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

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Aging Network Support Activities:			
National Eldercare Locator and Engagement	$ 2,023	$ 2,038	$ 2,038
National Alzheimer's Call Center	939	945	945
National Education & Resource Center on Women & Retirement	233	235	235
Pension Information and Counseling Program	1,611	1,623	1,623
National Resource Centers on Native Americans	650	655	655
National Minority Aging Organizations	1,157	1,165	1,165
Holocaust Survivor Assistance	0	2,500	2,500
Program Performance and Technical Assistance	793	799	799
Total, Aging Network Support Activities	**$7,406**	**$9,961**	**$9,961**

Grant Awards Table:

Aging Network Support Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	28	26	33
Average Award	$255,604	$377,865	$297,712
Range of Awards	$104,516 - $1,121,518	$104,516 - $2,391,817	$104,516 - $2,391,817

Resource and Program Data:

Aging Network Support Activities
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	6	897	11	4,936	10	3,126
Continuations	22	6,260	15	4,889	23	6,698
Contracts	2	35	2	20	2	20
Interagency Agreements	1	38	--	--	--	--
Program Support 1/		177		117		117
Total Resources		7,406		9,961		9,961

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

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Caregiver and Family Support Services

Summary of Request

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

Better support for informal caregivers is critical because often it is their availability - whether they are informal family caregivers, paraprofessionals, or unrelated friends and neighbors who volunteer their time - that determines whether an older person can remain in his or her home. In 2009, approximately 43.5 million adult caregivers provided uncompensated care to those 50 years of age and older.[68] In 2014, the Rand Corporation estimated the economic cost of replacing unpaid caregiving to be about $522 billion annually,[69] higher than that of *all* Medicaid spending in FY 2013 (Federal and state: $431 billion).[70]

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.[71] Providing support that makes caregiving easier for family caregivers, such as information, counseling and training, respite care, or supplemental services, is critical to sustaining caregivers' ability to continue in that role. Seventy-seven percent of the caregivers served by OAA programs report that these services allow them to provide care longer than they otherwise could.[72]

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

[69] *The Opportunity Costs of Informal Elder-Care in the United States.* Rand Corporation. http://www.rand.org/pubs/external_publications/EP66196.html. Also *Valuing the Invaluable: 2011 Update, The Growing Contributions and Costs of Family Caregiving*. AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

[70] "Total Medicaid Spending," The Henry J. Kaiser Family Foundation, 2013. http://kff.org/medicaid/state-indicator/total-medicaid-spending/.

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

[72] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

At the same time, ACL recognizes that it must also address the growing need for more caregivers every day. By 2020, it is projected that there will be 17.8 million non-institutionalized seniors age 65 and over with 1+ ADL deficits, an increase of 3.2 million seniors (or a 22 percent increase between 2014 and 2020) needing caregiver assistance.[73] To address these caregiver-related needs, ACL requests a total of $191,686,000, an increase of +$23,409,000 from the comparable FY 2015 enacted level level. The request includes:

- $150,586,000 for Family Caregiver Support Services, an increase of +$5,000,000 above the FY 2015 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.

- $15,000,000 in funding for the new Family Support program. This program will utilize known, evidence-based approaches to develop and implement a sustainable national strategy to provide supports that bolster the ability of families to provide high-quality care for their loved ones while maintaining a quality of life for themselves by accessing multi-dimensional, flexible support and leveraging and enhancing their local community resources.

- $6,800,000 for Native American Caregiver Support Services, an increase of +$769,000 above the FY 2015 enacted level. This program makes a range of services available to Native American caregivers, including information and outreach, access assistance, individual counseling, support groups and training, respite care and other supplemental services.

- $3,800,000 for Alzheimer's Disease Supportive Services, the same as the FY 2015 enacted level. This program is currently the only program at HHS focused specifically on supportive services for those with Alzheimer's Disease (AD) and their caregivers. One critical focus of this program is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue

[73] U.S. Census Bureau, "2014 National Population Projections," Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060. Released December 2014, http://www.census.gov/population/projections/data/national/2014/downloadablefiles.html. Accessed 08 January 2015.and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2012 Medicare Current Beneficiary Survey. [data tables 2.5a]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2012CNP.html. Accessed 23 October, 2014.

living in the community. Another focus is to expand the availability of evidence-based diagnostic and support services to those with Alzheimer's.

- $10,500,000 for services to individuals with Alzheimer's Disease (AD) and their families under the President's Alzheimer's Initiative, funded from the Prevention and Public Health Fund. The same amount was requested from the Prevention Fund in FY 2015. Funds will be used to expand efforts to develop more AD-capable long-term services and supports systems designed to meet the needs of AD caregivers. Caregivers will be linked to interventions shown to decrease their burden and depression and thus improve their health outcomes.

- $5,000,000 for Lifespan Respite Care, an increase of +$2,640,000 above the FY 2015 enacted level. This program funds grants to improve the quality and access to respite care for family caregivers of children or adults of any age with special needs.

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

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Family Caregiver Support Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Family Caregiver Support Services	$145,586,000	$145,586,000	$150,586,000	$5,000,000

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method.....Formula Grant

Program Description and Accomplishments:

Family Caregiver Support Services provides grants to States and Territories, based on their share of the population age 70 and over, to fund a range of supports that assist family and informal caregivers to care for their loved ones at home for as long as possible. The program includes five basic system components: information, access assistance, counseling and training, respite care, and supplemental services. These services work in conjunction with other OAA services to provide a coordinated set of supports which caregivers can access on behalf of seniors. Family Caregiver Support Services provide a variety of supports to family and informal caregivers. Based on FY 2013 data, the most recent available, services provided included:

- *Access Assistance Services* provided nearly 1.15 million contacts to caregivers assisting them in locating services from a variety of public and private agencies (Output I).

- *Counseling and Training Services* provided 125,948 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 63,000 caregivers with 5.9 million hours of temporary relief, at home or in an adult day care or nursing home setting, from their caregiving responsibilities (Output K).

Family and other informal caregivers are the backbone of America's long-term care system. On a daily basis, these individuals assist relatives and other loved ones with tasks ranging from personal care and homemaking to more complex health-related interventions like medication administration and wound care. In 2014, a Rand Corporation study estimated the economic cost

of replacing unpaid caregiving in to be about $522 billion annually,[74] higher than that of *all* Medicaid spending in FY 2013 (Federal and state: $431 billion).[75] The cost to replace that care with unskilled paid care at minimum wage was estimated at $221 billion, while replacing it with skilled nursing care could cost $642 billion, annually. Caregivers often experience conflicts between work and caregiving, with 25 percent reporting that they have had to make adjustments such as retiring or taking time away from work due to their caregiving responsibilities.

Research has also shown that caregiving exacts a heavy emotional, physical, and financial toll. As reported in ACL's National Survey of OAA Participants, 20 percent of caregivers are assisting two or more individuals. Sixty-seven percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and twenty-eight percent describe their own health as fair to poor.[76] The demands of caregiving can lead to a breakdown of the caregiver's health, and the illness, hospitalization, or death of a caregiver increases the risk for institutionalization of the care recipient.

Studies have shown that the types of supports provided through the Family Caregiver Support Services Program can reduce caregiver depression, anxiety, and stress and enable them to provide care longer while often continuing to work, thereby avoiding or delaying the need for costly institutional care for their loved ones. For example, one study indicates that counseling and support for caregivers of individuals with Alzheimer's disease can permit the care recipient to stay at home, at significantly less cost, for an additional year before being admitted to a nursing home.[77]

Additionally, data from ACL's National Surveys of caregivers of elderly clients also shows that OAA services, including those provided through Family Caregiver Support Services, are effective in helping caregivers keep their loved ones at home. Approximately 77 percent of caregivers of program clients reported that services enabled them to provide care longer than otherwise would have been possible.[78] Caregivers receiving services were also asked whether the care recipient would have been able to live in the same residence if the services had not been available. Forty-two percent of the caregivers of nursing home eligible care recipients indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without

[74] *The Opportunity Costs of Informal Elder-Care in the United States.* The Rand Corporation. 2014. http://www.rand.org/pubs/external_publications/EP66196.html.

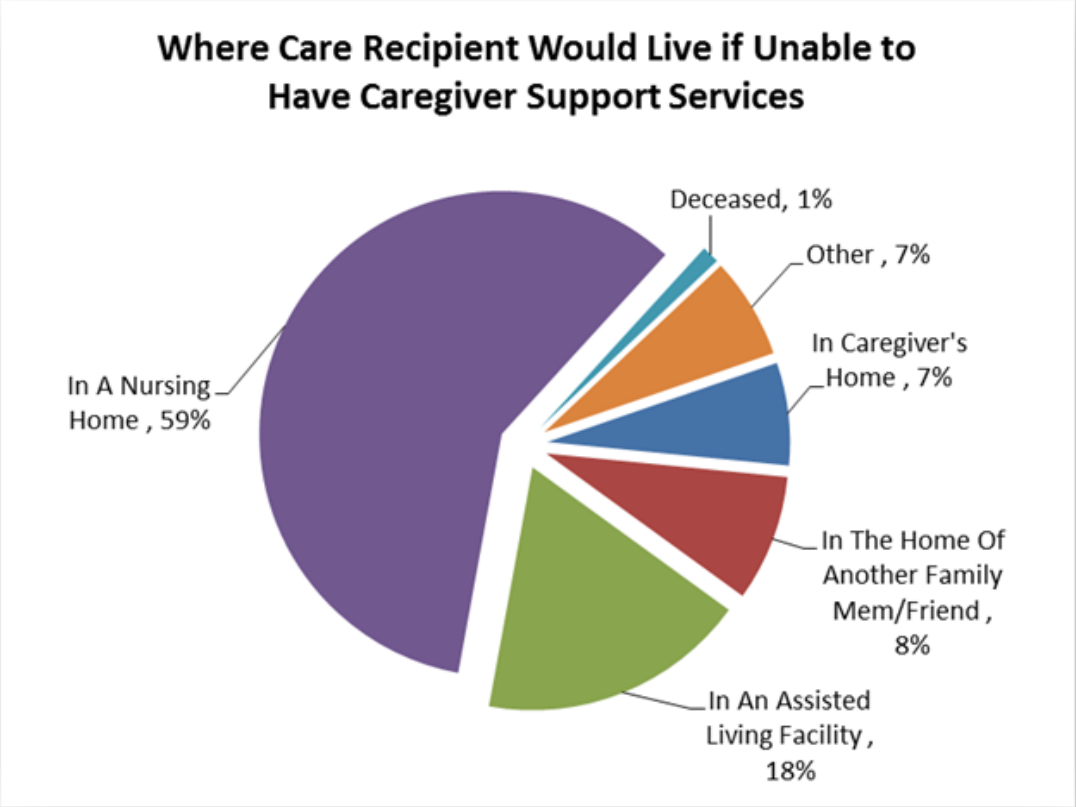
[75] "Total Medicaid Spending," The Henry J. Kaiser Family Foundation, 2013. http://kff.org/medicaid/state-indicator/total-medicaid-spending/.

[76] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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

[78] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

services. A significant majority of those caregivers, 77 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see below).



(based on responses from care recipients unable to live independently) [79]

Funding History:

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

FY 2011 .....$153,912,000
FY 2012 .....$153,621,000
FY 2013 .....$145,585,801
FY 2014 .....$145,586,000
FY 2015 .....$145,586,000

[79] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

Budget Request:

The FY 2016 request for Family Caregiver Support Services is $150,586,000, an increase of +$5,000,000 above the FY 2015 enacted level. Funding for Family Caregiver Support Services has remained flat and not kept pace with demand or inflation in recent years. The FY 2016 request will allow ACL to increase services, giving caregivers the assistance often needed to help them sustain their caregiving responsibilities and provide care longer. Funding at this level will allow 825,000 caregivers (Outcome 3.1) to receive supportive services, including respite care or other temporary relief from their caregiving responsibilities that will assist caregivers to continue providing care for their loved ones. Approximately 117,000 caregivers will also have the opportunity to participate in counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J), as indicated by the fact that 77 percent of caregivers report these services enable them to provide care longer.

In FY 2016, ACL expects the aging services network to meet or exceed the target of only 27 percent of caregivers experiencing difficulty obtaining services (Outcome 2.6). This is a substantial accomplishment that occurred at the State level as a result of ongoing program development, better coordination, and integration of the Family Caregiver program into the array of State home and community-based services. Baseline levels from 2003 showed that 64 percent of caregivers had difficulty getting services, and by 2013 that rate had been reduced by more than half to 31.6 percent of caregivers reporting difficulty getting services.

For FY 2016, the performance target for Family Caregiver Support Services Program participants who rate services good to excellent is 90 percent (Outcome 2.9c). The substantive improvements in program performance can be attributed to the successful implementation of the program. Client-reported assessment of service quality and program outcomes is also expected to remain at high levels.

Outcomes and Outputs Table:

Family Caregiver Support Services Outcomes and Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Outcome 2.6: Reduce the percent of caregivers who participate in the National Family Caregiver Support Program who report difficulty in getting services. *(Outcome)*	FY 2013: 31.6% Target: 28% (Target Not Met)	27%	27%	Maintain
Outcome 2.9c: Maintain at 90% or higher the percentage of National Family Caregiver Support Program clients who rate services good to excellent. *(Outcome)*	FY 2013: 94.6% Target: 90% (Target Exceeded)	90%	90%	Maintain
Outcome 3.1: Increase the number of caregivers served through the National Family Caregiver Support Program. *(Outcome)*	FY 2013: 1,046,159 Target: 800,000 (Target Exceeded)	790,000	825,000	+ 35,000
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output I: Caregivers access assistance units of service. *(Output)*	FY 2013: 1,148,615	1.03 M	1.05 M	+ 0.02 M
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2013: 125,948	118,000	117,000	- 1,000
Output K: Caregivers receiving respite care services. *(Output)*	FY 2013: 63,080	67,000	68,600	+ 1,600

Note: For presentation within the budget ACL highlighted specific measures that are most directly related to Family Caregiver Support Services, however multiple performance outcomes are impacted by this program because ACL's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.
* Measure seeks a decrease in the percentage of caregivers who report difficulty getting services. A negative change is the desired output.

Grant Awards Table:

Family Caregiver Supportive Services Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$2,573,753	$2,573,753	$2,662,145
Range of Awards	$90,081 - $14,702,604	$90,081 - $14,702,604	$93,175 - $15,239,106

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION ON AGING

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	2,206,505	2,206,505	2,277,029	70,524
Alaska	720,651	720,651	745,400	24,749
Arizona	3,103,554	3,103,554	3,266,453	162,899
Arkansas	1,408,847	1,408,847	1,449,006	40,159
California	14,702,604	14,702,604	15,239,106	536,502
Colorado	1,878,721	1,878,721	1,972,327	93,606
Connecticut	1,721,520	1,721,520	1,769,323	47,803
Delaware	720,651	720,651	745,400	24,749
District of Columbia	720,651	720,651	745,400	24,749
Florida	11,546,017	11,546,017	12,046,368	500,351
Georgia	3,455,065	3,455,065	3,628,955	173,890
Hawaii	720,651	720,651	745,400	24,749
Idaho	720,651	720,651	745,400	24,749
Illinois	5,472,900	5,472,900	5,621,952	149,052
Indiana	2,849,523	2,849,523	2,930,081	80,558
Iowa	1,577,341	1,577,341	1,602,567	25,226
Kansas	1,295,632	1,295,632	1,323,529	27,897
Kentucky	1,935,102	1,935,102	1,992,149	57,047
Louisiana	1,874,587	1,874,587	1,929,375	54,788
Maine	720,651	720,651	745,400	24,749
Maryland	2,396,329	2,396,329	2,493,966	97,637
Massachusetts	3,099,001	3,099,001	3,188,235	89,234
Michigan	4,618,195	4,618,195	4,761,406	143,211
Minnesota	2,374,116	2,374,116	2,453,672	79,556
Mississippi	1,281,036	1,281,036	1,317,318	36,282
Missouri	2,850,250	2,850,250	2,933,553	83,303
Montana	720,651	720,651	745,400	24,749
Nebraska	855,735	855,735	870,870	15,135
Nevada	1,087,045	1,087,045	1,151,609	64,564
New Hampshire	720,651	720,651	745,400	24,749

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	4,044,765	4,044,765	4,155,915	111,150
New Mexico	908,751	908,751	943,943	35,192
New York	8,956,618	8,956,618	9,183,543	226,925
North Carolina	4,195,336	4,195,336	4,379,698	184,362
North Dakota	720,651	720,651	745,400	24,749
Ohio	5,551,309	5,551,309	5,674,469	123,160
Oklahoma	1,703,328	1,703,328	1,752,159	48,831
Oregon	1,820,805	1,820,805	1,893,203	72,398
Pennsylvania	6,751,748	6,751,748	6,891,363	139,615
Rhode Island	720,651	720,651	745,400	24,749
South Carolina	2,125,724	2,125,724	2,231,258	105,534
South Dakota	720,651	720,651	745,400	24,749
Tennessee	2,863,391	2,863,391	2,968,716	105,325
Texas	8,842,879	8,842,879	9,213,916	371,037
Utah	853,564	853,564	891,533	37,969
Vermont	720,651	720,651	745,400	24,749
Virginia	3,301,214	3,301,214	3,438,516	137,302
Washington	2,808,735	2,808,735	2,932,554	123,819
West Virginia	997,669	997,669	1,017,022	19,353
Wisconsin	2,688,849	2,688,849	2,760,876	72,027
Wyoming	720,651	720,651	745,400	24,749
Subtotal, States	141,372,773	141,372,773	146,237,733	4,864,960
American Samoa	90,081	90,081	93,175	3,094
Guam	360,325	360,325	372,700	12,375
Northern Marianas Islands	90,081	90,081	93,175	3,094
Puerto Rico	1,856,555	1,856,555	1,910,657	54,102
Virgin Islands	360,325	360,325	372,700	12,375
Subtotal, States and Territories	144,130,140	144,130,140	149,080,140	4,950,000
Undistributed[80]	1,455,860	1,455,860	1,505,860	50,000
TOTAL	**145,586,000**	**145,586,000**	**150,586,000**	**5,000,000**

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

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Family Support

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Family Support	--	--	$15,000,000	$15,000,000

Authorizing Legislation: Title IV of the Older Americans Act of 1965, as amended, and Section 163 of the Developmental Disabilities Assistance and Bill of Rights Act

FY 2016 Older Americans Act Authorization .....Expired
FY 2016 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments:

Over eighty percent of the long-term services and supports provided to older adults in this country come from family members[81] and over 72 percent of people with intellectual and developmental disabilities live with family caregivers, of which nearly 25 percent of the caregivers are over 60 years old.[82] The White House's Middle Class Task Force recognized that many caregivers are part of the "sandwich generation," meaning that they care for their aging parents and children simultaneously, and as such, the Task Force recommended funding to address the needs of these caregivers as early as FY 2011.

At any given time, approximately 42.1 million Americans are providing supports for an adult family member with limitations in daily activities. The average family caregiver for an adult is female, 49 years old, and works outside of the home. Nevertheless, she spends almost 20 hours per week providing assistance for an average of five years.[83] Among family caregivers of children with intellectual/developmental disabilities (ID/DD), 58 percent report spending more than 40 hours per week providing support, including 40 percent who spend more than 80 hours.[84]

[81] Congressional Budget Office. "Rising Demand for Long Term Services and Supports for Elderly People." June 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44363-LTC.pdf

[82] "State of the States in Developmental Disabilities," 2013, University of Colorado, Braddock et al. http://www.stateofthestates.org/documents/UnitedStates.pdf

[83] "Valuing the Invaluable: 2011 Update." AARP Public Policy Institute. July 2011. http://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf.

[84] "Still in the Shadows with Their Futures Uncertain." The Arc. June 2011. http://www.thearc.org/document.doc?id=3672

In the aggregate, the care provided by informal (family and friend) caregivers of elderly adults has an estimated economic value of $522 billion.[85]

For the sake of comparison, Medicaid spending on Long Term Services and Supports (LTSS) in FY 2012 amounted to $140 billion.[86] The annual value of uncompensated caregiving is actually higher than that of *all* Medicaid spending (Federal and state: $431 billion) in the same year.[87] Two out of three older people with disabilities who receive LTSS at home get all of their care exclusively from family caregivers. Only 9 percent of at-home LTSS for this population is provided exclusively by paid providers.[88] Seventy-five percent of families caring for a child with ID/DD report they cannot find afterschool care, non-institutional community services, trained and reliable home care providers, summer care, residential care, respite and other services.[89] With the number of people currently needing LTSS at 10.9 million and expected to double by 2050, the need for additional support is becoming increasingly costly and dire.[90]

The support provided by families to older adults and people with disabilities will never be replaced by paid services; yet, in order to ensure that families do not collapse under the weight of their caregiving responsibilities, families need to be supported. The impacts on family finances and workplace productivity can be staggering. In 2009, 27 percent of caregivers reported a moderate to high degree of financial hardship as a result of caring for a loved one.[91] Although 58 percent of family caregivers are currently employed while caring for their loved one, 69 percent have had to make workplace accommodations, including in many cases ceasing to work entirely, in order to continue providing care.[92]

The toll on caregivers extends far further than their wallets. Sixty-nine percent of family caregivers report that caring for a loved one is their major source of stress,[93] and between 40 and 70 percent of family caregivers of adults have clinically significant symptoms of depression,

[85] "The Opportunity Costs of Informal Elder-Care in the United States." Rand Corporation. http://www.rand.org/pubs/external_publications/EP66196.html

[86] "Medicaid Expenditures for Long-Term Services and Supports in FFY 2012." http://nasuad.org/sites/nasuad/files/LTSS_Expenditures_2012.pdf

[87] "Total Medicaid Spending," The Henry J. Kaiser Family Foundation, 2013. http://kff.org/medicaid/state-indicator/total-medicaid-spending/.

[88] P. Doty, "The evolving balance of formal and informal, institutional and non-institutional long-term care for older Americans: A thirty-year perspective," Public Policy & Aging Report 20, no. 1 (2010):3–9.

[89] "Still in the Shadows with Their Futures Uncertain."

[90] H. Stephen Kaye, Charlene Harrinson and Mitchell P. LaPlante, "Long-Term Care: Who Gets It, Who Provides It, Who Pays and How Much?" Health Affairs, 29, no.1 (2010). http://content.healthaffairs.org/content/29/1/11.full

[91] NAC and AARP, Caregiving in the U.S. 2009.

[92] NAC and AARP. Caregiving in the U.S. 2009.

[93] Caring.com, 2011 Usage and Attitude Survey.

with one-fourth to one-half meeting the criteria for major depression.[94] The physical effects of caregiving are equally devastating, with highly-stressed family caregivers facing significantly increased rates of heart disease, hypertension, stroke, poorer immune function, slower wound healing, sleep problems, drug use, and even death.[95] This physical and emotional strain on the caregiver has been shown to be a significant predictor of whether an elder will be admitted to a nursing home, regardless of how significant their care needs are.[96]

Demographic trends will place additional pressures on the rapidly growing numbers of unsupported, uncompensated family caregivers. Americans are living longer, but with longer life comes a host of chronic health conditions and disabilities which can require extensive, sophisticated care. Increasingly, this care is being provided by unpaid family caregivers, who are themselves older and frailer than ever before.[97] These demographic trends present troubling questions about whether our current approach of primarily unsupported, unpaid family caregiving can be sustained. Additional attention and investments are needed to establish a comprehensive, coherent, and sustainable system of supports. The ever-growing segment of the American population caring for their loved ones is in crisis, and these trends may soon bring them to a breaking point. It has consistently been the policy of this administration (including through the creation of ACL) to support older people and people with disabilities to remain in their homes and communities. This cannot be fully accomplished without fully addressing the needs of the millions of working families that are providing care and support to their loved ones, and sometimes even to multiple generations of loved ones at once.

ACL has invested well over $1.5 billion over the past ten years into providing services and supports for caregivers, primarily through Older Americans Act programs that address the needs of older adults and the caregiving challenges of their families. At the same time, the Administration on Intellectual and Developmental Disabilities identified several promising practices in supporting families caring for members with lifelong disabilities through Family Support grants (over $51 million since FY 1999) and other initiatives of the Developmental Disabilities Network.

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[94] S. H. Zarit, "Assessment of family caregivers: A research perspective," In Caregiver Assessment: Voices and Views from the Field: Report from a National Consensus Development Conference, Vol. II, edited by the Family Caregiver Alliance. (San Francisco, CA: Family Caregiver Alliance, 2006), pp. 113–37.

[95] "Valuing the Invaluable."

[96] Spillman, Brenda C. and Long, Sharon K. *Does High Caregiver Stress Lead to Nursing Home Entry?*Urban Institute. January 26, 2007. http://aspe.hhs.gov/daltcp/reports/2007/NHentry.htm

[97] D. L. Redfoot and A. Houser, More Older People with Disabilities Living in the Community: Trends from the National Long-Term Care Survey, 1984–2004, AARP Public Policy Institute Research Report 2010-08 (Washington, DC: AARP, September 2010).

Through these investments, we have identified three primary strategies to be incorporated into programs and communities to improve support for families caring for older adults or people with disabilities:

- Knowledge, training, and skill development
- Emotional and social supports, and
- Goods and services (instrumental supports).[98]

Each of these three areas of support is critical to families' ability to facilitate full, productive lives in their communities for both the family members and the individual needing support. We have also identified two other important aspects that are essential to effectively supporting caregivers: first, families and caregivers need flexibility to be able to adapt the supports and services to their particular circumstances; and second, many caregiving solutions must be local and place-based, so communities can leverage their existing resources, thereby avoiding unnecessary duplication and encouraging local ownership. Consistent with other place-based strategies supported by the Administration, ACL's Family Support program would be designed to "to catalyze and empower local action while busting silos, prioritizing public-private partnerships, and making existing programs more effective and efficient." [99]

Many of ACL's prior and current efforts have been focused on the provision of goods and services (such as the National Family Caregiver Support Program and the AIDD Family Support Grants). Other programs, such as Lifespan Respite Care, the Alzheimer's Disease Demonstration Grants, and the Supporting Families Community of Practice, have provided some opportunities to develop models for practice and to foster collaborations between state aging and/or disability agencies, public health departments, private foundations, universities, physicians and managed care organizations, as well as a variety of local community service providers and other community-based organizations. However, these investments have been limited to a specific service or segment of the population, and they have not produced the rigorous research and evidence-base needed to build foundational comprehensive, sustainable, systems of family support across the lifespan.

[98] Community of Practice, *The Goal of Supporting Families*, June 2013. http://supportstofamilies.org/cop/wp-content/uploads/COP-four-pager-final.pdf

[99] http://www.whitehouse.gov/administration/eop/oua/initiatives/neighborhood-revitalization

Funding History:

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

FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$0
FY 2015 .....$0

Budget Request:

In FY 2016, ACL requests $15,000,000 in new funding to develop and implement a comprehensive and sustainable national strategy to ensure the optimal deployment of public and private resources at the state and community level to support family caregivers in America, utilizing known evidence-based approaches, as well as developing innovative and promising practices.

Rather than merely providing transitory social services, these approaches will decrease or even head off reliance on services such as Medicaid HCBS residential care, institutional care and nursing facility care. This initiative will focus instead on approaches that can bolster the ability of families to provide high-quality care for their loved ones while maintaining a quality of life for themselves by accessing multi-dimensional, flexible supports and leveraging and enhancing their local community resources. Of particular interest are supports and services for families balancing workforce participation and caregiving responsibilities. A focus on community-wide participation will access the vast array of existing community assets that can be used to build sustainable family caregiver support systems.

Applicants are expected to be state partnerships including state units on aging, state disability agencies, mental health agencies and other agencies providing support to families across the lifespan. In addition, applicants must demonstrate meaningful engagement with the communities who will receive the bulk of the funding through sub-grants. For FY 2016, grants will be awarded to an estimated 5-7 states with this funding. States will be required to expend a minimum of 75% of the funds on evidence-based and promising practices in supports and services to family caregivers, and up to 25% on innovative approaches, data collection, and evaluation.

Before applying, each state will undertake an environmental assessment, identifying both strengths and weaknesses in their service and support systems for families with caregiving needs, across the populations of older adults and people with disabilities, in the three categories identified above (knowledge, training and skill development; emotional and social supports; and

goods and services). This analysis of strengths and weaknesses will be included in their application, along with a proposal to use grant funds to augment areas of identified weakness.

States would focus on the following priorities:

- Ensure a comprehensive system of supporting caregiver families in the state to minimize out of home placement in residential care for older adults and people with disabilities and to improve family caregiver resiliency;

- Build upon existing caregiving and family support programs and expand promising and evidence-based approaches provided across the life course, particularly encompassing the working age population when economic stressors are most prevalent;

- Expand supports that provide access to futures planning targeted towards families and caregivers, including benefits counseling, financial planning, advance care directives, and alternatives to guardianship;

- Improve and expand the use of technology for purposes such as family mentoring, caregiver support groups, futures and benefits planning, and reducing caregiver isolation;

- Develop, expand, and support peer-to-peer models such as family support networks and dementia care peer supports for caregivers that build upon strength-based models and the shared lived experience, as well as reduce isolation and improve emotional well-being;

- Work with local communities to develop and implement innovative approaches to supporting families through leveraging existing community assets through place-based strategies such as Asset-Based Community Development work;[100]

- Develop rigorous evaluations, including use of rapid-cycle learning to enable adjustments in policy and practice that meets the needs of families and uses federal funds efficiently.

States will use these funds to deploy promising evidence-based approaches in a limited number of communities within their state. As these approaches are implemented and results are documented, a rapid-cycle evaluation will be used so that lessons learned can be used to refine the implementation as it is brought up to statewide scale. Grantee states will be expected to provide significant reporting to ACL and its evaluation contractor in order to facilitate the expansion of the evidence base surrounding family caregiving and supports.

[100] http://www.abcdinstitute.org/

Grant Awards Tables:

Family Support Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	--	--	5-7
Average Award	--	--	$2,000,000
Range of Awards	--	--	$1,000,000 - $5,000,000

Resource and Program Data:

Family Support
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	5-7	12,000
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	1	2,500
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		500
Total Resources		--		--		15,000

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

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Native American Caregiver Support Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Native American Caregiver Support Services…….....	$6,031,000	$6,031,000	$6,800,000	$769,000

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

FY 2016 Authorization .....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

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

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

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

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

Funding History:

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

FY 2011 .....$6,376,000
FY 2012 .....$6,364,000
FY 2013 .....$6,031,076
FY 2014 .....$6,031,000
FY 2015 .....$6,031,000

Budget Request:

The FY 2016 request for Native American Caregiver Support Services is $6,800,000, an increase of +$769,000 above the FY 2015 enacted level. Continued 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.

An estimated 591,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[101] Over 291,000 of those elders identify as Native American or Alaskan Native with no other racial group[102]. Caregiver support services help Native American elders, many of whom have limitations in activities of daily living that make it difficult to care for themselves, to remain at home, in the community, or on the reservation for as long as possible and desired. Studies have shown that providing assistance to caregivers can help them cope with the emotional, physical and financial toll associated with caregiving, thereby enabling them to provide care for their loved ones longer and avoid or delay the need for costly nursing home care.

[101] U.S. Census Bureau, 2012 American Community Survey. . S0201: Selected Population Profile In The United States. http://factfinder.census.gov. Accessed 12 January 2015. And 2010 Census Summary File 2. DP-1-Geography-United States POPGROUP-American Indian and Alaska Native alone or in combination with one or more other races (300, A01-Z99) & (100-299) or (300, A01-Z99) or (400-999): Profile of General Population and Housing Characteristics: 2010. Accessed 26 August 2013.

[102] Administration for Community Living, http://www.agid.acl.gov/DataGlance/. Data-at-a-Glance: American Community Survey (ACS) Public Use Microdata Sample (PUMS) 1-Year Files (2012), accessed January, 08, 2015.

Performance data indicates that these programs are an efficient means to help Native American Elders remain independent and in the community. In FY 2016, funding for the Native American Caregiver Support Program will continue to assist family and informal caregivers, whose assistance is critical to enabling Native American elders to remain at home, in the community, and/or on the reservation. It is estimated that in FY 2016 more than 420,000 units of caregiver-related services including respite care, information and referral, caregiver training, lending closets, and support groups will have been provided by Native American Tribal organizations.

Outcome Table:

Native American Caregivers Supportive Services Outcome

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Outcome 3.1: Increase the number of caregivers served through the National Family Caregiver Support Program. *(Outcome)*	FY 2013: 1,046,159 Target: 800,000 (Target Exceeded)	790,000	825,000	+ 35,000

Grant Awards Table:

Native American Caregivers Supportive Services Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	231	231	231
Average Award	$26,108	$26,043	$29,364
Range of Awards	$11,480 - $47,362	$11,480 - $47,362	$12,940 - $53,330

Resource and Program Data:

Native American Caregiver Support Services
(Dollars in thousands)

Mechanism	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	231	6,031	231	6,016	231	6,783
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		15		17
Total Resources		6,031		6,031		6,800

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

Alzheimer's Disease Supportive Services Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
ADSSP……..	$3,772,000	$3,800,000	$3,800,000	--

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

FY 2016 Authorization .....Expired

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

Program Description and Accomplishments:

The Alzheimer's Disease Supportive Services Program (ADSSP) funds competitive grants to States to expand the availability of evidence-based interventions and dementia-capable long term services and supports (LTSS) systems. These systems are able to identify those with dementia and their family caregivers, understand their unique circumstances, communicate appropriately with them, help them choose services that meet their needs, and provide supports to ease caregiver stress. Dementia-capable systems also help persons with dementia and their family caregivers remain independent. The primary components of the ADSSP program include delivering evidence-based LTSS; translating evidence-based interventions for persons with dementia and their caregivers at the community level; incorporating evidence-based research in the formulation of innovative projects; and promoting dementia-capable LTSS. The statute governing the ADSSP requires that States "expend not less than 50 percent of the federal grant funds for the provision of (direct) services" to individuals with Alzheimer's disease or related dementias, and their family caregivers.

The most recent grant projects are designed to ensure that states provide people with dementia and their family caregivers with access to a sustainable home and community-based services (HCBS) system that is dementia capable. There are presently fifteen states engaged in projects dedicated to the implementation of dementia-capable services.

One example of an evidence-based intervention is the New York University Caregiver Intervention, a spousal caregiver support program that in a randomized-control trial delayed

institutionalization of persons with dementia by an average of 557 days.[103] Minnesota has translated this intervention and results are consistent with the original study.[104] Other grant projects are focused on innovations in areas of great need, such as programs to ensure that the States' LTSS systems are dementia capable. Overall, these demonstrations offer direct services and other supports to thousands of families, while ensuring continuous quality improvement and evaluation of these services.

Family caregivers remain the major source of support for most people with Alzheimer's disease. The nature of the disease – a slow loss of cognitive and functional/physical independence – means that most people with Alzheimer's disease rely on family and LTSS 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 health and LTSS systems are responsive to persons with dementia and effectively coordinated.

Funding History:

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

FY 2011 .....$11,441,000
FY 2012 .....$4,010,000
FY 2013 .....$3,785,653
FY 2014 .....$3,772,000
FY 2015 .....$3,800,000

Budget Request:

The FY 2016 request for the Alzheimer's Disease Supportive Services Program is $3,800,000, the same as the FY 2015 enacted level.

The need for cutting edge approaches that serve those with Alzheimer's and their caregivers continues to grow as the incidence and population and with the disease increase. One study estimates that there were 454,000 new cases of Alzheimer's disease in 2010. The annual number of new cases is projected to be 615,000 by 2030, and 959,000 by 2050. Currently, about 5 million individuals have this disease. [105]

[103] 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.

[104] Mittelman, M.S., Bartels, S.J. "Translating Research into Practice: Case Study of a Community-based Dementia Caregiver Intervention," Health Affairs. April 2014 vol. 33 no. 4 587-595.

[105] Alzheimer's Association, (2014). "2014 Alzheimer's Disease Facts and Figures". Accessed August 08, 2014 from: http://www.alz.org/downloads/facts_figures_2014.pdf

The FY 2016 funding request will allow ACL to continue to respond to this growing need by supporting new grants that provide direct services to approximately 35,000 persons with Alzheimer's disease and their family caregivers. This will enable communities across the nation to continue implementing evidence-based interventions such as the New York University Caregiver Intervention referenced above. In addition, without this funding, ACL will be unable to undertake subsequent translations of research funded by National Institute on Aging, Centers for Disease Control and Prevention, and other science agencies. Funds will be used to broadly disseminate those translated, evidence-based interventions that have proven successful over the past 6 years of funding and to test new evidence-based interventions as they are identified. In addition, funds will be used to expand the delivery of dementia-capable LTSS, thus helping a much broader population of families struggling to cope with this disease.

ACL is examining how these interventions can be effectively provided through State LTSS systems, while ensuring fidelity to the original intervention. Successful translation of these research interventions to community settings will have a significant impact on supporting and sustaining family caregivers.

By the end of FY 2015, ACL anticipates the release a joint analysis of results from a six-state translation effort of the New York University Caregiver Intervention, which aims to significantly delay institutionalization of persons with dementia by providing education, support, and counseling to spousal and other family caregivers. ACL projects that it will also have an analysis of a three-state translation of the *Savvy Caregiver Intervention.* This intervention trains caregivers to think about their situation objectively and provides them with the knowledge, skills, and attitudes they need to manage stress and carry out the caregiving role effectively.

Outcome and Outputs Table:

Alzheimer's Disease Supportive Services Program Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
Outcome ALZ2. Increase number of individuals served with evidence-based interventions – cumulative[106] *(Outcome)*	FY 2013: 19,261 Target: 15,800 (Target Exceeded)	21,500	21,957	+ 457
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output AC: Number of individuals served – cumulative[107] *(Output)*	FY 2013: 42,354	48,000	48,750	+ 750
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	FY 2013: 21%	21%	21%	Maintain

Note: For presentation within the budget ACL 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 ACL's performance measures (efficiency, effective targeting, and client outcomes) assess network-wide performance in achieving current strategic objectives.

Grant Awards Table:

Alzheimer's Disease Supportive Services Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	7	6	6
Average Award	$402,250	$475,376	$475,376
Range of Awards	$250,000-$450,000	$250,000-$600,000	$250,000-$600,000

[106] Cumulative count began in 2008.

[107] Cumulative count began in 2008.

Resource and Program Data:

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	7	2,816	6	2,852	6	2,852
Continuations	--	--	--	--	--	--
Contracts	1	791	1	791	1	791
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		165		156		156
Total Resources		3,722		3,800		3,800

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

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Alzheimer's Disease Initiative - Specialized Supportive Services

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alzheimer's Disease Initiative – Services (Prevention Fund)	$10,500,000	$10,500,000	$10,500,000	--

Note: Funding in FY 2014 and FY 2015 was provided from the Prevention and Public Health Fund, and FY 2016 funding is requested from the same source.

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

FY 2016 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

On January 4, 2011, the President announced a new effort to fight Alzheimer's disease. An estimated 5 million people in the United States may have Alzheimer's, the effects of which are devastating for people with the disease and their families. Individuals with Alzheimer's generally require significant levels of health care and intensive long-term services and supports (LTSS) – including but not limited to management of chronic conditions, assistance with medication management, round-the-clock supervision and care due to behavioral symptoms, and assistance with personal care activities, such as eating, bathing, and dressing.

Research has shown that caregiving exacts a heavy emotional, physical, and financial toll on family caregivers of persons with Alzheimer's disease. They have a greater risk of stress and ill health than other caregivers. Dementia caregivers provide an average of one to four more years of care than caregivers for people with other conditions. (43 percent vs. 33 percent). They are also more likely to be providing care for five years or longer (32 percent vs. 28 percent).[108] In another study, 44 percent of caregivers of people with dementia indicated depressive symptoms, compared with 27 percent of caregivers of people who had cognitive impairment but no dementia.[109] Data from the 2010 BRFSS caregiver survey found that 7 percent of dementia

[108] Alzheimer's Association, (2014). "2014 Alzheimer's Disease Facts and Figures". Accessed August 08, 2014 from: http://www.alz.org/downloads/facts_figures_2014.pdf.

[109] Fisher GG, Franks MM, Plassman BL, Brown SL, Potter GG, Llewellyn D, et al. Caring for individuals with dementia and cognitive impairment, not dementia: Findings from The Aging, Demographics, and Memory Study. J Am Ger Soc 2011;59(3):488–94.

caregivers say the greatest difficulty of caregiving is that it creates or aggravates their own health problems compared with 2 percent of other caregivers.[110]

Developing more dementia capable LTSS systems designed to meet the needs of caregivers of individuals with Alzheimer's Disease and related dementias is critical to helping these individuals continue to provide care. The Alzheimer's Disease Initiative – Specialized Supportive Services fills gaps in dementia-capable LTSS systems for persons living with the disease and their family caregivers. The Initiative will provide specialized, person-centered services that will help them remain independent and safe in their communities. Through this Initiative, ACL is working with public and private entities to identify and address the special needs of persons with Alzheimer's disease and their caregivers when they seek assistance. Examples of special needs are services for people living alone, those at highest risk of having Alzheimer's, or people with behavioral symptoms that might lead to institutionalization. Public and private entities include, but are not limited to, State, local, and tribal governments, the Aging Network, and community level organizations.

Funding History:

FY 2011 .....$0
FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$10,500,000
FY 2015 .....$10,500,000

Budget Request:

The FY 2016 request for Alzheimer's disease services is $10,500,000 to continue the President's efforts to fight Alzheimer's disease, and for development and expansion of the specialized supportive services for those impacted by the disease. This is the same level of funding that was requested in the FY 2015 enacted level. ACL renews its request of these funds, first provided in the FY 2014 Prevention and Public Health Fund appropriation.

ACL will use the $10.5 million it is requesting in FY 2016 to expand approaches to improving care for those with Alzheimer's disease and their caregivers that was initiated in FY 2014. This Initiative focuses on strengthening dementia-capability through development of specialized supportive services in a handful of States, tribal entities, and/or localities. A dementia-capable

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

LTSS system is able to identify those with dementia and their caregivers, understand their unique circumstances, communicate appropriately with them, help them choose services that meet their needs, and provide supports to ease the burden on caregivers.

ACL will hold a competition to award cooperative agreements to States, tribes, or other localities. Successful applicants will build on existing dementia-capable systems by providing specialized supportive services that will be integrated into:

- information, screening, referral, and access;
- LTSS options counseling and assistance;
- streamlined applications and eligibility determinations for public programs; and
- person-centered, service coordination across multiple settings and across care transitions.

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

- comprehensive set of services;
- robust quality assurance system; and
- sustainable service system.

The specialized supportive services resulting from this funding opportunity will assist people with Alzheimer's disease and their family caregivers by ensuring that their unique needs are addressed. Since the focus of the cooperative agreements will be to facilitate permanent systems change, an emphasis will be placed on implementing specialized supportive services that can operate out of ongoing funding streams and will not require new sources of funds to maintain. ACL awarded 10 grants in September 2014 to begin this work.

Grant Awards Table:

Alzheimer's Disease Initiative – Specialized Supportive Services

	FY 2014 Final	**FY 2015 Enacted**	**FY 2016 President's Budget**
Number of Awards	10	10	10
Average Award	$977,500	$982,500	$982,500
Range of Awards	$750,000 - $1,000,000	$750,000 - $1,000,000	$750,000 - $1,000,000

Resource and Program Data:

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	10	9,775	10	9,825	10	9,825
Continuations	--	--	--	--	--	--
Contracts	3	639	2	639	2	639
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		86		36		36
Total Resources		10,500		10,500		10,500

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

Lifespan Respite Care

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Lifespan Respite Care……..	$2,342,000	$2,360,000	$5,000,000	$2,640,000

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

FY 2016 Authorization .....Expired

Allocation Method .....Competitive Grants

Program Description and Accomplishments:

Family caregiving is not just an aging issue. Family caregiving for persons with disabilities occurs across the age spectrum from birth to death. Family caregivers are often called upon to provide care to individuals of varying ages and disabilities and do so willingly, often for long periods of time and for many years. In 2009, AARP and the National Alliance for Caregiving estimated that 65.7 million people served as unpaid family caregivers to an adult or child with special needs. For many of these caregivers, providing care can take a toll: a majority of caregivers (51 percent) caring for someone over age 18 have medium or high levels of burden and 31 percent of all family caregivers indicated they experienced high levels of stress.[111]

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[112] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers.[113] Even though respite services are often the preferred mode of family caregiver support, they are often under-used, difficult to find and access, unaffordable, or in short supply. A 2009 survey found that many caregivers reported difficulty managing both physical and emotional stress and balancing work and family responsibilities. As a result, nearly 90 percent of family caregivers receive no respite at all.[114] The barriers to accessing and using respite services are often significant for specific populations

[111] 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

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

[113] National Alliance for Caregiving and AARP, 2009

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

such as family caregivers of individuals with Multiple Sclerosis, persons with intellectual and developmental disabilities, and for caregivers of veterans and individuals with Alzheimer's disease, spinal cord injuries, autism, and serious emotional disorders. [115]

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

The Lifespan Respite care program also supports resource center activities designed to maintain a national database on lifespan respite care; provide training and technical assistance to grantees and State, community, and nonprofit respite care programs; and conduct public information, referral, and education programs on respite care. Since 2009, the Lifespan Respite Care Program has made grants to eligible state agencies and for the funding of a National Technical Assistance Resource Center as follows:

- Grants to new states each year have allowed for the initial development of Lifespan Respite Programs. To date, 32 states and the District of Columbia have received initial three-year grants;

- In FY 2011 and FY 2012, a total of ten states (eight in 2011 and two in 2012) were awarded competitive expansion supplements to focus specifically on providing respite services to meet demand and fill gaps in service where identified;

- Integration and Sustainability grants in FY 2012 and FY 2013 have been awarded to a total of fifteen states (seven in 2012 and eight in 2013) enabling them to more fully

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

- embed the concept of respite and family support into statewide home and community-based services and long-term services and supports (LTSS) system reform efforts across the age and disability spectrum;

- In FY 2014, 16 states received three-year grants to focus on the provision of respite services, more fully integrate the concepts of Lifespan Respite in state LTSS reform activities, and ensure the long-term sustainability of program efforts beyond the Federal funding period;

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

Examples of grantee accomplishments to date include:

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

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

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

- Expansion of toll free “helplines,” dedicated websites and statewide respite registries to provide caregivers with information about available respite programs.

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

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

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

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

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

- Provision of direct respite services to family caregivers of children with intellectual and developmental disabilities, adults with physical disabilities, and older Americans.

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

Funding History:

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

FY 2011 .....$2,495,000
FY 2012 .....$2,490,000
FY 2013 .....$2,350,722
FY 2014 .....$2,342,000
FY 2015 .....$2,360,000

Budget Request:

The FY 2016 request for Lifespan Respite is $5,000,000, an increase of +$2,640,000 above the FY 2015 enacted level. At this level, ACL will make competitive grants available to support a range of possible activities, including grants to two new states to begin work building or enhancing Lifespan Respite Programs; grants to further integrate and sustain Lifespan Respite activities into broader long-term services and supports in the state; and/or grants to provide additional respite services to family caregivers across the age and disability spectrum. ACL recognizes the unique opportunity the Lifespan Respite Care Program presents to consider the

critical role that support for family caregivers plays in ensuring the health and independence of individuals across the age and disability spectrum. By expanding investments in this program, ACL seeks to provide more and better targeted services that will allow caregivers to continue to care for their loved ones longer and thereby allow more care recipients to remain at home and independent for longer periods at lower cost than could be realized if these same individuals had to be institutionalized.

The Lifespan Respite Care Program helps to ensure respite quality and choice; and allows for respite development, training and coordination regardless of age or disability. The Lifespan Respite Care program demonstrates ACL's commitment to include caregivers of children or adults of any age with special needs. According to the National Respite Coalition, nearly 90 percent of family caregivers of care recipients age 18 and older, and 81 percent of family caregivers of children with special needs currently are unable to access or use respite services. Caregivers report numerous barriers ranging from cost considerations and restrictive eligibility criteria to waiting lists, limited respite options, inadequate supply of trained providers or appropriate programs and gaps in service availability.[116]

The additional resources requested for FY 2016 will be used to address these issues by:

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

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

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

Output Table:

Lifespan Respite Care Output

Indicator	Most Recent Result	FY 2015 Projection	FY 2016 Projection	FY 2016 +/- FY 2015
Output AJ The number of states that have participated in the Lifespan Respite Care program. *(Output)*	FY 2014: 33 (Actual)	34	36	+ 2

Grant Awards Table:

Lifespan Respite Care Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	18	18	31
Average Award	$126,278	$127,652	$286,177
Range of Awards	$75,000 - $200,000	$73,000 - $259,000	$73,000 - $500,000

Resource and Program Data:

Lifespan Respite Care Program
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	17	2,024	2	440	17	2,754
Continuations	1	249	16	1,858	16	2,111
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		69		62		135
Total Resources		2,342		2,360		5,000

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

Protection of Vulnerable Adults

Summary of Request

Protection of Vulnerable Adults consists of several distinct but complementary programs designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. As the population of older Americans increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, the number of reported cases of elder abuse, neglect, and exploitation are on the rise. A 2004 national survey of State Adult Protective Services (APS) programs conducted by AoA's National Center on Elder Abuse showed a 16 percent increase in the number of elder abuse cases from an identical study conducted in 2000.[117] 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.[118] Consistent with these earlier findings, the most recent data on the prevalence of elder abuse, neglect, and exploitation suggest that at least 10 percent, or approximately 5 million, older Americans experience abuse each year, and many experience it in multiple forms.[119]

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.[120] 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.[121] 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, both at home and in institutional settings.

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[117] 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

[118] 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

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

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

[120] 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.

[121] 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.

The total FY 2016 request for Protection of Vulnerable Adults is $67,152,000; an increase of +$21,000,000 above the FY 2015 enacted level. For FY 2016, specific program requests include:

- $15,885,000 for the Long-Term Care Ombudsman Program, the same as the FY 2015 enacted level. This consumer advocacy program improves the quality of care for the residents of long-term care facilities in all States.

- $4,773,000 for Prevention of Elder Abuse and Neglect, the same as the FY 2015 enacted level. This program provides formula grants to states to train, educate, and promote public awareness of elder abuse prevention efforts.

- $8,910,000 for the Senior Medicare Patrol Program, the same as the FY 2015 enacted level. SMP funds competitive grants to support a volunteer-based network that helps to prevent and combat healthcare fraud and abuse and helps to preserve the financial integrity of Medicare and Medicaid. This program is also supported by Health Care Fraud and Abuse Control (HCFAC) "wedge" funding, the level for which is determined annually as a result of negotiations between the Attorney General and the Secretary of HHS. HCFAC funds pay for infrastructure that supports States' Senior Medicare Patrols, as well as expansion grants to SMPs targeted to high-fraud states.

- $28,874,000 for Elder Rights Support Activities, an increase of +$21,000,000 above the FY 2015 enacted level. This program provides funding for resource centers and activities that provide information, training, and technical assistance on elder rights issues to the national Aging Services Network. The increase will advance ACL's Elder Justice initiative to help fulfill the promise of the Elder Justice Act of 2009. Funds will support the implementation of a nationwide Adult Protective Services data system, and fund research and evaluation activities.

These elder rights and elder justice programs will build a foundation and establish best practices for States to develop programs to expand and improve the protection of individuals living in their communities and in long-term care settings; increase the information and technical assistance available to the public, States, and localities in preventing and addressing abuse; protect the rights of older adults and prevent their exploitation; reduce health-care fraud and abuse; and provide assistance to Tribes in developing elder justice systems. This multifaceted approach to preventing, detecting, and resolving elder abuse, neglect, and exploitation is essential to successfully fulfilling the shared mission of the Older Americans Act and the Elder Justice Act to maintain the health and independence of older Americans and adults with disabilities.

Long-Term Care Ombudsman Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Long-Term Care Ombudsman Program	$15,885,000	$15,885,000	$15,885,000	--

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method ..... Formula Grants

Program Description and Accomplishments:

The Long-Term Care (LTC) Ombudsman Program is a consumer advocacy program that improves the quality of life and quality of care for the estimated 2.9 million individuals who reside in 69,508 long-term care facilities.[122] Formula grants to States and Territories based on the number of individuals age 60 and older provide funding for the training, travel, and other operating costs of nearly 10,000 ombudsmen (both staff and certified volunteers) who resolve complaints with and on behalf of these residents, advocate for systemic improvement of long-term care systems, and routinely monitor the condition of long-term care facilities.

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

Much of the efficiency of the Ombudsman Program is due to strong reliance on volunteers who make up the bulk of those who resolve resident issues.[123] All but four States have volunteer ombudsman programs. These certified volunteer ombudsmen donated over 735,411 hours in FY 2011, a six percent increase over FY 2009. In FY 2013 output data for the Long-Term Care Ombudsman Program highlights the accomplishments achieved by this program and the

[122] National Ombudsman Reporting System (NORS) – Federal Fiscal 2011.
[123] Shaughnessy, Carol V. *The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet*. National Health Policy Forum. December 9, 2009.

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

- 1,185 paid and 9,065 certified volunteer ombudsmen regularly visited residents in 27,785 facilities, more than 70 percent of all nursing home facilities and nearly 33 percent of all licensed board and care facilities (Output S). At least another 3,320 volunteers support these paid staff and certified volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 190,592 complaints (Output Q).

- Ombudsmen provided over 464,806 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).

Today's landscape is changing, however, as individuals in need of long-term care services and supports are increasingly choosing to live in community settings. Encouraging community living is a strategic DHHS priority, as has been supported by a number of Federal and state policies promoting alternatives to nursing homes and other institutional settings that recognize the value of consumer preference and the attendant potential fiscal savings that can result.

The desire to re-balance and thereby give consumers more community living options has been promoted and accelerated through a variety of federal laws and initiatives: the Affordable Care Act, Olmstead implementation and enforcement, Money Follows the Person, Home and Community Service (HCBS) revised regulations, and managed care, to name a few, are continuing to change the long-term care landscape across the country. There is also a growing federal awareness and response to the uncharted area of abuse, neglect and exploitation of older adults, and persons with disabilities. Addressing this troubling trend is also a priority of ACL.

All of these changes have created new challenges for LTC Ombudsman Programs as well as for Protection & Advocacy Systems serving the disability community that are also supported by ACL. Going forward, LTCOP's and P&As will need to learn a new regulatory and service environment at the same time that they will have to cope with the continuing accelerated growth of community based services.

Funding History:

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

FY 2011 .....$16,793,000
FY 2012 .....$16,761,000
FY 2013 .....$15,885,000
FY 2014 .....$15,885,000
FY 2015 .....$15,885,000

Budget Request:

The FY 2016 request for the LTC Ombudsman Program is $15,885,000, the same as the FY 2015 enacted level.

Funds will continue to be spent to support the existing infrastructure and activities of the Ombudsman program. With the senior population continuing to grow, the need for safe, high-quality long-term care services (including non-nursing home alternatives) continues to increase, even as we seek to help more people remain in the community for longer periods. Outcome data (displayed in the summary tables at the end of this section) have demonstrated the success of this program in protecting older Americans in an efficient and effective manner. The percentage of the complaints processed by ombudsmen that were fully or partially resolved to the satisfaction of the resident has consistently remained near 73 percent,[124] demonstrating both the efficiency of the program and its ability to produce positive outcomes for residents. The FY 2013 average number of complaints per facility, at 2.72, exceeds the target of 3.0. Outcome 2.14 targets a decrease in complaints that the program was unable to resolve to the satisfaction of the resident.

Ombudsman activities represent an important element of ACL's focus on elder rights, which expands and improves upon ACL's successful elder rights programs to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation. This request also supports Federal regulations and policy for quality alternatives to nursing home care. LTC Ombudsmen frequently support individuals who choose to transition out of nursing home facilities into more integrated settings. They also advocate for quality care and individual rights and well-being in other congregate long-term care settings, such as board and care and assisted living. In addition, LTC Ombudsmen serve individuals in these settings regardless of the individuals' eligibility for Medicaid or other public benefits. Ombudsmen are the only Federally-funded entity providing services to all of these residents. Going forward, outreach, access, complaint investigation and advocacy in board and care and assisted living will require

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

Ombudsmen to employ new strategies compared to the work now done primarily in nursing home settings.

Outcomes and Outputs Table:

Long-Term Care Ombudsman Program Outcomes and Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY16 Target +/- FY 2015
Outcome 2.12: Decrease the average number of complaints per LTC facility *(Outcome* *	FY 2013: 2.72 Target: 3.0 (Target Exceeded)	2.8	2.8	Maintain
Outcome 2.14 : Decrease the number of complaints not resolved to the satisfaction of the resident *(Outcome)**	FY 2013: 9,090 Target: 10,778	9,700	9,700	Maintain
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 Projection +/- FY 2015**
Output Q: Decrease the Number of Complaints *(Output)*	FY 2013: 190,592	190,000	190,000	Maintain
Output R: Number of Ombudsman Consultations *(Output)*	FY 2013: 464,806	450,000	450,000	Maintain
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2013: 27,785	27,600	27,600	Maintain

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

Grant Awards Table:

Long-Term Care Ombudsman Program Formula Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$280,824	$280,824	$280,824
Range of Awards	$9,829 - $1,618,546	$9,829 - $1,618,546	$9,829 - $1,618,546

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	243,821	243,821	243,821	--
Alaska	78,631	78,631	78,631	--
Arizona	333,076	333,076	333,076	--
Arkansas	151,860	151,860	151,860	--
California	1,618,546	1,618,546	1,618,546	--
Colorado	223,864	223,864	223,864	--
Connecticut	183,391	183,391	183,391	--
Delaware	78,631	78,631	78,631	--
District of Columbia	78,631	78,631	78,631	--
Florida	1,159,301	1,159,301	1,159,301	--
Georgia	410,859	410,859	410,859	--
Hawaii	78,631	78,631	78,631	--
Idaho	78,631	78,631	78,631	--
Illinois	593,323	593,323	593,323	--
Indiana	311,549	311,549	311,549	--
Iowa	161,021	161,021	161,021	--
Kansas	136,820	136,820	136,820	--
Kentucky	216,856	216,856	216,856	--
Louisiana	210,866	210,866	210,866	--
Maine	79,365	79,365	79,365	--
Maryland	271,260	271,260	271,260	--
Massachusetts	333,272	333,272	333,272	--
Michigan	506,369	506,369	506,369	--
Minnesota	255,908	255,908	255,908	--
Mississippi	141,354	141,354	141,354	--
Missouri	305,063	305,063	305,063	--
Montana	78,631	78,631	78,631	--
Nebraska	89,354	89,354	89,354	--
Nevada	128,082	128,082	128,082	--
New Hampshire	78,631	78,631	78,631	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	431,948	431,948	431,948	--
New Mexico	102,123	102,123	102,123	--
New York	956,337	956,337	956,337	--
North Carolina	472,374	472,374	472,374	--
North Dakota	78,631	78,631	78,631	--
Ohio	595,409	595,409	595,409	--
Oklahoma	184,565	184,565	184,565	--
Oregon	206,248	206,248	206,248	--
Pennsylvania	698,693	698,693	698,693	--
Rhode Island	78,631	78,631	78,631	--
South Carolina	244,203	244,203	244,203	--
South Dakota	78,631	78,631	78,631	--
Tennessee	322,310	322,310	322,310	--
Texas	1,013,204	1,013,204	1,013,204	--
Utah	95,715	95,715	95,715	--
Vermont	78,631	78,631	78,631	--
Virginia	376,622	376,622	376,622	--
Washington	325,251	325,251	325,251	--
West Virginia	109,488	109,488	109,488	--
Wisconsin	287,835	287,835	287,835	--
Wyoming	78,631	78,631	78,631	--
Subtotal, States	15,431,077	15,431,077	15,431,077	--
American Samoa	9,829	9,829	9,829	--
Guam	39,315	39,315	39,315	--
Northern Mariana Islands	9,829	9,829	9,829	--
Puerto Rico	196,785	196,785	196,785	--
Virgin Islands	39,315	39,315	39,315	--
Subtotal, States and Territories	15,726,150	15,726,150	15,726,150	--
Undistributed[125]	158,850	158,850	158,850	--
TOTAL	**15,885,000**	**15,885,000**	**15,885,000**	--

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

Prevention of Elder Abuse and Neglect

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Prevention of Elder Abuse & Neglect…..	$4,773,000	$4,773,000	$4,773,000	--

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Prevention of Elder Abuse and Neglect program provides formula grants to States and Territories based on their share of the population 60 and over for training, education, and promoting public awareness of elder abuse. The program also supports State and local elder abuse prevention coalitions and multi-disciplinary teams. These activities are important elements of ACL's focus on elder rights and elder justice. The program coordinates activities with State and local Adult Protective Services programs (over half of which are directly administered by State Units on Aging) and other professionals who work to address issues of elder abuse and elder justice. The importance of these services at the State and local level is demonstrated by the fact that States significantly leverage Older Americans Act (OAA) funds to obtain other funding for these activities. In FY 2012 over $28 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of approximately $7 ($6.85) of non-OAA funds for every $1 investment of ACL funds.

Examples of State elder abuse prevention activities include:

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

- In Illinois, the Illinois Department on Aging utilizes its elder abuse funds to support volunteer community based multi-disciplinary teams (M-Teams) that serve in a technical advisory role to more than 40 elder abuse provider agencies throughout the state. The

objectives of the M-Team are to provide case consultation and assistance to caseworkers and to encourage cooperation among various service agencies. Each M-Team is composed of the M-Team Coordinator and representatives of the mental health, medical, legal, law enforcement, faith community, and financial professions.

The Prevention of Elder Abuse and Neglect program demonstrates ACL'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 2011 .....$5,046,000
FY 2012 .....$5,036,000
FY 2013 .....$4,773,000
FY 2014 .....$4,773,000
FY 2015 .....$4,773,000

Budget Request and Anticipated Accomplishments:

The FY 2016 request for the Prevention of Elder Abuse and Neglect program is $4,773,000, the same as the FY 2015 enacted level. The FY 2016 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 ACL's continued focus in FY 2016 on elder rights and elder justice, which seeks to improve upon ACL's successful elder rights programs, including the Prevention of Elder Abuse and Neglect program. This enhanced focus will allow the creation of a full array of services to protect elder rights and prevent, detect, and resolve elder abuse, neglect, and exploitation. Prevention of Elder Abuse and Neglect programs complement Adult Protective Services by funding the infrastructure on which best practices may be developed and evaluated. Past examples of these efforts undertaken by states include creation of informational cards for law enforcement officers to provide crucial resource information to victims of elder

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

Output Table:

Prevention of Elder Abuse and Neglect Output

Indicator	Most Recent Result	FY 2015 Projection	FY 2016 Projection	FY 2016 +/- FY 2015
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, dollars in thousands)*	FY 2012: $28,452	$28,100	$27,900	-$200

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$84,500	$84,500	$84,500
Range of Awards	$2,958 - $471,073	$2,958 - $471,073	$2,958 - $471,073

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	76,215	76,215	76,215	--
Alaska	23,660	23,660	23,660	--
Arizona	81,500	81,500	81,500	--
Arkansas	48,157	48,157	48,157	--
California	471,073	471,073	471,073	--
Colorado	56,082	56,082	56,082	--
Connecticut	59,907	59,907	59,907	--
Delaware	23,660	23,660	23,660	--
District of Columbia	23,660	23,660	23,660	--
Florida	344,252	344,252	344,252	--
Georgia	103,321	103,321	103,321	--
Hawaii	23,660	23,660	23,660	--
Idaho	23,660	23,660	23,660	--
Illinois	197,384	197,384	197,384	--
Indiana	98,224	98,224	98,224	--
Iowa	55,927	55,927	55,927	--
Kansas	45,843	45,843	45,843	--
Kentucky	66,595	66,595	66,595	--
Louisiana	68,518	68,518	68,518	--
Maine	23,660	23,660	23,660	--
Maryland	78,087	78,087	78,087	--
Massachusetts	109,606	109,606	109,606	--
Michigan	160,862	160,862	160,862	--
Minnesota	76,347	76,347	76,347	--
Mississippi	45,198	45,198	45,198	--
Missouri	97,643	97,643	97,643	--
Montana	23,660	23,660	23,660	--
Nebraska	29,770	29,770	29,770	--
Nevada	27,629	27,629	27,629	--
New Hampshire	23,660	23,660	23,660	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	143,950	143,950	143,950	--
New Mexico	26,393	26,393	26,393	--
New York	318,066	318,066	318,066	--
North Carolina	126,782	126,782	126,782	--
North Dakota	23,660	23,660	23,660	--
Ohio	197,185	197,185	197,185	--
Oklahoma	60,208	60,208	60,208	--
Oregon	56,795	56,795	56,795	--
Pennsylvania	242,944	242,944	242,944	--
Rhode Island	23,660	23,660	23,660	--
South Carolina	63,080	63,080	63,080	--
South Dakota	23,660	23,660	23,660	--
Tennessee	91,810	91,810	91,810	--
Texas	274,281	274,281	274,281	--
Utah	24,837	24,837	24,837	--
Vermont	23,660	23,660	23,660	--
Virginia	102,820	102,820	102,820	--
Washington	86,291	86,291	86,291	--
West Virginia	36,736	36,736	36,736	--
Wisconsin	90,309	90,309	90,309	--
Wyoming	23,660	23,660	23,660	--
Subtotal, States	4,648,207	4,648,207	4,648,207	--
American Samoa	2,958	2,958	2,958	--
Guam	11,830	11,830	11,830	--
Northern Mariana Islands	2,958	2,958	2,958	--
Puerto Rico	54,217	54,217	54,217	--
Virgin Islands	11,830	11,830	11,830	--
Subtotal, States and Territories	4,732,000	4,732,000	4,732,000	--
Undistributed 126/	41,000	41,000	41,000	--
TOTAL	**4,773,000**	**4,773,000**	**4,773,000**	--

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

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Senior Medicare Patrol Program

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Senior Medicare Patrol Program…….	$8,888,000	$8,910,000	$8,910,000	--
HCFAC Expansion Grants 1/…….	$3,212,752	$5,331,814	$5,331,814	--
HCFAC Base Funds.....	$3,378,222	$3,378,222	$3,378,222	--
Total……..	$15,478,974	$17,620,136	$17,620,136	--
FTE……..	7	8	8	--

1/ Authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HCFAC Expansion Grants are provided to SMP program grantees to support infrastructure. HCFAC amounts in FY 2016 are placeholders. The Secretary and Attorney General will determine the final amount.

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

FY 2016 Older Americans Act Authorization.....Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

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

Data obtained from the SMARTFACTS Data Tracking System and published in the annual OIG report for calendar year 2012 shows that SMP projects:

- Maintained 5,137 active volunteers who worked over 120,953 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;

- Educated 449,509 beneficiaries in 14,748 group education sessions and held 113,457 one-on-one counseling sessions with or on behalf of beneficiaries;

- Conducted 10,032 community outreach education events; and

- Resolved 83,856 inquiries for information or assistance from beneficiaries.

In addition, the Senior Medicare Patrol program's data show that since the program's inception 17 years ago, SMP projects have educated nearly 4 million beneficiaries in 108,825 group education sessions and 1,292,647 one-on-one counseling sessions, and conducted 93,894 community outreach education events.

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

In the past five years, the critically important role of the SMP program has continued to be recognized by partners in Medicare fraud prevention in the private and public sectors. In FY 2010 and FY 2011, CMS provided funding for the award of an additional $9 million in grants from its Program Integrity funding, administered by ACL, targeted to help more than 50 SMP projects fight Medicare fraud in high fraud areas and expand the capacity of the program to reach more beneficiaries. In FY 2012 and FY 2013, ACL received an additional $7.3 million from HCFAC funds to again fight Medicare fraud and continue program expansion and enhancement activities. In FY 2014, ACL received $3.2 million from HCFAC funds for the same purpose.

Funding History:

Funding for the SMP discretionary appropriations is as follows:

FY 2011 .....$9,420,000
FY 2012 .....$9,402,000
FY 2013 .....$8,875,000
FY 2014 .....$8,888,000
FY 2015 .....$8,910,000

Budget Request:

The FY 2016 request for the Senior Medicare Patrol (SMP) program is $8,910,000, the same as the FY 2015 enacted level. This amount will enable ACL to continue the proven fraud prevention activities of the SMP program. The SMP program was also supported by $3.2 million in HCFAC expansion grants to States in FY 2014, and by $5.3 million in FY 2015.

Since the program's inception, SMP projects have educated over 3.5 million beneficiaries and received nearly 30,000 complex issues (complaints) from beneficiaries who have detected billing or other discrepancies based on that information. While SMPs make numerous referrals of potential fraud to CMS and the OIG, there is no mechanism for tracking the actions (investigation, prosecution, collection) required to realize actual savings to the government as a result of these referrals. There is also no current mechanism to quantify the effects of prevention education conducted by the SMP, which hinders the program's ability to measure the extent and cost of fraud and abuse. ACL is working to overcome these limitations by undertaking a variety of steps, including:

- A program evaluation contract, concluded in 2013, to examine the program's performance metrics, and a future realignment of those metrics to reflect the results of the program evaluation;

- An ongoing process in cooperation with OIG to track fraud referrals and their outcomes; and

- Award of a three year grant to conduct research on prevention education to determine how to best measure and quantify the effects of SMP program efforts. The results of this study should be available in the fall of 2016.

Outcomes and Outputs Table:

Senior Medicare Patrol Program Outputs

Indicator	Most Recent Result	CY 2015 Projection	CY 2016 Projection	FY 2016 +/- FY 2015
Output W: Beneficiaries Educated and Served *(Output)*	CY 2013: 738,234	500,000	600,000	+ 100,000

Grant Awards Table:

Senior Medicare Patrol Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	52	52	52
Average Award	$170,915	$171,346	$171,346
Range of Awards	$75,000-$177,927	$75,000-$177,927	$75,000-$177,927

Resource and Program Data:

Senior Medicare Patrols
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	24	4,206	52	8,910	--	--
Continuations	28	4,682	--	--	52	8,910
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		--
Total Resources		8,888		8,910		8,910

Elder Rights Support Activities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Elder Rights Support Activities	$3,845,000	$7,874,000	$28,874,000	$21,000,000
FTE	--	2	4	+ 2

Authorizing Legislation: Sections 201, 202, 411, and 751 of the Older Americans Act of 1965, as amended, Title XX of the Social Security Act, Subtitle B, as amended by the Affordable Care Act.

FY 2016 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

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

Model Approaches to Statewide Legal Assistance Systems

Model Approaches to Statewide Legal Assistance Systems helps States develop and implement cost-effective, replicable approaches for integrating senior legal helplines into the broader tapestry of State legal service delivery networks. The cornerstone of these projects is legal helplines, which assist seniors in accessing quality legal services. By ensuring strong leadership at the State level, Model Approaches projects create linkages between the existing legal assistance community and service providers, and professionals in the broader community-based aging and elder rights networks, including Areas Agencies on Aging, Aging and Disability Resource Centers, State Long-Term Care Ombudsmen, and Adult Protective Services. These linkages leverage the strengths of both elder rights and aging service networks for the provision of quality service to seniors most in need. Recently, Model Approaches – Phase II grants were developed that promote legal service delivery systems that are optimally responsive to complex legal issues emerging from cases of elder abuse, neglect, and financial exploitation.

National Legal Assistance and Support Projects

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

National Center on Elder Abuse

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

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

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

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

- Continued to support systems change by identifying 342 local elder justice community coalitions and reaching out to those communities to learn how they leverage local resources and expertise to prevent and combat elder abuse, neglect, and exploitation, as well as to offer technical assistance on operating, invigorating, and sustaining coalitions; and compiling the first comprehensive inventory of tribal elder abuse codes, currently

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

National Long-Term Care Ombudsman Resource Center

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

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

Elder Justice and Adult Protective Services

The Elder Justice Act of 2009 established the Elder Justice Coordinating Council (EJCC) to coordinate activities related to elder abuse, neglect, and exploitation across the Federal government. As Chair of the EJCC, the Secretary of HHS has lead responsibility for identifying and proposing solutions to the problems surrounding elder abuse. The Secretary has assigned responsibility for implementing the EJCC to the Administration for Community Living.

To combat the rising scourge of elder abuse, neglect, and exploitation in America, ACL's goal is to put in place, in coordination with the Elder Justice Coordinating Council, a comprehensive system to serve as a coordinated and seamless response for helping adult victims of abuse, to prevent abuse before it happens, and to develop new and innovative approaches to preventing, detecting, and responding to abuse, neglect, and exploitation.

Unlike Child Protective Services, there is currently no federal infrastructure to support basic programmatic standards for Adult Protective Services, which has led to inconsistent data systems and non-uniform reporting requirements at the national level and prevented APS programs from evaluating their services or conducting meaningful program evaluations. States are further challenged by the increasing complexity of elder and other adult abuse cases, the rising older population, and difficult State and local budget conditions. APS programs and administrators lack reliable information and guidance on best practice and standards for conducting case investigations and for staffing and managing APS programs. Additionally, GAO has identified the challenges faced by APS programs across the country in collecting, maintaining, and reporting statewide, case-level data. These challenges, which include chronic underfunding, unprecedented budget reductions, and increasing caseloads, impair States' ability to assess client outcomes and the effectiveness of the services they are providing.[127] They also lead to systems that are less equipped to respond in an effective and timely way to reports of elder abuse, neglect and exploitation.

Funding will support demonstration grants to enhance state APS data systems; provide significant, on-going technical assistance to states to facilitate their participation on a regular basis in a national APS data collection efforts; enhance State APS services; and conduct research and oversight. As recommended by the GAO, in FY 2013 ACL, in partnership with ASPE, undertook an effort to begin developing the technology infrastructure for a national APS data collection system, the National Adult Maltreatment Reporting System (NAMRS), where all states can report data collected through APS investigations. Similarly to what GAO found with the National Child Abuse and Neglect Data System (NCANDS), states need significant assistance initially to improve their technological capacity to a level where they will be able to participate.

Funding History:

Comparable funding for Elder Rights Support Activities is as follows:

FY 2011 .....$4,096,000
FY 2012 .....$4,088,000
FY 2013 .....$3,859,000
FY 2014 .....$3,845,000
FY 2015 .....$7,874,000

[127] U.S. Government Accountability Office. (2011). *ELDER JUSTICE: Stronger Federal Leadership Could Enhance National Response to Elder Abuse.* (GAO-11-208). Washington, D.C.: U.S. Government Printing Office.

Budget Request:

The FY 2016 request for Elder Rights Support Activities is $28,874,000, an increase of +$21,000,000 above the FY 2015 enacted level. This request reflects ACL's commitment to supporting and integrating State APS systems, as well as coordinating services related to elder abuse, neglect, and exploitation across the Federal government. The funding requested in FY 2016 will assist with the following efforts needed to expand and conduct research and evaluation of Adult Protective Services across the nation.

Demonstration Grants to Enhance State APS Data Systems ($15 million)

As recommended by the GAO, in FY 2013 ACL, in partnership with ASPE, undertook an effort to begin developing the technology infrastructure for a national APS data collection system, the National Adult Maltreatment Reporting System (NAMRS), where all states can report data collected through APS investigations. Similarly to what GAO found with the National Child Abuse and Neglect Data System (NCANDS), states need significant assistance initially to improve their technological capacity to a level where they will be able to participate.

In FY 2016, ACL is investing $15 million to continue the phased implementation of the NAMRS begun in FY 2015. FY 2015 funding is being distributed through competitive grants to approximately ten states for APS program and service enhancements within a state, including to develop and/or update systems of technology that support the adult protective services program and track reports of elder and adult abuse and neglect from intake through final disposition and allow information exchange with NAMRS. FY 2016 funds will be used for additional new grants to expand participation in NAMRS to up to 15 additional states, bringing approximately 45% of the 56 APS jurisdictions on-line in the second year of implementation.

NAMRS, Operation and Maintenance, and Technical Assistance ($3 million)

GAO also recommended significant, on-going technical assistance to states to facilitate their participation on a regular basis in a national APS data collection effort, again as with NCANDS.[128] FY 2016 funds will continue the implementation of NAMRS begun in FY 2015, to operate and maintain the system, and provide technical assistance to the approximately 25 states ACL anticipates will use the system in the second year of operation. This activity supports and implements Recommendation 3 of the EJCC, "Develop a National Adult Protective Services System."

[128] *Id.*

Enhancing APS Services ($3.25 million)

Currently, there exists only a basic understanding of the services provided by APS and the program standards for each state. Even less is known about the effectiveness of these services at reducing abuse and preventing re-referral to the APS system. A meta-analysis of service components for programs designed to intervene in family violence, specifically child protective services and adult protective services, will identify evidence-based and best practices for service delivery. This type of evaluation is needed to understand the current state of APS systems. Together, these complementary efforts will help guide the development of APS program standards to help states improve the quality and consistency of APS programs, and the design of more effective systems in the future.

Because state APS program resources are already insufficient to meet the current need for services, states are not able to spare additional staff or resources to carry out the needed meta-analyses or evaluation to inform program design. Moreover, the effort required to carry out these activities is most efficiently carried out by a single entity, rather than having each of the states conduct their own evaluations of the same programs and resources, an unnecessary duplication of effort in an already stretched system. The FY 2016 President's Budget recognizes the economy of scale achieved in having a comprehensive evaluation and analysis conducted, and proposes $3.25 million to continue the work of planning and executing the evaluation and meta-analysis begun in FY 2015.

Research ($3 million)

Research in the area of elder abuse, neglect, and exploitation is still in its infancy, with little known about risk and protective factors for being a victim or perpetrator, nor about effective and evidence-based prevention, intervention, and remediation practices. Further research also is needed regarding the impacts of elder abuse on health and long-term care systems and on the costs of care. This fundamental research work is needed to develop credible benchmarks for elder abuse, neglect, and exploitation prevention or control.

The FY 2016 President's Budget includes $3 million for research grants to increase the evidence-base that establishes the benefits over harm of screening for elder abuse, neglect, and exploitation, and to invest in the foundational research essential for understanding the problem and the best ways to prevent and address it.

Program Implementation and Oversight ($0.75 million)

The FY 2016 President's budget included $750,000 for salaries and overhead costs supporting four FTE carrying out the Elder Justice initiative and supporting the ongoing work of the EJCC.

The National Center on Elder Abuse, the National Long-Term Care Ombudsman Resource Center, the Statewide Model Approaches and Legal Assistance programs, and the Elder Justice and Adult Protective Services program, 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. These activities are a critical component of ACL's successful elder rights programs and help to create a full array of services to prevent, detect, and resolve elder abuse, neglect, and exploitation. Continued support for these programs and resource centers will provide the best and most efficient services and supports possible to support ACL's efforts to promote elder rights and elder justice.

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

Activity	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Elder Rights Support Activities:			
Model Approaches to Statewide Legal Assistance	$ 1,867	$ 1,888	$ 1,888
National Legal Assistance and Support Projects	697	705	705
National Center on Elder Abuse	765	765	765
National Long-Term Care Ombudsman Resource Center	516	516	516
Elder Justice and Adult Protective Services	--	4,000	25,000
Total, Elder Rights Support Activities	**$ 3,845**	**$ 7,874**	**$ 28,874**

Grant Awards Table:

Elder Rights Support Activities Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	21	29	19
Average Award	$178,555	$232,961	$1,473,993
Range of Awards	$50,000 - $240,000	$50,000 - $350,000	$50,000 - $2,000,000

Resource and Program Data:

Elder Rights Support Activities
(Dollars in thousands)

Mechanism	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	2	1,232	16	3,867	11	17,099
Continuations	19	2,518	13	2,888	8	10,907
Contracts	--	--	1	795	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		95		324		868
Total Resources		3,845		7,874		28,874

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

Disability Programs, Research, and Services

Summary of Request

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

The total FY 2016 request for Disability Programs, Research, and Services is $377,728,000, an increase of +$15,618,000 over the FY 2015 enacted level. For FY 2016, specific program requests include:

- $71,692,000 to continue funding for State Councils on Developmental Disabilities (DD Councils) in each State and Territory, the same as the FY 2015 enacted level. DD Councils are charged with engaging in advocacy, capacity building, and systemic change activities that contribute to a coordinated and comprehensive system of community supports and services that promote self-determination, integration and inclusion for people with developmental disabilities.

- $38,734,000 for Developmental Disability Protection and Advocacy systems, the same as the FY 2015 enacted level. Protection and Advocacy systems in each State and Territory protect the legal and human rights of all people with developmental disabilities, and have the authority to pursue legal, administrative and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect.

- $38,619,000 for University Centers for Excellence in Developmental Disabilities (UCEDDs), an increase of +$945,000 above the FY 2015 enacted level. UCEDDs in each State and Territory provide interdisciplinary pre-service training, community services, research, and information dissemination activities that promote opportunities for people with developmental disabilities to exercise self-determination and to be independent, productive, integrated, and included in the community.

- $14,500,000 for Projects of National Significance, an increase of +$5,643 above the FY 2015 enacted level. Projects of National Significance fund grants, cooperative agreements, and contracts to explore innovative opportunities for individuals with developmental disabilities, including transitioning youth, to directly and fully contribute to, and participate in, all facets of community life.

- $108,000,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), an increase of +$4,030,000 above the FY 2015 enacted level. NIDILRR was transferred to ACL in FY 2014 by the Workforce Innovation and Opportunity Act. NIDILRR generates knowledge and promotes its use to improve the abilities of people with disabilities to perform activities of their choice in the community, and also to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities.

- $106,183,000 for Independent Living, an increase of +$5,000,000 above the FY 2015 enacted level. The Independent Living program was transferred to ACL in FY 2014 by the Workforce Innovation and Opportunity Act, and provides financial assistance to improve independent living services, support statewide networks of centers for independent living, and foster working relationships among various entities to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and to integrate these individuals into the mainstream of American society.

State Councils on Developmental Disabilities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
State DD Councils	$70,692,000	$71,692,000	$71,692,000	--

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

FY 2016 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

State Councils on Developmental Disabilities (DD Councils) are charged with identifying the most pressing needs of people with developmental disabilities in their state and territory. DD Councils are in a strategic position in each State and Territory to set priorities and pursue systems change efforts designed to turn fragmented approaches into a comprehensive and effective statewide, person-centered and family-centered system that provides a coordinated array of culturally-competent services and other forms of assistance for people with intellectual and developmental disabilities, including individuals with autism, and their families. DD Councils do not provide services directly, but rather examine and conduct in-depth analysis of the quantity and quality of services and supports that are provided at the State and local level. Each DD Council develops a strategic State plan based on their analysis, with goals and objectives designed to move the State towards an effective, coordinated system of supports and services that advance community living for all people with developmental disabilities. Working in partnership with stakeholders, including people with developmental disabilities, each State DD Council determines priority areas and implements activities based on the strategic state plan to:

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

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

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

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

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

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

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

The State Councils have a significant impact upon promoting self-sufficiency and community living for persons with developmental disabilities. Due to increased technical assistance and guidance, Councils reported that in FY 2012, 14.33 percent of individuals nationwide with developmental disabilities were independent, self-sufficient, and integrated into the community as a result of their efforts, exceeding the FY 2012 target of 13.79 percent. To receive funds, each State and Territory must have an established DD Council as prescribed under the Developmental Disabilities Assistance and Bill of Rights Act ("DD Act"). Examples of State Council activities include:

- Early Intervention: The Maine Developmental Disabilities Council has engaged in and supported a variety of collaborative state level efforts to raise awareness about developmental and behavioral screening. Activities include awareness campaigns and training initiatives targeted at twelve pediatric and family practices that served an estimated 20,000 children with Medicaid coverage. Their combined efforts have facilitated significant, long-term systemic improvements towards early identification and coordinated care for young children with Autism Spectrum Disorder (ASD). Recent studies showed that in Maine children with ASD were more likely to be identified at a younger age and the developmental and autism screening rates more than doubled in the targeted sites.

- Self-Advocacy: The Maryland Developmental Disabilities Council continues to support self-advocacy through Maryland's statewide self-advocacy group, People on the Go of

Maryland (POG). Through two grants funded by the Council, (POG) continued to advocate for community supports, educate facilitators, and support local self-advocacy groups in becoming active in systems advocacy. POG educated 1,200 students and school staff about disability awareness by presenting in four different counties. POG also presented self-advocacy work at several local, state, and national conferences, including the Maryland Transitioning Youth Conference, National Disability Rights Network, and Ready at 21, a non-profit organization dedicated to transitioning youth to college, work, and life.

- Community Living: The Illinois Developmental Disabilities Council published 2 reports that have been recognized throughout Illinois as a major influence on the Governor's 2012 "Rebalancing Initiative" to transition hundreds of people with disabilities from institutions back to the community.[129] Through collaboration with statewide organizations, the first of the two institutions closed in November 2012 and 183 people with developmental disabilities are now living in the community. The Governor's office requested that the Council coordinate efforts to ensure a successful transition of individuals from state institutions into the community. Through collaboration with statewide organizations, the Council formed a workgroup and an initiative of peer-to-peer mentoring, in which self-advocates from the Alliance worked alongside staff to provide support for individuals as they sought a life beyond the institution.

- Transition/Employment: The Kansas Developmental Disabilities Council provides funding to Project SEARCH, which provides real-life work experience to help youth with developmental disabilities make successful transitions from school to adult life. Project SEARCH in Kansas currently operates in 7 locations, has served more than 150 students, and have a 75% employment success rate for students with developmental disabilities. SEARCH interns have been hired in jobs working 15-40 hours per week and earning from $7.25 to $12 per hour. Three additional locations are planned for fall of 2014, and four more communities are working on applications to begin projects in their area. The Council also plans to expand the program to include a non-school program targeted towards young adults.

DD Council funding is allotted based on a formula that takes into account the population, the extent of need for services for persons with developmental disabilities, and financial need. There are 56 Councils. Council members are appointed by the Governor and serve in a volunteer capacity. Under current law, not less than 60 percent of the Council membership must be composed of persons with developmental disabilities and/or their family members.

[129] The Council published "Blueprint for System Redesign in Illinois" and "Illinois at the Tipping Point," in 2008 and 2012, respectively.

Funding History:

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

FY 2011 .....$74,916,000
FY 2012 .....$74,774,000
FY 2013 .....$70,555,000
FY 2014 .....$70,692,000
FY 2015 .....$71,692,000

Budget Request:

The FY 2016 budget request for State Councils is $71,692,000, the same as the FY 2015 enacted level. This request will provide continued support for advocacy, systems change and capacity building activities that improve services for people with developmental disabilities and their families. In FY 2016, the program expects to increase the percentage of individuals with developmental disabilities who are independent, self-sufficient and integrated into the community as a result of Council efforts by at least 0.1 percent over the previous year's result.

Within ACL's Projects of National Significance (PNS) program, $643,000 will be used to ensure continued training and technical assistance for State Councils since the $76,000,000 trigger established in legislation for State Councils to fund these activities has not been met. This increase in PNS funds will provide for necessary technical assistance for State Councils, while allowing other PNS funds to support innovative projects that help persons with disabilities to live independently and to exert control and choice in their own lives.

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

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

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
8.1LT and 8A: Increase the percentage of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. (Outcome)	FY 2013: 14.42% Target: 14.34% (Target Exceeded)	Prior Result +0.1%	Prior Result +0.1%	N/A
8E: Increase the number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community per $1,000 of federal funding to the Councils. (Outcome)	FY 2013: 9.62 Target: 9.62 (Target Met)	Prior Result +1%	Prior Result +1%	N/A
8i: Number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. (Output)	FY 2013: 717,785 (Actual)	N/A	N/A	N/A
8ii: Number of all individuals trained by the Councils. (Output)	FY 2013: 264,570 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

State Councils on Developmental Disabilities Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$1,262,357	$1,280,214	$1,280,214
Range of Awards	$235,613 - $6,508,782	$246,990 - $6,481,606	$246,990 - $6,481,606

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	1,283,254	1,271,544	1,271,544	--
Alaska	452,431	474,276	474,276	--
Arizona	1,395,485	1,382,310	1,382,310	--
Arkansas	753,809	755,220	755,220	--
California	6,508,782	6,481,606	6,481,606	--
Colorado	861,131	853,001	853,001	--
Connecticut	682,794	676,347	676,347	--
Delaware	452,431	474,276	474,276	--
District of Columbia	452,431	474,276	474,276	--
Florida	3,506,220	3,473,119	3,473,119	--
Georgia	2,045,418	2,026,107	2,026,107	--
Hawaii	452,431	474,276	474,276	--
Idaho	452,431	474,276	474,276	--
Illinois	2,482,149	2,600,050	2,600,050	--
Indiana	1,411,820	1,474,493	1,474,493	--
Iowa	731,546	766,868	766,868	--
Kansas	580,746	608,786	608,786	--
Kentucky	1,198,064	1,186,753	1,186,753	--
Louisiana	1,330,740	1,362,735	1,362,735	--
Maine	452,431	474,276	474,276	--
Maryland	952,645	998,642	998,642	--
Massachusetts	1,322,999	1,310,534	1,310,534	--
Michigan	2,444,467	2,446,017	2,446,017	--
Minnesota	968,836	1,015,615	1,015,615	--
Mississippi	908,001	905,607	905,607	--
Missouri	1,296,762	1,341,178	1,341,178	--
Montana	452,431	474,276	474,276	--
Nebraska	452,431	474,276	474,276	--
Nevada	469,919	474,284	474,284	--
New Hampshire	452,431	474,276	474,276	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	1,495,803	1,538,655	1,538,655	--
New Mexico	480,330	485,612	485,612	--
New York	4,115,718	4,076,862	4,076,862	--
North Carolina	2,001,972	1,983,072	1,983,072	--
North Dakota	452,431	474,276	474,276	--
Ohio	2,701,094	2,819,846	2,819,846	--
Oklahoma	847,842	888,779	888,779	--
Oregon	783,264	775,869	775,869	--
Pennsylvania	2,964,431	2,997,948	2,997,948	--
Rhode Island	452,431	474,276	474,276	--
South Carolina	1,075,207	1,086,644	1,086,644	--
South Dakota	452,431	474,276	474,276	--
Tennessee	1,428,901	1,447,598	1,447,598	--
Texas	4,804,064	4,758,710	4,758,710	--
Utah	638,862	632,830	632,830	--
Vermont	452,431	474,276	474,276	--
Virginia	1,419,224	1,487,749	1,487,749	--
Washington	1,185,351	1,174,160	1,174,160	--
West Virginia	741,812	734,808	734,808	--
Wisconsin	1,227,167	1,280,955	1,280,955	--
Wyoming	452,431	474,276	474,276	--
Subtotal, States	67,380,663	68,220,777	68,220,777	--
American Samoa	235,613	246,990	246,990	--
Guam	235,613	246,990	246,990	--
Northern Mariana Islands	235,613	246,990	246,990	--
Puerto Rico	2,368,885	2,483,263	2,483,263	--
Virgin Islands	235,613	246,990	246,990	--
Subtotal, States and Territories	**70,692,000**	**71,692,000**	**71,692,000**	--
TOTAL	**$70,692,000**	**$71,692,000**	**$71,692,000**	**--**

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Developmental Disabilities – Protection and Advocacy

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
DD – Protection & Advocacy……..	$38,634,000	$38,734,000	$38,734,000	--

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

FY 2016 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Developmental Disabilities Protection and Advocacy program (P&A) provides formula grants to establish and maintain a P&A system in each State, the Territories, and the District of Columbia. The program also funds a Native American Consortium to protect the legal and human rights of Native Americans with developmental disabilities. There are 57 Protection and Advocacy systems. Funding for the program is allotted to States and Territories based on population and the extent of need for persons with developmental disabilities, weighted by the per capita income for each State and Territory.

P&As provide legal support to traditionally unserved or underserved populations to help them navigate the legal system to achieve resolution of concerns and encourage systems change. They also ensure that individuals with disabilities are able to exercise their rights to make choices, contribute to society, and live independently. P&A systems have the authority to pursue legal, administrative, and other appropriate remedies or approaches, including the authority to investigate incidents of abuse and neglect.

P&As have been involved in a significant number of landmark cases, including the U.S. Supreme Court's 1999 decision in *Olmstead* v. *L.C.*, which requires states to eliminate unnecessary segregation of people with disabilities, and to ensure that they receive services in the most integrated setting possible.

P&As have made great strides in increasing opportunities for individuals with developmental disabilities to make decisions for themselves about where and with whom they live. Examples of P&A accomplishments include:

- The Illinois P&A and other legal and non-legal groups filed the lawsuit Ligas v. Hamos (formerly Ligas v. Maram) in 2005 on behalf of people with developmental disabilities living in large, private, state-funded institutions or who were likely to be placed there. The clients wanted to receive community services, but the state of Illinois denied their requests. In July 2011, a judge approved an agreement that required the state provide institution residents who want community placement with an individualized, independent evaluation, and the opportunity to live in the community with appropriate services.

- The Georgia P&A oversees the implementation of the Georgia Olmstead settlement agreement. In its role, the P&A monitors the transition from institutions to community living for people with developmental disabilities as well as the development of community supports and services for people with developmental disabilities. Through this monitoring, the P&A has identified concerns about effective discharge planning and continuity of service between the hospitals and community services.

P&As also provide substantial advocacy and legal services on educational issues, and work to ensure that students receive an appropriate education in an inclusive setting. Twenty-six percent of P&A cases are in the area of education. As one example:

- Nearly seven years after the lawsuit was filed, the New Jersey P&A, along with other legal firms and disability groups, entered into a settlement with the New Jersey Department of Education to ensure that New Jersey students with disabilities receive an appropriate education in the "least restrictive environment." The lawsuit cited New Jersey's failure to implement the Individuals with Disabilities Education Act (IDEA), which requires the provision of a "free and appropriate public education" in the "least restrictive environment" to all eligible students. The plaintiffs alleged that children were inappropriately and unnecessarily sent out of district and denied in-class aids, services and accommodations needed to receive an appropriate education in the general education classroom.

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

Today’s landscape is changing, however, as individuals in need of long-term care services and supports are increasingly choosing to live not in institutions but in other community settings. Encouraging community living is a strategic DHHS priority, and has been supported by a

number of Federal and state policies promoting alternatives to nursing homes and other institutional settings that recognize the value of consumer preference and the attendant potential fiscal savings that can result.

The desire to re-balance and thereby give consumers more community living options has been promoted and accelerated through a variety of federal laws and initiatives: the Affordable Care Act, Olmstead implementation and enforcement, Money Follows the Person, Home and Community Service (HCBS) revised regulations, and managed care, to name a few, are continuing to change the long-term care landscape across the country. There is also a growing federal awareness and response to the uncharted area of abuse, neglect and exploitation of older adults, and persons with disabilities. Addressing this troubling trend is also a priority of ACL.

All of these changes have created new challenges for Protection and Advocacy programs as well as for the Long-Term Care Ombudsman program that is also supported by ACL. Going forward, P&As and LTCOP's will need to learn a new regulatory and service environment at the same time that they will have to cope with the continuing accelerated growth of community based services. The number of people with intellectual and developmental disabilities receiving Home and Community Based waiver services has steadily increased with 86 percent of the P&A clients living in the community.[130] This creates a heightened role for P&As to monitor and develop new strategies to address these new services. A recent successful response example that built on the P&A as a national resource is the Representative Payee Program. SSA is providing funds for P&As to review organizational payees who did not necessarily employ beneficiaries and to require that the P&As review the financial records of a sample of beneficiaries selected by SSA. The goal is to ensure representative payees are performing their payee duties satisfactorily and to protect beneficiaries from misuse.

Funding History:

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

FY 2011 .....$40,942,000
FY 2012 .....$40,865,000
FY 2013 .....$38,559,000
FY 2014 .....$38,634,000
FY 2015 .....$38,734,000

[130] U.S. Profile, FY 1977 – 2011, State of the State in Developmental Disabilities.

Budget Request:

The FY 2016 budget request for PADD is $38,734,000, the same as the FY 2015 enacted level.

This request will maintain the same level of funding provided through formula grants to States and Territories in FY 2015 to allow the P&A system to provide training, legal and advocacy services both to groups and to individuals with developmental disabilities, as well as information and referral services. The P&As form a national system that play a critical role in ensuring that people with developmental disabilities are free of abuse and neglect. People with developmental disabilities, including children, are at increased risk of experiencing abuse and neglect.[131] A 2009 report from the Government Accountability Office found hundreds of allegations of abuse and neglect at public and private schools across the nation between the years 1990 and 2009, almost all of which involved children with disabilities.[132] The 57 P&As stay at the forefront of these issues. P&As maintain a presence in facilities that care for people with disabilities, where they monitor, investigate, and attempt to remedy adverse conditions. In FY 2011, the 57 P&As remedied 9,470 complaints of abuse and neglect.

Without the P&A presence, people with developmental disabilities and their families would have limited to no access to cost-effective, low level advocacy and legal interventions. Of the inquiries and issues received by the P&As in FY 2013:

- 31 percent were resolved using short-term assistance strategies;
- 18 percent were addressed through technical assistance in self-advocacy;
- 14 percent involved investigation and monitoring; and
- 30 percent were addressed through negotiation.

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

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

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
8B: Increase the percentage of individuals who have their complaint of abuse, neglect, discrimination, or other human or civil rights corrected compared to the total assisted. (Outcome)	FY 2013: 87.10% Target: 85.63% (Target Exceeded)	Prior Result +0.5%	Prior Result +0.5%	N/A
8iii: Number of clients receiving professional individual legal advocacy for the Protection and Advocacy program. (Output)	FY 2013: 19,128 (Actual)	N/A	N/A	N/A
8iv: Number of people receiving information and referral from the Protection and Advocacy program. (Output)	FY 2013: 43,736 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

Developmental Disabilities – Protection and Advocacy Formula Grant Awards[133]

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	56	56	56
Average Award	$672,628	$674,378	$674,378
Range of Awards	$194,139 - $3,297,167	$194,139 - $3,308,268	$194,139 - $3,308,268

[133] Excludes grants to tribal organizations.

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	619,708	621,790	621,790	--
Alaska	362,881	362,881	362,881	--
Arizona	659,935	662,160	662,160	--
Arkansas	382,159	382,623	382,623	--
California	3,297,167	3,308,268	3,308,268	--
Colorado	447,027	448,132	448,132	--
Connecticut	373,697	374,133	374,133	--
Delaware	362,881	362,881	362,881	--
District of Columbia	362,881	362,881	362,881	--
Florida	1,864,949	1,871,228	1,871,228	--
Georgia	1,045,869	1,049,391	1,049,391	--
Hawaii	362,881	362,881	362,881	--
Idaho	362,881	362,881	362,881	--
Illinois	1,265,728	1,269,981	1,269,981	--
Indiana	764,876	767,447	767,447	--
Iowa	372,163	372,593	372,593	--
Kansas	362,881	362,881	362,881	--
Kentucky	577,204	579,143	579,143	--
Louisiana	566,770	568,672	568,672	--
Maine	362,881	362,881	362,881	--
Maryland	466,854	468,424	468,424	--
Massachusetts	604,505	606,532	606,532	--
Michigan	1,239,838	1,244,002	1,244,002	--
Minnesota	512,759	514,482	514,482	--
Mississippi	424,574	425,999	425,999	--
Missouri	687,561	689,871	689,871	--
Montana	362,881	362,881	362,881	--
Nebraska	362,881	362,881	362,881	--
Nevada	362,881	362,881	362,881	--
New Hampshire	362,881	362,881	362,881	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	743,327	745,824	745,824	--
New Mexico	362,881	362,881	362,881	--
New York	1,829,821	1,835,961	1,835,961	--
North Carolina	1,089,450	1,093,115	1,093,115	--
North Dakota	362,881	362,881	362,881	--
Ohio	1,332,036	1,336,512	1,336,512	--
Oklahoma	418,336	419,743	419,743	--
Oregon	407,305	408,276	408,276	--
Pennsylvania	1,370,712	1,375,314	1,375,314	--
Rhode Island	362,881	362,881	362,881	--
South Carolina	573,680	575,609	575,609	--
South Dakota	362,881	362,881	362,881	--
Tennessee	748,866	751,384	751,384	--
Texas	2,432,653	2,440,848	2,440,848	--
Utah	362,881	362,881	362,881	--
Vermont	362,881	362,881	362,881	--
Virginia	729,693	732,147	732,147	--
Washington	618,587	620,668	620,668	--
West Virginia	365,960	366,370	366,370	--
Wisconsin	637,929	640,072	640,072	--
Wyoming	362,881	362,881	362,881	--
Subtotal, States	36,003,556	36,098,572	36,098,572	--
American Samoa	194,139	194,139	194,139	--
Guam	194,139	194,139	194,139	--
Northern Mariana Islands	194,139	194,139	194,139	--
Puerto Rico	887,069	890,053	890,053	--
Virgin Islands	194,139	194,139	194,139	--
Subtotal, States and Territories	37,667,181	37,765,181	37,765,181	--
Grants to Tribes	194,139	194,139	194,139	--
Training and Technical Assistance[134]	772,680	774,680	774,680	--
TOTAL	**$38,634,000**	**$38,734,000**	**$38,734,000**	**--**

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

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University Centers for Excellence in Developmental Disabilities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
UCEDDs……...	$36,674,000	$37,674,000	$38,619,000	$945,000

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

FY 2016 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

University Centers for Excellence in Developmental Disabilities (UCEDDs), first established in 1963, are interdisciplinary education, research and public service units of a university system or public or not-for-profit entities associated with universities. UCEDDs provide leadership in, advise Federal, State, and community policymakers about, and promote opportunities for individuals with developmental disabilities to exercise self-determination, be independent, productive, and integrated and included in all facets of community life. In FY 2013, the Administration on Intellectual and Developmental Disabilities (ACL/AIDD) awarded 68 grants to continue funding for University Centers to engage in interdisciplinary pre-service training, community services, research, and information dissemination activities. The grant designates the Center and provides infrastructure support for UCEDDs to leverage additional funds for carrying out core activities.

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

- Integrate knowledge and methods from two or more distinct disciplines;
- Integrate direct contributions to the field made by people with disabilities and family members; and
- Examine and advance professional practice, scholarship and policy that impacts the lives of people with developmental and other disabilities and their families.

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

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

Funding History:

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

FY 2011 .....$38,865,000
FY 2012 .....$38,792,000
FY 2013 .....$36,602,000
FY 2014 .....$36,674,000
FY 2015 .....$37,674,000

Budget Request:

The FY 2016 request for UCEDDs is $38,619,000, an increase of +$945,000 above the FY 2015 enacted level. This request will provide operational and administrative support to maintain the existing 68 UCEDDs. This funding will also provide continued support for the training and technical assistance to the UCEDDs to support improvements in the programs' performance and ability to meet performance targets, which would otherwise not be possible due to provisions in the funding formula of the Developmental Disabilities Act that requires appropriated funds to provide cost of living adjustments (COLA) to Centers before funding National Training Initiatives (NTI) and technical assistance to Centers. Without an increase in FY 2016, funding would not be at a level necessary to maintain the UCEDD core grants at their current level and pay for the COLA, NTI grants, and technical assistance to Centers. The additional funds will provide sufficient money to award UCEDD grants with the COLA, continued funding of a National Training Initiative grant focused on violence against people with developmental disabilities, supplemental funds supporting people with developmental disabilities participating

in UCEDD training programs, and technical assistance to Centers.

Continued funding of the UCEDDs will support this network of independent but interlinked centers, representing an expansive national resource for addressing issues, finding solutions, and advancing research related to the needs of individuals with developmental disabilities and their families. At the local level, UCEDDs are vital to the training of future professionals with the specialized expertise in developmental disabilities. Of the UCEDD trainees who graduated 5 to 10 years ago, 82 percent are in leadership positions with:

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

It is estimated that over 36 percent of people with developmental disabilities are receiving services from former UCEDD trainees.

In the absence of continued funding for UCEDDs, specialized services would no longer be available at the local level and local organizations as well as state agencies would not have the benefit of receiving technical assistance from UCEDDs to improve services and supports for people with developmental disabilities across the life span. A lack of funding would also create a tremendous gap in new knowledge generated by UCEDD-conducted research. For example, a growing body of research has documented that persons with developmental and other disabilities are more likely to experience health disparities compared to the general population. The University of New Hampshire UCEDD is conducting the Health and Health Care Disparities among Individuals with Disabilities project to determine what factors relate to or explain health outcomes and health care access among the diverse populations of individuals with disabilities. The goal of the Health Disparities Project is to generate new knowledge about health access and health outcomes among sub-groups of people with disabilities and translate and disseminate the findings for researchers, policy makers, and others.

UCEDD funds help to place these centers in a strategic position to lead national efforts such as *The National Gateway to Self-determination,* which is a collaborative effort of five UCEDDs and the National Self-Determination Alliance to establish a sustainable, evidence-based training system that enhances self-determination training programs that lead to quality of life outcomes for individuals with developmental disabilities throughout the lifespan. Another example is *The Consortium to Enhance Postsecondary Education for Individuals with Developmental Disabilities,* which is a project led by the Institute for Community Inclusion in Massachusetts in

collaboration with seven UCEDDs (Delaware, Minnesota, Hawaii, South Carolina, Tennessee [Vanderbilt], Ohio, and California) and the Association of University Centers on Disabilities. The Consortium is conducting research, providing training and technical assistance, and disseminating information on promising practices that support individuals with developmental disabilities to increase their independence, productivity, and inclusion through access to postsecondary education, resulting in improved long-term independent living and employment outcomes.

Funding for UCEDDs also provides infrastructure support for initiatives with effects felt internationally, such as the University of Hawaii UCEDD's Asia-United States Partnership (AUSP). The goal of this partnership is to improve child health through cross-cultural exchanges in early childhood development with leaders in East Asia (Beijing, Shanghai, and Hong Kong SAR, Philippines, Singapore, and Thailand) and the United States.

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

Outputs and Outcomes Table:

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
8D: Increase the percentage of individuals with developmental disabilities receiving the benefit of services through activities in which professionals were involved who completed University Centers of Excellence in Developmental Disabilities (UCEDDs) state-of-the-art training within the past 10 years. (Outcome)	FY 2013: 40.98% Target: 40.07% (Target Exceeded)	Prior Result +1%	Prior Result +1%	N/A
8viii: Number of professionals trained by UCEDDs. (Output)	FY 2013: 5,891 (Actual)	N/A	N/A	N/A
8ix: Number of people reached through UCEDD community training and technical assistance activities. (Output)	FY 2013: 691,369 (Actual)	N/A	N/A	N/A
8x: Number of people receiving direct or model demonstration services from UCEDDs. (Output)	FY 2013: 81,295 (Actual)	N/A	N/A	N/A

Grant Awards Tables:

University Centers of Excellence in Developmental Disabilities Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	67	72	68
Average Award	$535,215	$512,785	$556,846
Range of Awards	$535,215	$200,000 - $738,000	$200,000 - $738,000

Resource and Program Data:

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	3	1,606	4	1,982	1	344
Continuations	64	34,254	68	34,939	67	37,522
Contracts	1	802	1	728	1	728
Interagency Agreements	--	--	--	--	--	--
Program Support /1		12		25		25
Total Resources		36,674		37,674		38,619

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

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Developmental Disabilities – Projects of National Significance

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
DD – Projects of National Significance	$8,821,000	$8,857,000	$14,500,000	$5,643,000

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

FY 2016 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

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

Program Description and Accomplishments:

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

In FY 2013, PNS resources funded systems change grants to improve access to competitive, integrated supported employment for people with intellectual and developmental disabilities, with a particular focus on youth and young adults, as well as the evaluation of such efforts. It also funded promising practices in states to promote competitive, integrated employment and family support activities, as well as technical assistance to self-advocacy organizations. PNS funds continue to support longitudinal research studies of trends in residential services and supports, employment, community supports, family supports, and quality indicators related to publicly funded DD services. In FY 2014, PNS resources funded a new project related to gathering and disseminating information and providing technical assistance to people and entities interested in supported decision making as an alternative to guardianship. In addition, Congress added $1,000,000 to the FY 2014 and FY 2015 appropriation to support a grant related to inclusive transportation for those with disabilities.

In FY 2016, ACL/AIDD will continue to prioritize these efforts as well as a Youth Transitions Initiative with the goal of bringing together entities such as state Developmental Disabilities agency, Department of Education, Vocational Rehabilitation, Council on Developmental Disabilities, University Centers for Excellence in Developmental Disabilities and other agencies to address the comprehensive needs of youth with intellectual and developmental disabilities as they transition from adolescence into young adult life across all systems – health, education, employment, human services, and community living. The July 2012 GAO Report, *Students with Disabilities: Better Federal Coordination Could Lessen Challenges in the Transition from High School*, strongly recommended development of an interagency approach across HHS, Education, Labor, and Social Security to work towards improving common outcomes for transitioning youth with disabilities and their families related to health, education, employment, support services and community living. HHS' response to this report acknowledged that "more must be done toward developing a coordinated, integrated transition strategy." The GAO report builds upon a long and demonstrated history of reports and data indicating the need to ensure that youth with disabilities are not exiting high school only to become dependent upon Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid at a cost of tens of billions of federal dollars – and that the lack of coordination across systems is a major contributor to this trend.

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

Building on the work of these demonstrations, through the Youth Transitions initiative, ACL will invest in state initiatives, with the goal of generating results similar to the Washington state model, that bring together entities such as state Developmental Disabilities agency, Department of Education, Vocational Rehabilitation, Council on Developmental Disabilities, University Centers for Excellence in Developmental Disabilities and other agencies to address the comprehensive needs of youth with intellectual and developmental disabilities as they transition from adolescence into young adult life across all systems – health, education, employment, human services, and community living. These entities will identify federal, state, and local laws,

regulations, and policies that create barriers to employment for youth with Intellectual or Developmental Disabilities, develop plans to deconstruct such barriers, and implement inter-agency programs that produce better outcomes for this population. ACL will also fund an evaluation component for the initiative in 2016.

The models would be required to address transitioning across several systems for youth with Intellectual or Developmental Disabilities, including pediatric to adult health care, education to post-secondary education, and vocational systems to produce successful outcomes in competitive, integrated employment. Of specific interest is implementing approaches that provide ongoing long-term services and supports which will provide meaningful assistance to these youth into adulthood through Medicaid or other funding streams. Family supports will be critical to successful models as well, with a holistic approach on providing family members supporting their youth with targeting, ongoing assistance. For example, a successful model may include implementing training curriculums on best practices within and outside of disability services for accessing and coordinating community supports, leadership development, and self-advocacy – and would be made available to youth, siblings, parents and other family supporting the transitioning youth with Intellectual or Developmental Disabilities.

Funding History:

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

FY 2011 .....$14,134,000
FY 2012 .....$8,317,000
FY 2013 .....$8,828,000
FY 2014 .....$8,821,000
FY 2015 .....$8,857,000

Budget Request:

The FY 2016 request for the Projects of National Significance program is $14,500,000, an increase of +$5,643,000 above the FY 2015 enacted level. Within this request, $5,000,000 is to support ACL's Youth Transitions initiative, which will support youth with disabilities transitioning from childhood to adulthood, as well as enhance coordination across Federal agencies currently serving this population. The request also includes +$643,000 to support inclusive employment initiatives, transportation, technical assistance, longitudinal data collection and analysis, evaluation, and monitoring for the State Councils on Developmental Disabilities, as described in that program section. In addition, AIDD will provide self-advocacy organizations with an opportunity to thrive and grow through a targeted technical assistance effort.

PNS projects reflect the current and emerging needs of individuals with developmental disabilities. For instance, funds for Youth Transitions will fund demonstration projects in nine States through grants, cooperative agreements, and coordinated interagency program implementation to:

- Promote innovative utilization of health and long-term supports in coordination with education, vocational rehabilitation, and employment services;
- Encourage integration of health and LTSS transition planning into secondary and post-secondary education programs;
- Provide technical assistance and training to ensure integration of health and long-term supports with education, vocational rehabilitation and employment services; and
- Establish and implement a coordinated federal evaluation agenda to ensure that outcomes across systems are measured and reported.

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

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

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

In FY 2016 ACL will also continue to issue grants totaling $1 million to communities with the models that best demonstrate the inclusion of people with disabilities, including intellectual and

developmental and/or physical disabilities, and seniors in the development and planning of the community transportation systems. These funds were appropriated directly to ACL for the first time in FY 2014.

Grant Awards Tables:

Developmental Disabilities – Projects of National Significance Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	27	25	37
Average Award	$280,356	$288,876	$345,125
Range of Awards	$100,000 - $575,000	$100,000 - $575,000	$100,000 - $575,000

Resource and Program Data:

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	6	770	--	--	10	5,000
Continuations	21	6,800	25	7,222	27	7,770
Contracts	5	1,065	7	1,343	7	1,363
Interagency Agreements	--	--	--	--	--	--
Program Support /1		187		292		368
Total Resources		8,821		8,857		14,500

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

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National Institute on Disability, Independent Living, and Rehabilitation Research

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
National Institute on Disability, Independent Living, and Rehabilitation Research……....	$103,970,000	$103,970,000	$108,000,000	$4,030,000

Authorizing Legislation: Title II of the Rehabilitation Act of 1973, as amended

FY 2016 Rehabilitation Act Authorization.....$112,001,000

Allocation Method .....Discretionary Grants and Contracts

Program Description and Accomplishments:

The mission of the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) is to generate knowledge and promote its effective use to improve the abilities of people with disabilities to perform activities of their choice in the community, and also to expand society's capacity to provide full opportunities and accommodations for its citizens with disabilities. NIDILRR sponsors comprehensive and coordinated programs of research and related activities to maximize the full inclusion, social integration, employment, and independent living of individuals with disabilities of all ages. The purposes of NIDILRR are to:

- Promote, coordinate, and provide for research, demonstration and training, and related activities with respect to individuals with disabilities;

- Widely disseminate findings, conclusions, and recommendations resulting from its activities; and

- Provide research-based knowledge toward advancing the quality of life of individuals with disabilities.

NIDILRR's research is conducted through a network of individual research projects and centers of excellence located throughout the nation. Most funding is awarded through competitive grants, and most of the funds are awarded to universities or providers of rehabilitation or related services.

As required by the Rehabilitation Act in §202(h), NIDILRR operates under a Long-Range Plan (LRP), published April 4, 2013 in the Federal Register, entitled "*Long-Range Plan for Fiscal Years 2013-2017."* This plan outlines four long-term performance goals and its strategies for achieving these goals. These goals are:

- Goal 1: Create a portfolio of research, development, and other activities that balances domains, populations of focus, and who, whether NIDILRR or the grant applicant, defines the specific approach to a disability or rehabilitation research topic.

- Goal 2: Support centers and projects that conduct well-designed research and development activities using a range of appropriate methods.

- Goal 3: Promote the effective use of knowledge in areas of importance to individuals with disabilities and their families.

- Goal 4: Improve program administration.

The following is a description of the primary grant mechanisms under which NIDILRR makes awards:

- *Rehabilitation Research and Training Centers (RRTCs).* RRTCs receive funding to conduct coordinated and advanced programs of research, training, and information dissemination in problem areas that are specified by NIDILRR. More specifically, RRTCs conduct research to improve rehabilitation methodologies and service delivery systems, alleviate or stabilize disabling conditions, and promote maximum social and economic independence for persons with disabilities. In addition, RRTCs provide training, including graduate, pre-service, and in-service training, to help rehabilitation personnel provide more effective rehabilitation services to individuals with disabilities; and serve as centers of excellence in rehabilitation research for providers and for individuals with disabilities and their representatives. Typically, awards are for 5 years.

- *Rehabilitation Engineering Research Centers (RERCs).* The RERCs conduct research on issues dealing with rehabilitation technology, including rehabilitation engineering and assistive technology devices and services. RERC activities include developing and disseminating innovative methods of applying advanced technology, scientific achievements, and psychological and social knowledge to rehabilitation issues such as the removal of environmental barriers; developing and disseminating technology designed to lessen the effects of sensory loss, mobility impairment, chronic pain, and communication difficulties; scientific research to assist in meeting the employment and independent living needs of

individuals with severe disabilities; and stimulating the production and distribution of equipment in the private sector, as well as clinical evaluations of equipment. Each RERC must provide training opportunities to enable individuals, including individuals with disabilities, to become researchers and practitioners in the field of rehabilitation technology. Typically, awards are for 5 years.

- *Model Systems*. NIDILRR funds model systems projects in three areas: spinal cord injury, traumatic brain injury, and burn injury. Model systems funding supports 5-year grants to establish innovative projects for the delivery, demonstration, and evaluation of comprehensive medical, vocational, and other rehabilitation services to meet the wide range of needs of individuals in these areas. Grantees in each of the three areas contribute to their respective injury-specific national database that is supported by NIDILRR funding. These model systems programs have become platforms for conducting multi-site research, including randomized controlled trials to determine the efficacy of interventions.

    - *Spinal Cord Injury Model Systems*. The Spinal Cord Injury (SCI) program funds research to meet the wide range of needs of individuals with spinal cord injuries. (See http://www.ncddr.org/rpp/hf/hfdw/mscis/.) The projects also disseminate information to individuals with SCI and others.

    - *Traumatic Brain Injury Model Systems*. The Traumatic Brain Injury (TBI) Model Systems projects are research grants designed to advance the understanding of TBI and its consequences and improve rehabilitation outcomes. Currently, the NIDILRR TBI model systems is the largest nonmilitary TBI service delivery/research entity participating in various intergovernmental efforts to improve treatment and outcomes for returning veterans. (See http://www.tbindsc.org.)

    - *Burn Model Systems*. The Burn Model Systems (BMS) projects are research grants designed to establish, demonstrate, and evaluate a model system of care for burn injury survivors. Projects aim to reduce disability by improving treatment and rehabilitation. See http://mama.uchsc.edu/pub/NIDILRR/index.html.

- *Field-Initiated Projects (FIPs).* Field-Initiated Projects supplement NIDILRR's directed research and address a wide range of topics identified by investigators, including research, demonstrations, development, and knowledge translation. These projects allow NIDILRR to address emerging developments in the field beyond the scope of announced priorities. Most of these awards are made for 3 years.

- *Disability and Rehabilitation Research Projects (DRRPs).* Grantees under this program focus on discrete research topics identified by NIDILRR and address problems encountered by people with disabilities through a variety of methods that may include research, demonstrations, training, dissemination, utilization, technical assistance, or combinations of these activities.

- *ADA National Network Centers (ADA Network).* The ADA Network supports 10 regional centers that provide detailed technical assistance, disseminate information, and provide training related to the requirements of the Americans with Disabilities Act (ADA) and promote awareness of the ADA. Typically, these awards are for 5 years.

- *Advanced Rehabilitation Research Training (ARRT).* The ARRT program supports grants to institutions of higher education to provide advanced postdoctoral training in areas that are directly related to NIDILRR's research domains, including community living and participation, employment, and health and function. Grants are made to institutions of higher education to recruit qualified persons with doctoral or similar advanced degrees and prepare them to conduct independent research in areas related to disability and rehabilitation. These training programs must operate in interdisciplinary environments and provide training in rigorous scientific methods.

- *Small Business Innovation Research (SBIR).* SBIR awards support the development of new rehabilitation technologies that are useful to persons with disabilities by inviting the participation of small business firms with strong research capabilities in science, engineering, or educational technology. This 2-phase program takes a product from development to market readiness. During Phase I, firms conduct feasibility studies to evaluate the scientific and technical merit of an idea. During Phase II, they expand on the results and pursue further development. In order to be eligible, small businesses must be American-owned and independently operated and be for-profit with no more than 500 employees. The principal researcher must be employed by the business.

- *Switzer Research Fellowships.* Switzer research fellows receive 1-year fellowships to carry out discrete research activities that are related to NIDILRR's research priorities or to pursue studies in areas of importance to the disability and rehabilitation community.

- *Outreach to Minority Institutions*. The Rehabilitation Act (§21) requires that 1 percent of funds appropriated for programs authorized under certain titles be reserved for awards to minority entities and Indian tribes, or to provide outreach and assistance to minority entities and Indian tribes.

- *Other Activities:* NIDILRR funding also supports a variety of other activities, including knowledge translation; collaborative projects with other agencies; development and maintenance of grantee reporting systems; program review; and reporting, evaluation, long-range planning, and the *Interagency Committee on Disability Research* (ICDR). The primary purpose of the ICDR is to promote cooperation across various Federal agencies in the development and execution of disability and rehabilitation research activities. (See http://www.icdr.us/.)

Funding History:

Funding for NIDILRR during the past five years is as follows:

FY 2011 .....$109,023,000
FY 2012 .....$108,817,000
FY 2013 .....$103,125,000
FY 2014 .....$103,970,000
FY 2015 .....$103,970,000

Budget Request:

ACL requests $108,000,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research in FY 2016, an increase of +$4,030,000 above the FY 2015 enacted level. Funding at this level will enable NIDILRR to fund Rehabilitation Engineering Research Centers (RERCs) on technologies to improve employment outcomes of individuals with disabilities, support community living strategies for families of individuals with disabilities, and support NIDILRR's Spinal Cord Injury (SCI) program. About 72 percent of the funds requested would be used to cover the costs of grants that began in previous fiscal years ($77 million). In addition, an estimated $31.4 million would be used to fund new grant awards under a revised regulatory framework that NIDILRR proposes to publish for its research in fiscal year 2016.

ACL plans to publish a Notice of Proposed Rule Making in FY 2016 that would amend 34 CFR Part 350, governing NIDILRR's Disability and Rehabilitation Research Projects and Centers Program. NIDILRR believes that these regulations will strengthen its overall research portfolio by expanding opportunities for field-initiated work within a clear framework that is designed to both encourage innovation and promote rigorous research, and by allowing for a regular schedule of competitions in pre-established priority areas. To establish clear and consistent requirements for similar types of projects, the regulations will define the types of projects to be supported and specify the application requirements for each of them. Under the proposed framework, NIDILRR would support the following four types of projects.

- *Exploration and Discovery*: Generate new and refined analyses, findings, hypotheses, and theories that enhance knowledge of the barriers to and facilitators of improved outcomes for individuals with disabilities. This research can also be used to identify existing practices, programs, or policies that are associated with better outcomes for individuals with disabilities. The results from this work may either inform the development of interventions or lead to evaluations of interventions.

- *Intervention Development*: Generate and test interventions—such as research tools, products, programs, practices, and policies—that have potential to improve outcomes for individuals with disabilities. NIDILRR supports grants to develop innovative interventions or to improve existing interventions.

- *Intervention Efficacy*: Evaluate the efficacy of interventions—such as research tools, products, programs, practices, and policies—to determine whether they are feasible and practical and can have a positive impact on outcomes for individuals with disabilities. Efficacy studies can be used to assess the strength of an intervention's impact on a desired outcome. Efficacy studies often apply experimental or quasi-experimental research methods.

- *Scale-up Evaluation:* Conduct evaluations to determine whether interventions—such as research tools, products, programs, practices, and policies—are effective in producing improved outcomes for individuals with disabilities when implemented in multiple real-world settings.

Through priorities published in the Federal Register in fiscal year 2013 based on NIDILRR's revised Long-Range Plan (published in final in April 2013), NIDILRR established three domains—employment, health and function, and community living and participation. To improve outcomes for people with disabilities, NIDILRR will expand research across these domains.

Within each domain, NIDILRR plans to structure its competitions to target its research/investments in four broad disability categories—physical, psychiatric, developmental/intellectual, and sensory disabilities. These priorities would remain in place for up to five years. Having these priority areas in place for a prolonged period of time would provide the field with stable opportunities for funding. Applicants who are not successful in one competition would be able to revise and improve their applications knowing that there will soon be another opportunity to have their proposal funded. Using recurring topical priorities would also simplify the management of NIDILRR's competitions by reducing the need for annual rule-making.

NIDILRR established the use of these domains beginning in fiscal year 2012 through rule-making on individual grant priorities under the DRRP, RRTC, and RERC programs. During fiscal year 2016, NIDILRR plans to focus on the following broad priority topics in its domain areas:

Employment

- Technology to improve employment outcomes for individuals with physical disabilities.
- Individual and environmental factors associated with improved employment outcomes for individuals with physical disabilities.
- Interventions that contribute to improved employment outcomes for individuals with physical disabilities. Interventions include any strategy, practice, program, policy, or tool that, when implemented as intended, contributes to improvements in outcomes for individuals with physical disabilities.
- Effects of government practices, policies, and programs on employment outcomes for individuals with physical disabilities.
- Practices and policies that contribute to improved employment outcomes for transition-aged youth with physical disabilities.
- Vocational rehabilitation (VR) practices that contribute to improved employment outcomes for individuals with physical disabilities.

Community Living and Participation

- Technology to improve community living and participation outcomes for individuals with physical disabilities.
- Individual and environmental factors associated with improved community living and participation outcomes for individuals with physical disabilities.
- Interventions that contribute to improved community living and participation outcomes for individuals with physical disabilities. Interventions include any strategy, practice, program, policy, or tool that, when implemented as intended, contributes to improvements in outcomes for individuals with physical disabilities.
- Effects of government practices, policies, and programs on community living and participation outcomes for individuals with physical disabilities.
- Practices and policies that contribute to improved community living and participation outcomes for transition-aged youth with physical disabilities.

Health and Function

- Technology to improve health and function outcomes for individuals with intellectual and developmental disabilities.
- Individual and environmental factors associated with improved access to rehabilitation and health care and improved health and function outcomes for individuals with intellectual and developmental disabilities.

- Interventions that contribute to improved health and function outcomes for individuals with intellectual and developmental disabilities. Interventions include any strategy, practice, program, policy, or tool that, when implemented as intended, contributes to improvements in outcomes for the specified population.
- Effects of government practices, policies, and programs on health care access and on health and function outcomes for individuals with intellectual and developmental disabilities.
- Practices and policies that contribute to improved health and function outcomes for transition-aged youth with intellectual and developmental disabilities.

Output Table:

ACL will work with all relevant parties to review, develop, or refine performance measures and performance data collection for all WIOA programs during the transition.

Resource and Program Data:

National Institute on Disability, Independent Living, and Rehabilitation Research
(Dollars in Thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
New Discretionary	72	20,919	58	16,893	77	32,993
Continuations	165	77,324	166	79,524	147	68,397
Contracts		4,927		6,229		5,910
Peer Review of new grant applications		800		824		700
Interagency Agreements	--	--	--	500	--	--
Total Resources		103,970		103,970		108,000

Independent Living

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Independent Living State Grants…….……..	$22,878,000	$22,878,000	$22,878,000	$0
Centers for Independent Living……...	$78,305,000	$78,305,000	$83,305,000	$5,000,000
Total……..	$101,183,000	$101,183,000	$106,183,000	$5,000,000

Authorizing Legislation: Rehabilitation Act of 1973, Title VII, Parts B and C, and Chapter 2, as amended by the Workforce Innovation and Opportunities Act (Rehabilitation Act)

FY 2016 Rehabilitation Act Authorizations:

Independent Living State Grants $24,645,000
Centers for Independent Living $84,353,000

Allocation Method .....Formula and Discretionary Grants

Program Description and Accomplishments:

Independent living (IL) programs maximize the leadership, empowerment, independence, and productivity of individuals with disabilities, and work to integrate these individuals into the mainstream of American society. Independent living programs provide financial assistance to sustain, expand, and improve independent living services; develop and support statewide networks of centers for independent living; and foster working relationships among State independent living rehabilitation programs, centers for independent living, Statewide Independent Living Councils, Rehabilitation Act programs outside of Title VII, and other relevant Federal and non-Federal programs.

The Independent Living State Grants program supports formula grants to States, with funds allotted based on total population. States participating in the State Grants program must match 10 percent of their grant with non-Federal cash or in-kind resources in the year for which the Federal funds are appropriated. The fiscal year 2014 State distributions were based on the July 1, 2012 estimates released in December 2012, and the fiscal year 2015 allotments will be based on the July 1, 2013 estimates published by the Census Bureau in December 2013.

To be eligible for financial assistance under the Independent Living (IL) State Grants or Centers for Independent Living program, States are required to establish a Statewide Independent Living Council (SILC). Each State must also submit a State Plan for Independent Living. In addition to developing the State plan, the Council may, consistent with the State plan and State law, work to coordinate services provided to individuals with disabilities, conduct resource development activities, and perform other functions to support the purposes of the law. The remaining funds shall be used for one or more of the following purposes, consistent with the approved State plan:

- To demonstrate ways to expand and improve independent living services, particularly those in unserved areas of the State'' after ''disabilities' ;
- To provide independent living services;
- To support the operation of centers for independent living;
- To increase the capacity of public or nonprofit agencies and organizations and other entities to develop comprehensive approaches or systems for providing independent living services;
- To conduct studies and analyses, gather information, develop model policies and procedures, and present information, approaches, strategies, findings, conclusions, and recommendations to Federal, State, and local policymakers;
- To provide training on the independent living philosophy; and/or
- To provide outreach to populations who are not served or are underserved by programs under Title VII of the Rehabilitation Act, including minority groups and urban and rural populations.

The 2014 reauthorization of the Workforce Innovation and Opportunity Act (WIOA) added a new requirement that the Department annually reserve between 1.8 and 2.0 percent of the appropriated IL State funds to provide either directly or through grants, contracts, or cooperative agreements, training and technical assistance to Statewide Independent Living Councils (SILCs). In addition, WIOA requires that the ACL Administrator conduct a survey of SILCs regarding their training and technical assistance needs.

The Centers for Independent Living (CIL) program provides grants for consumer-controlled, community-based, cross-disability, private nonprofit agencies that are designed and operated within a local community by individuals with disabilities and provide an array of independent

living services. At a minimum, centers are required to provide the core services of information and referral, independent living skills training, peer counseling, transition services, and individual and systems advocacy. The 2014 reauthorization of the Workforce Innovation and Opportunity Act added a fifth core service that the CILs must provide to eligible individuals with significant disabilities that requires CILs to:

- Facilitate the transition of individuals with significant disabilities from nursing homes and other institutions to home and community based residences, with necessary supports to remain in the community;

- Assist individuals with significant disabilities at risk of institutionalization so that they may remain in the community; and

- Facilitate the transition of youth who are individuals with significant disabilities who are eligible for IDEA and who either completed school or left school to transition to postsecondary life.

A population-based formula determines the total amount that is available for discretionary grants to centers in each State. In most cases, funds are awarded directly to centers for independent living. In fiscal year 2013, 354 centers and two States received funding from the CIL program. If State funding for CIL operation exceeds the level of Federal CIL funding in any fiscal year, the State may apply for the authority to award grants under this program through its designated state unit. There are currently only two States, Massachusetts and Minnesota, that are both eligible and have elected to manage their own CIL programs.

In addition to funding centers for independent living, the Department must award between 1.8 and 2 percent of the funds appropriated for this program for grants, contracts, or cooperative agreements to provide training and technical assistance with respect to planning, developing, conducting, administering, and evaluating centers for independent living. The Rehabilitation Act requires the Department to conduct a survey of Statewide CILs to determine funding priorities for such grants, contracts or cooperative arrangements.

The WIOA requires that within a year after the date of enactment of the law, ACL shall develop and publish in the Federal Register indicators of minimum compliance for centers for independent living, and indicators of minimum compliance for Statewide Independent Living Councils, consistent with the requirements of the law.

The following standards are used in evaluating compliance in the following areas: philosophy, including consumer control and equal access; provision of services on a cross-disability basis; support of the development and achievement of the independent living goals chosen by

consumers; increasing the availability and quality of community options for independent living; provision of independent living core services; resource development; and community capacity-building activities, such as community advocacy, technical assistance, and outreach. WIOA requires that grants be awarded to any eligible agency that had been awarded a grant for the preceding fiscal year.

Funding History:

Funding for Independent Living activities during the past five years is as follows:

Independent Living State Grants:
FY 2011 .....$23,403,000
FY 2012 .....$23,359,000
FY 2013 .....$23,137,000
FY 2014 .....$22,137,000
FY 2015 .....$22,878,000

Centers for Independent Living:
FY 2011 .....$80,105,000
FY 2012 .....$79,953,000
FY 2013 .....$75,772,000
FY 2014 .....$78,305,000
FY 2015 .....$78,305,000

Budget Request:

ACL's FY 2016 budget request is for $106,183,000, an increase of +$5,000,000 above the FY 2015 enacted level. Of this amount, $22,900,000 is provided to the Independent Living State Grants program (IL State Grants) and $83,300,000 million is for the Centers for Independent Living program (CIL). At these levels, State Grants will remain the same as the FY 2015 levels, and CILs will continue to provide the core requirements for information and referral services, independent living skills training, peer counseling, and individual and systems advocacy. The +$5,000,000 requested increase will also be provided to the CILs to implement the new, fifth core service required by the 2014 Workforce Innovation and Opportunity Act to facilitate the transition of individuals with significant disabilities into the community. As part of this requirement, CILs are directed to develop protocols, provide outreach and education, and provide and track activities. In 2012, CILs served about 213,000 of the estimated 38 million

individuals with a significant disability living in the United States.[135] The new fifth core service represents a significant new activity for many CILs, and without additional resources, CILs will be forced to reduce current service levels in order to provide this new core service.

The request for the CIL program would continue support for existing centers, including any new center grants awarded in FY 2015. Approximately 75 new centers have been funded, as funding for this program has increased since FY 2000. These new and existing centers provide essential services that help individuals with disabilities to live independently and participate as productive members of their communities.

Output Table:

ACL will work with all relevant parties to review, develop, or refine performance measures and performance data collection for all WIOA programs during the transition.

[135] Department of Education, "Annual Report: Fiscal Year 2012: Report on Federal Activities Under the Rehabilitation Act of 1973, as Amended," issued 2014. Accessed 12/4/14. http://www2.ed.gov/about/reports/annual/rsa/2012/rsa-2012-annual-report.pdf.

U.S. Census Bureau, "Americans with Disabilities 2010" issued July 2012. Accessed 12/4/14. http://www.census.gov/prod/2012pubs/p70-131.pdf

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Consumer Information, Access, and Outreach

Summary of Request

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

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

Equally important, however, are the programs that help people with disabilities and older Americans to more fully participate in all aspects of community life. Grants provided under the Help America Vote Act (HAVA) assist States in making polling places accessible to individuals with the full range of disabilities, and the Assistive Technology program helps support individuals with disabilities to obtain Assistive Technology devices and services. Further, the Alzheimer's Disease Initiative Communications Campaign, funded from the Prevention and Public Health Fund, the National Clearinghouse for Long-Term Care Information, the Limb Loss Resource Center, and the Paralysis Resource Center, each reach out to key populations to assist them in accessing services and in planning for future needs.

The FY 2016 request for these programs is $122,788,000, an increase of +$4,141,000 above the FY 2015 enacted level. This request would provide:

- $20,000,000 in discretionary funding for ADRCs, an increase of +$13,881,000 above the FY 2015 enacted level. FY 2014 is the final year that mandatory funding was provided for this program under the ACA. Therefore, this discretionary request represents the sole source of funding for ADRCs going forward. ADRCs support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and

integrated access by creating "one-stop shop" entry points into long-term care at the community-level.

- $4,200,000 for the Alzheimer's Disease Initiative Outreach Campaign, the same as the FY 2015 enacted level. This outreach campaign informs those who are caring for people with Alzheimer's disease about the Federal, state, local, and nonprofit resources available to help them. This funding is proposed from the Prevention and Public Health Fund.

- $52,115,000 for State Health Insurance Assistance Programs (SHIPs), transferred to ACL from the Centers for Medicare and Medicaid Services in FY 2014. SHIPs provide free, one-on-one counseling and assistance to help aging and disabled Medicare beneficiaries navigate the complexities of health and long-term care systems. The SHIPs, two-thirds of which are currently administered by State Units on Aging, fit naturally within ACL's mission of promoting community living, and benefit from deeper connections to ACL's aging and disability services networks.

- $4,963,000 for HAVA, the same as the FY 2015 enacted level. HAVA grants assist Protection and Advocacy systems in each State and Territory to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places.

- $31,000,000 for Assistive Technology, a decrease of -$2,000,000 below the FY 2015 enacted level. Assistive Technology was transferred to ACL from the Department of Education in FY 2014 by the Workforce Innovation and Opportunity Act, and financially supports State programs that maximize the abilities of individuals with disabilities and their families to obtain AT devices and services, including computer or technology aids, modified driving controls, and durable medical equipment such as wheelchairs or walkers.

- $1,000,000 for the National Clearinghouse for Long-Term Care Information. This outreach effort increases awareness of the need to plan ahead for long-term care.

- $2,810,000 for Limb Loss, an increase of +$10,000 above the FY 2015 enacted level. The Limb Loss program was transferred to ACL from the Centers for Disease Control in FY 2015, and supports a national resource center and related activities that provide comprehensive information and resources to assist individuals and families dealing with limb loss.

- $6,700,000 for the Paralysis Resource Center (PRC), the same as the FY 2015 enacted level. The PRC was transferred to ACL from the Centers for Disease Control and

Prevention in FY 2014, and provides comprehensive information and referral services for people living with paralysis and their families and caregivers. Under ACL's administration the PRC benefits from extensive ties to ACL's disability networks.

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Aging and Disability Resource Centers

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Discretionary…….	$6,067,000	$6,119,000	$20,000,000	$13,881,000
Mandatory…….	$9,280,000	--	--	--
Total……..	$15,347,000	$6,119,000	$20,000,000	$13,881,000
FTE…….....	3	--	--	--

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

FY 2016 Authorization .....Expired

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

Program Description and Accomplishments:

Aging and Disability Resource Centers (ADRCs) support State efforts to develop more efficient, cost-effective, and consumer-responsive systems of information and integrated access by creating consumer-friendly entry points into long-term care at the community-level. ADRCs grew out of best practice innovations in some states known as "No Wrong Door"[136] (NWD) and "Single Points of Entry" programs, where people of all ages may turn for objective information and one-on-one assistance on their long-term services and support options. Since 2003, the Administration for Community Living, along with the Centers for Medicare & Medicaid Services (CMS) and most recently the Veterans Health Administration (VHA), have entered into cooperative agreements with States to develop the foundational infrastructure for delivering one-on-one person-centered counseling and streamlined access to public programs that make it easier for individuals to learn about and access their health and long-term services and support options. ACL, CMS, and the VHA are now working with eight ADRC states to build on the lessons learned and best practices from prior ADRC investments to develop national standards for a "high-performing" NWD system that serves all populations and all payers.

[136] 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).

NWD/ADRC systems help States make better use of taxpayer dollars by streamlining access to community services and supports (both publicly and privately funded) and diverting individuals from more costly forms of care, including institutional care and unnecessary hospital re-admissions. These systems are a key component in transforming States' long-term supports and services programs, work which is not only vital, but ongoing. Services for all populations and all payers provided by NWD/ADRC systems which highlight the need for continued funding include:

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

- "One-on-one" person-centered counseling to help consumers, families, and caregivers fully understand the options, including private pay, available to them;

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

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

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

In November 2014, ACL completed an evaluation of this program, and the final evaluation report is available on ACL's website.[137] The evaluation includes process and outcome studies and is designed to produce generalizable outcomes about the degree to which ADRCs are meeting their goals of effectively integrating and streamlining access to LTSS. The evaluation results will also inform program refinement and continuous quality management.

With FY 2012 funds, ADRCs responded to more than five million contacts to help individuals make better informed decisions about their health and long-term services and support options, with the vast majority of these decisions resulting in referrals for community-based services. High performing NWD/ADRC systems that serve all populations including Medicaid-eligible

[137] ACL. "National Study of Aging and Disability Resource Centers: Process and Outcome Study Report," issued November 30, 2014. http://www.aoa.acl.gov/Program_Results/docs/ADRCs-final-study-report.pdf.

individuals satisfy one of three statewide system change requirements states must meet in order to qualify for enhanced Federal match under the CMS Medicaid Balancing Incentive Program.

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

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

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

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

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

Funding History:

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

FY 2011 .....$16,469,000
FY 2012 .....$16,457,000
FY 2013 .....$15,585,000
FY 2014 .....$15,347,000
FY 2015 .....$6,119,000

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

Budget Request:

ACL's FY 2016 request for ADRCs is $20,000,000 in discretionary funding, an increase $13,881,000 above the FY 2015 enacted level.

ACL hopes to invest $20,000,000 to fund approximately 35 new state grantees to finalize their development and operation of sustainable NWD systems based on the national standards established by ACL, CMS and the VHA. Funded states will replicate the national standards to develop person-centered, conflict-free access system for long-term services and supports for all populations and all payers. In addition to the grants to states, funding would be used to support a technical assistance contract.

Activities in the 35 states funded by this proposal to develop sustainable NWD systems represent a substantial state-wide reform of access to long-term services and supports. Building on past ADRC activities, the transformation brought about by this funding will include:

- Funded state's program will meet national standards established by ACL, CMS, and VHA for NWD Systems and be required to report on its progress and performance using Federally prescribed efficiency and consumer outcome measures that align with the national standards;

- Governors of funded states will have to establish a multi-agency governance structure to oversee the development, financing and administration of its NWD System, and this structure must include the State Unit on Aging, the State Medicaid Agency, State Independent Living programs, and the other state agencies responsible for serving the people with physical disabilities as well as those with intellectual and developmental disabilities;

- Funded states will commit to using Medicaid administrative funding to support the NWD infrastructure on an on-going basis; and

- Funded states will ensure that local NWD sites:

    - Include a full range of organizations that play a formal reimbursable role in carrying out the NWD functions they have been designated by the state to perform to ensure the state's NWD System can effectively serve all LTSS populations;
    - Use nationally certified person-centered counselors to provide one-on-one assistance to consumers; and
    - Conduct formal functional and financial assessments that are required to determine an individual's eligibility for the public LTSS programs that are administered by the state, including Medicaid.

Finally, funded states' NWD systems, including local sites, will use the Federally-prescribed reporting data to continually evaluate performance and make improvements in NWD systems at

the state and local site level. Funded states will actively involve consumer stakeholders in this process.

Outcome and Outputs Table:

Aging and Disability Resource Centers Outcome and Outputs

Measure	Most Recent Result	FY 2015 Target	FY 2016 Target	FY 2016 +/- FY 2015
LTC.2: Percent of individuals who indicate ADRC information and counseling contribute to informed decision making *(Outcome)*	FY 2013: 75% Target:80% (Target Not Met)	83%	83%	Maintain
Indicator	**Most Recent Result**	**FY 2015 Projection**	**FY 2016 Projection**	**FY 2016 +/- FY 2015**
Output AF: Total number of ADRC contacts *(Output)*	FY 2013: 4.3 M	4.0 M	4.5 M	+ 0.5 M
Output AG: Increase in the number of ADRC programs *(Output)*	FY 2013: 509	509	509	Maintain

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

Resource and Program Data:

Aging and Disability Resource Centers
(Dollars in thousands)
Discretionary and Mandatory

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	30	5,827	6	4,185	9	10,973
Continuations	9	6,601	9	1,221	15	6,227
Contracts	2	2,283	1	530	2	2,530
Interagency Agreements	--	--	--	--	--	--
Program Support /1		636		183		250
Total Resources		15,347		6,119		20,000

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

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State Health Insurance Assistance Programs

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
State Health Insurance Assistance Programs…..	$52,115,000	$52,115,000	$52,115,000	--
FTE…….	2	8	8	--

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

FY 2016 Authorization .....Expired

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

Program Description and Accomplishments:

The State Health Insurance Assistance Program (SHIP) provides grants to States to fund infrastructure, training, and outreach support to over 12,000 (mostly volunteer) counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Under the direction and support of State program directors and trainers, SHIP counselors receive extensive training and continuous ongoing information updates about health plan options, Medicare entitlement and enrollment, Medigap, long-term care insurance, Medicare Part D prescription drug benefits, preventive benefits, and programs for beneficiaries with limited income and resources such as the Medicare Part D Extra Help/Low-Income Subsidy, the Medicare Savings Programs, and Medicaid.

SHIPs provide free, one-on-one counseling and assistance to help aging and disabled Medicare and Medicaid beneficiaries as well as coming-of-agers navigate the complexities of health and long-term care systems. Services are provided via telephone and face-to-face interactive sessions, public education presentations and programs, and media activities. In CY 2013, SHIPs had nearly 2.9 million one-on-one client contacts and more than 87,000 Public and Media events. SHIP activities align with the objective of developing a comprehensive, coordinated and cost-effective system of home and community-based services that helps elderly individuals and people with disabilities maintain their health and independence in their homes and communities.

In FY 2014 the SHIP program was transferred from the Centers for Medicare & Medicaid Services to the Administration for Community Living. This transfer reflects the natural synergies between the SHIP programs and the networks that ACL serves. About two-thirds of the 54 state SHIP programs are already administered by State Units on Aging, with most of the remaining

programs administered by State Insurance Commissions. At the community level, many SHIPs are either housed in or create local partnerships with Area Agencies on Aging. Similarly, almost 50 percent of the SHIPs are co-located with the Senior Medicare Patrol program, which is also administered by ACL.

SHIP activities complement programs authorized through the Older Americans Act, including but not limited to Information and Referral/Assistance (I&R/A), Aging and Disability Resource Centers (ADRCs), and Benefits Counseling. SHIPs also have a long history of outreach and assistance to underserved populations, including people with limited incomes, under-65 Medicare beneficiaries with disabilities, dual eligibles, and people with cognitive and/or mental disabilities.

Funding History:

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

FY 2011 .....$52,000,000
FY 2012 .....$52,115,000
FY 2013 .....$46,040,000
FY 2014 .....$52,115,000
FY 2015 .....$52,115,000

Budget Request:

The SHIP budget request for FY 2016 is $52,115,000, the same as the level requested in the FY 2015 enacted level. This includes funding for 8 FTEs and related administrative expenses to administer the program.

Funds will be used to continue SHIP grants and enable States to continue the personalized counseling that they have been providing while making further improvements to better streamline the program. Funds will also be used to provide administrative support for the SHIPs program, including technical assistance to grantees and management of data systems.

The needs of the over 46 million Americans who depend on Medicare for their health care are multifaceted and diverse. More than one-quarter of beneficiaries have cognitive impairments; almost one-third have limitations in activities of daily living such as eating and dressing; almost one-third have not graduated from high school; and more than one in ten are over 85 years of age. These beneficiaries can face any number of difficulties in trying to navigate the health care system. Recent and upcoming changes in the system as a result of the Affordable Care Act (ACA) will provide opportunities to beneficiaries for improved care, including increased

Medicare preventive services. These opportunities will increase the responsibilities of the SHIP counselors in terms of training, outreach and one-on-one counseling. The counselor knowledge base will need to include the inter-relationship of Medicare, Early Retiree Insurance Program, Pre-Existing Condition Insurance Plan (PCIP), Medicare covered preventive benefits, state Medicaid programs, and planning for the State-based Exchanges in addition to other long-term care support options that beneficiaries need to remain in the community.

Research has consistently found that Medicare beneficiaries prefer to receive information about Medicare and other supports through one-on-one assistance rather than through other means, such as written materials, mass media, and the internet. Given the large number and variety of private plan options available in the Medicare program and the new opportunities for beneficiaries through the ACA, the type of one-on-one beneficiary counseling and decisions support provided by SHIPs is an essential component to the information provided more generally through www.Medicare.gov and 1-800-MEDICARE.

Outcomes and Outputs:

In CY 2013, SHIPs had over 2.9 million one-on-one client contacts and more than 88,000 Public and Media events

Funds will be used to make SHIP grants to States to continue the personalized counseling that they provide and to make further improvements, which are anticipated to include:

- Continuing the number of community outreach and public forums to raise awareness of long-term care options including prevention and relevant ACA opportunities.

- Continuing the number of individual client contacts to individuals on Medicare under the age of 65.

Outcome and Outputs Table:

State Health Insurance Assistance Programs

Indicator	Most Recent Result	FY 2015 Projection	FY 2016 Projection	FY 2016 +/- FY 2015
Output AH: Number of SHIP Public Media Events *(Output)*	FY 2013: 88,084	90,000	95,000	+ 5,000
Output AI: Number of SHIP Client Contacts *(Output)*	FY 2013: 2,917,918	3 M	3 M	Maintain

Grant Awards Table:

State Health Insurance Assistance Programs Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	54	55	55
Average Award	$925,879	$892,772	$892,772
Range of Awards	$44,760 - $5,507,717	$44,760 - $5,507,717	$44,760 - $5,507,717

Resource and Program Data:

State Health Insurance Assistance Program
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	65	6,553	1	156	54	48,352
Continuations	54	43,905	55	48,736	1	750
Contracts	3	480	3	1,427	3	702
Interagency Agreements	3	968	1	164	1	500
Program Support /1		209		1,632		1,811
Total Resources		52,115		52,115		52,115

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

Voting Access for Individuals with Disabilities

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Voting Access for People with Disabilities	$4,963,000	$4,963,000	$4,963,000	--

Authorizing Legislation: Section 291 of the Help America Vote Act

FY 2016 Authorization .....Such Sums

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Voting Access for Individuals with Disabilities program is authorized by the Help America Vote Act (HAVA), P.L. 107-252. Funding currently supports Protection and Advocacy (P&A) systems in each State and Territory, through formula grants, to ensure full participation in the electoral process for individuals with disabilities, including registering to vote, casting a vote, and accessing polling places. These funds provide services to individuals with disabilities within the State, as well as advocacy for and education about the electoral process and monitoring of the accessibility of the electoral process for people with disabilities. Additionally, training and technical assistance grants to assist the P&As in their promotion of full participation in the electoral process are provided through competitive one-year awards.

HAVA P&A grantees use funds to promote systematic efforts to ensure individuals with disabilities have the opportunity to participate in every step of the electoral process. For example, grantees support systems change efforts to improve information on the location of accessible polling places, and adopt voting procedures that enable individuals with disabilities to vote privately and independently. Grantees also work to educate election officials, poll workers, and election volunteers on the rights of voters with disabilities and best practices. P&As provide assistance to State and other government entities by surveying polling places, identifying potential modifications to make specific polling places accessible, and developing criteria for identifying accessible polling places.

Through the program, ACL also makes discretionary grants to eligible nonprofit organizations to assist P&As in developing proficiency in the use of voting systems, identifying and implementing technologies to assist individuals with disabilities in voting, and demonstrating and evaluating the use of such systems and technologies. P&As also receive training and technical assistance for providing non-visual access in the voting process. These grants are authorized under section 291 of HAVA as a seven percent set-aside of the total appropriation for P&As. After receiving training and technical assistance, P&As may inform others on the availability of accessible voting equipment and its use.

Funding History:

Funding during the last five years has been as follows:

FY 2011 .....$17,375,000
FY 2012 .....$5,235,000
FY 2013 .....$4,961,000
FY 2014 .....$4,963,000
FY 2015 .....$4,963,000

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

Budget Request:

The FY 2016 budget request for Voting Access for Individuals with Disabilities to the Protection and Advocacy Systems and related technical assistance is $4,963,000, the same as the FY 2015 enacted level.

As an example of the activities undertaken with this funding, in Charleston, SC the P&A sponsored a site used by an Election Protection (EP) volunteer attorney to staff a hotline and train law student volunteers to canvass polling places in Charleston for accessibility issues. Accessibility in voting continues to be an ongoing challenge throughout the country. A 2013 report by the National Council on Disability identified a 2012 incident in Arizona where a voter who used a wheelchair could not get through the front door of her polling place to deliver an early ballot. The same report details a complaint from Bladensburg, MD where voters with disabilities were told that they had to "prove their disability" in order to be seated in line. Additionally, the Maryland P&A had to notify a Montgomery County judge to unlock the assigned accessible door to a polling place so that voters with disabilities could enter the building.

Being able to participate fully in the election process is a right, not a privilege, and funding for this activity helps to ensure that individuals with the full range of disabilities are not denied the right to the same opportunity for access and participation in the electoral process as voters with no disabilities.

Grant Awards Table:

Voting Access for Individuals with Disabilities Grant Awards

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget
Number of Awards	55	55	55
Average Award	$83,920	$83,920	$83,920
Range of Awards	$35,000 - $348,401	$35,000 - $348,401	$35,000 - $348,401

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

FY 2016 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alabama	70,000	70,000	70,000	--
Alaska	70,000	70,000	70,000	--
Arizona	70,000	70,000	70,000	--
Arkansas	70,000	70,000	70,000	--
California	348,401	348,401	348,401	--
Colorado	70,000	70,000	70,000	--
Connecticut	70,000	70,000	70,000	--
Delaware	70,000	70,000	70,000	--
District of Columbia	70,000	70,000	70,000	--
Florida	176,919	176,919	176,919	--
Georgia	90,851	90,851	90,851	--
Hawaii	70,000	70,000	70,000	--
Idaho	70,000	70,000	70,000	--
Illinois	117,917	117,917	117,917	---
Indiana	70,000	70,000	70,000	--
Iowa	70,000	70,000	70,000	--
Kansas	70,000	70,000	70,000	--
Kentucky	70,000	70,000	70,000	--
Louisiana	70,000	70,000	70,000	--
Maine	70,000	70,000	70,000	--
Maryland	70,000	70,000	70,000	--
Massachusetts	70,000	70,000	70,000	--
Michigan	90,516	90,516	90,516	--
Minnesota	70,000	70,000	70,000	--
Mississippi	70,000	70,000	70,000	--
Missouri	70,000	70,000	70,000	--
Montana	70,000	70,000	70,000	--
Nebraska	70,000	70,000	70,000	--
Nevada	70,000	70,000	70,000	--
New Hampshire	70,000	70,000	70,000	--

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

State/Territory	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
New Jersey	81,186	81,186	81,186	--
New Mexico	70,000	70,000	70,000	--
New York	179,233	179,233	179,233	--
North Carolina	89,314	89,314	89,314	--
North Dakota	70,000	70,000	70,000	--
Ohio	105,727	105,727	105,727	--
Oklahoma	70,000	70,000	70,000	--
Oregon	70,000	70,000	70,000	--
Pennsylvania	116,894	116,894	116,894	--
Rhode Island	70,000	70,000	70,000	--
South Carolina	70,000	70,000	70,000	--
South Dakota	70,000	70,000	70,000	--
Tennessee	70,000	70,000	70,000	--
Texas	238,662	238,662	238,662	--
Utah	70,000	70,000	70,000	--
Vermont	70,000	70,000	70,000	--
Virginia	74,970	74,970	74,970	--
Washington	70,000	70,000	70,000	--
West Virginia	70,000	70,000	70,000	--
Wisconsin	70,000	70,000	70,000	--
Wyoming	70,000	70,000	70,000	--
Subtotal, States	4,440,590	4,440,590	4,440,590	--
American Samoa	35,000	35,000	35,000	--
Guam	35,000	35,000	35,000	--
Puerto Rico	70,000	70,000	70,000	--
Virgin Islands	35,000	35,000	35,000	--
Subtotal, States and Territories	4,615,590	4,615,590	4,615,590	--
Training and Technical Assistance[138]	347,410	347,410	347,410	--
TOTAL	**$4,963,000**	**$4,963,000**	**$4,963,000**	--

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

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Assistive Technology

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Assistive Technology	$33,000,000	$33,000,000	$31,000,000	($2,000,000)

Note: In FY 2014 and FY 2015, $2,000,000 was appropriated for an alternative financing program (AFP). In fiscal year 2005 Congress amended the Assistive Technology Act to eliminate the separate AFP and establish an AT State grant program that requires States to conduct State financing activities, including alternative financing loan programs. Since the AFP program is no longer authorized by law, ACL is not requesting funds for it in FY 2016.

Authorizing Legislation: Assistive Technology Act of 1998

FY 2016 Assistive Technology Act of 1998.....Expired[139]

Allocation Method .....Competitive and Formula Grants

Program Description and Accomplishments:

The purpose of the Assistive Technology (AT) Act is to provide States with financial assistance that supports programs designed to maximize the ability of individuals with disabilities of all ages and their family members, guardians, advocates, and authorized representatives to obtain AT devices and AT services. AT devices are defined as any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities. A few examples of such devices are computer or technology aids, modified driving controls, and durable medical equipment such as wheelchairs or walkers. Grants support comprehensive statewide programs that are designed to increase the:

- Availability of, funding for, access to, provision of, and training about AT devices and services;
- Ability of individuals with disabilities of all ages to secure and maintain possession of AT during periods of transition, such as transition between school or home and home and work;
- Capacity of public and private entities to provide and pay for AT devices and services;
- Involvement of individuals with disabilities in decisions about AT devices and services;

[139] The GEPA extension expired September 30, 2011. The Administration proposes to continue funding this program in FY 2016 through appropriations language. Up to $1,235,000 may be used for National Activities, unless the amount available for AT State grants exceeds $20,953,534, in which case up to $1,900,000 may be used for National Activities.

- Coordination of AT-related activities among State and local agencies and other private entities;
- Awareness of and facilitate changes in law, regulations, procedures, policies, practices, and organizational structures, in order to improve access to AT; and
- Awareness of the benefits of AT among targeted individuals and entities in the general population.

Assistive Technology (AT) State grant program

The AT State grant program is a population-based formula grant program to support comprehensive statewide programs that maximize the ability of individuals with disabilities of all ages to access and acquire AT. States must establish consumer-responsive advisory councils with a majority membership of individuals with disabilities who use AT to advise on the planning, implementation, and evaluation of these statewide programs.

Under the formula, States and outlying areas are initially allocated a base amount equal to the amount of funds they received under the AT program in fiscal year 2004 (totaling $20,288,534). Any funds appropriated in excess of the fiscal year 2004 appropriation are initially distributed among the eligible entities with 50 percent of available funds distributed equally amongst them and 50 percent distributed according to the population of the State until each entity receives at least $410,000. If any appropriated funds remain after each State receives this minimum, they are distributed with 20 percent divided equally amongst the States and 80 percent distributed according to their populations. To date, appropriated funds under this program have not been at a level to necessitate this second round of distribution. The fiscal year 2013 State distributions were based on the July 1, 2011 estimates published in December 2011. The fiscal year 2014 State distributions are based on the July 1, 2012 estimates published on December 20, 2012. The fiscal year 2015 State distributions would be based on the July 1, 2013 estimates published on December 30, 2013.

Each State must set measurable goals, with timelines, that address the AT needs of individuals with disabilities related to: education (including goals related to the delivery of AT devices and services to students receiving services under the Individuals with Disabilities Education Act (IDEA)); employment (including goals related to the Rehabilitation Act's Vocational Rehabilitation State Grant program); telecommunications and information technology; and community living. The State must determine whether it has met its goals each year. States are held accountable for a lack of progress toward these goals through technical assistance, as well as corrective actions and/or sanctions if States are determined to be in noncompliance with the applicable requirements of the AT Act or have not made substantial progress toward achieving the measureable goals.

The State must implement each of the activities required under the program, which include State-level activities and State leadership activities. States must spend a minimum of 60 percent (unless the State elects to comply with the State flexibility provision in section 4(e)(6) of the AT Act, as described below) of their formula grant funds on four State-level activities: State financing programs, device reutilization programs, device loan programs, and device demonstrations. States may, however, direct their funds towards these activities in varying amounts if they use other State or non-Federal funds to support these activities at a comparable or greater level.

States may use up to 40 percent of their AT State grant program funding on State leadership activities, with at least 5 percent of that amount devoted to technical assistance and training related to transition for students exiting school or adults entering community living. The State leadership activities include the provision of technical assistance and training to targeted individuals and entities focused on promoting the general awareness of the benefits of AT; skills development for persons involved in the assessment of the need for AT; the appropriate application of AT; and the integration of AT devices and services in plans required to be developed under other Federal laws, such as the IDEA's Individualized Education Program and the Rehabilitation Act's Individualized Plan for Employment. In addition, States must use a portion of their grant funds on public awareness activities, including the continuation and maintenance of a statewide system of information and referral, and coordination and collaboration activities amongst entities in the States that are responsible for the provision of AT. The law provides States with flexibility to decide to carry out only two or three State-level activities, rather than all four. If a State elects to carry out two or three State-level activities, it must spend a minimum of 70 percent of its funds on those activities, while spending not more than 30 percent on the State leadership activities.

The AT Act specifies what a State must include in its annual progress report, including data on: the State's financing program, device loan program activities, device reutilization programs, and device demonstrations, including an analysis of those individuals who benefited from each of these programs; training activities; the statewide system of information and referral; and the outcomes of any improvement initiatives carried out by the State. The report must also provide data on the use of resources, including any contributed to the program by other public and private entities, and the level of customer satisfaction.

Protection and Advocacy for Assistive Technology

Formula grants for protection and advocacy (P&A) systems established under the Developmental Disabilities Assistance and Bill of Rights Act support protection and advocacy services to assist individuals with disabilities of all ages in the acquisition, utilization, or maintenance of AT services or devices. Funds are distributed on a State population basis, with a minimum annual grant of $50,000. Outlying areas must receive not less than $30,000 annually. Also, the Act

requires a minimum award of $30,000 to the P&A system serving the American Indian consortium. The fiscal year 2013 State distributions were based on the

July 1, 2011 estimates published in December 2011. The fiscal year 2014 State distributions are based on the July 1, 2012 estimates published on December 20, 2012. The fiscal year 2015 State distributions would be based on the July 1, 2013 estimates published on December 30, 2013.

National Activities

The AT Act provides authority for the provision of technical assistance—through grants, contracts, or cooperative agreements awarded on a competitive basis—to individuals with disabilities of all ages, to AT State grant program grantees, and to protection and advocacy systems. The AT Act also requires the Secretary to make an award to renovate, update, and maintain a national public Internet site (http://www.assistivetech.net). In addition, the AT Act includes authority for grants, contracts, or cooperative agreements to assist grantees in developing and implementing effective data collection and reporting systems.

In designing technical assistance activities, input from directors of AT State grant programs and Alternative Financing programs, individuals with disabilities who use AT, family members, and protection and advocacy service providers, among others is considered. The technical assistance must respond to specific requests for information and disseminate information to States, entities funded under the AT Act, and any other public entities that seek information about AT. The technical assistance must provide model approaches for the removal of barriers to accessing AT, examples of effective program coordination, and practices that increase funding for AT devices.

Funding History:

Funding for Assistive Technology during the past five years is as follows:

FY 2011 .....$30,898,000
FY 2012 .....$32,836,000
FY 2013 .....$31,118,000
FY 2014 .....$33,000,000
FY 2015 .....$33,000,000

Budget Request:

ACL's FY 2016 budget request for Assistive Technology (AT) programs is $31,000,000, a decrease of -$2,000,000 below the FY 2015 enacted level. The request does not include funds for an alternative financing program (AFP), a one-year competitive grant program that was

authorized through appropriations language in both FY 2014 and FY 2015. In fiscal year 2005 Congress amended the AT Act to eliminate the separate AFP and establish an AT State grant program that requires States to conduct State financing activities, including alternative financing loan programs. Since the AFP program is no longer authorized by law, ACL is not requesting funds for it in FY 2016.

Funding is requested for the AT State grant program, the Protection and Advocacy for Assistive Technology program, and National Activities. These programs enable individuals with disabilities to acquire technology they might not otherwise be able to obtain—technology that improves their quality of life, and in many cases, enables them to work or participate in other productive endeavors.

Assistive Technology (AT) State grant program

The request includes $25.704 million for the AT State grant program, the same as the fiscal year 2015 level. These funds will be used by States to carry out the second year of their 3-year State plan. State plans must describe how the State intends to carry out its AT State grant program to meet the AT needs of individuals with disabilities in the State, achieve the measurable goals required by the AT Act, and comply with all applicable statutory and regulatory requirements.

Protection and Advocacy for Assistive Technology

The fiscal year 2016 President's Budget includes $4.3 million for the Protection and Advocacy for Assistive Technology (PAAT) program, the same as the fiscal year 2015 enacted level. At this level, 28 States would receive $50,000, the minimum amount allowed under the AT Act for the protection and advocacy systems established under the Developmental Disabilities Assistance and Bill of Rights Act to carry out this program. Outlying areas each would receive $30,000. Funds would be used to assist individuals with disabilities of all ages in the acquisition, utilization, or maintenance of AT services or devices.

National Activities

The fiscal year 2016 President's Budget also includes $996,000 for National Activities, the same as the fiscal year 2015 enacted level. The Act requires support for State training, technical assistance, data collection, and reporting assistance, and authorizes a one-time grant to provide national public awareness about AT, and support for AT research and development activities. To support these activities, RSA competitively awards 3 grants. In fiscal year 2016, funds would be used for 2 new competitions in order to award a grant for State training and technical assistance, and a grant award for the AT Act informational website. Funds would also be used to continue support for the AT Act data collection activities in fiscal year 2016.

Output Table:

ACL will work with all relevant parties to review, develop, or refine performance measures and performance data collection for all WIOA programs during the transition.

National Clearinghouse for Long-Term Care Information

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
National Clearinghouse for Long-Term Care Information…	--	--	$1,000,000	$1,000,000

Authorizing Legislation: Section 6021(d) of the Deficit Reduction Act of 2005 (P.L. 106-224).

FY 2016 Authorization .....Expired

Allocation Method .....Contract

Program Description and Accomplishments:

The National Clearinghouse for Long-Term Care Information (Clearinghouse) provides objective information on how to plan ahead for a person's long-term care needs. First authorized by the Deficit Reduction Act of 2005, the Clearinghouse educates consumers about public and private options available to plan and pay for long-term care. Beginning with the "Own Your Future" direct mail campaign in 2005, the Clearinghouse has progressed toward a state-of-the-art strategy using broadcast and social media to direct consumers to a web site containing objective information on how to plan ahead for long-term care.

The American Taxpayer Relief Act repealed Title VIII of the Affordable Care Act, which included the mandatory funding for the Clearinghouse, save for amounts obligated through January 3, 2013. However, the Clearinghouse pre-dates the Affordable Care Act and has a separate and important purpose. Accordingly, ACL is continuing to request discretionary funding to continue the Clearinghouse's important educational and informative mission. Clearinghouse initiatives will include an ongoing evaluation of both website content and outreach strategy and a more robust social media presence.

Funding History:

Funding for the past 5 years is as follows:

FY 2011 1/	$3,000,000
FY 2012	$3,000,000
FY 2013 2/	$85,523
FY 2014	$0
FY 2015	$0

1/ Prior to FY 2012, funding for this activity was administered by CMS.
2/ Reflects obligations prior to January 3, 2013 when funding was rescinded.

Budget Request:

The FY 2016 Request for the National Clearinghouse on Long-Term Care is $1,000,000, an increase of +$1,000,000 above the FY 2015 enacted level.

The need for a comprehensive, objective, and easy-to-use source for information on long-term care has never been greater. As Americans live longer lives, their need to plan for their long-term care increases dramatically. Approximately 70 percent of Americans over age 65 will require some type of long-term services and supports.[140] Costs for this care can range from $19,000 per year for a home health aide to assist three times per week to $83,585 per year for nursing home care.[141] Many consumers are not aware that Medicare does not cover long-term care needs, placing recipients of this care at high risk of spend-down to Medicaid. Americans need a reliable source of information about these costs and how to plan for and afford them, and the 415,039 visits to the site recorded during the last 9 months of 2012 indicate that there is a strong demand for this information.

In addition to the costs of operating the website, this request also supports activities designed to raise awareness of and direct traffic to the website. These activities include digital banner advertisements and search engine optimization, with extensive market research determining how best to reach prospective consumers. Additionally, as the Clearinghouse has grown, the amount of information can seem overwhelming. The web site now features a decision tool to provide streamlined calls to action and related information. Longtermcare.gov is now the first organic search result in a Google search on the term “long-term care.” Continued funding will ensures that consumers will find objective information on how best to prepare for long-term care.

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

Resource and Program Data:

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

Mechanism	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	1	985
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		15
Total Resources		--		--		1,000

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

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Alzheimer's Disease Initiative - Outreach Campaign

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Alzheimer's Disease Initiative – Outreach (Prevention Fund)	$4,200,000	$4,200,000	$4,200,000	--

Note: Funding in FY 2014 and FY 2015 was provided from the Prevention and Public Health Fund, and FY 2016 funding is requested from the same source.

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

FY 2016 Authorization .....Expired

Allocation Method ..... Contracts

Program Description and Accomplishments:

On January 4, 2011, the President announced a new effort to fight Alzheimer's disease, and in FY 2012, ACL received $4,000,000 in initial funding from the Prevention and Public Health Fund to begin a public awareness Alzheimer's Disease Outreach Campaign. According to one study, approximately 5 million American's are currently battling Alzheimer's, and nearly half a million new cases develop each year.[142] With the prevalence of this disease growing, public awareness is a critical component of a larger effort to effectively educate Americans who are at risk or who care for someone at risk of developing this disease.

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

The campaign's goal is to inform people caring for people with Alzheimer's disease that there are federal, state, local, and nonprofit resources available to help them. The campaign highlights the alzheimers.gov website and deploys television, radio and print advertisements as well as search engine optimization and advertisements on specific web sites. Traffic to the new web site

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

will be studied to determine what information care givers appear to value most and to adjust outreach strategies accordingly.

Funding History:

FY 2011 .....$0
FY 2012 .....$4,000,000
FY 2013 .....$150,000
FY 2014 .....$4,200,000
FY 2015 .....$4,200,000

Budget Request:

The FY 2016 budget includes $4,200,000 in funding for the Alzheimer's Disease Initiative Outreach Campaign from the Prevention and Public Health Fund (PPHF) under the Affordable Care Act, the same as the amount requested from the Fund in FY 2015.

As recommended by the Clinical Care Subcommittee of the President's Advisory Council on Alzheimer' Research, Care, and Services, the majority of the funds will be used to launch a new awareness campaign for older adults with memory or other brain health problems. The campaign will seek to reduce the cultural stigma associated with Alzheimer's disease and encourage older adults who are experiencing memory or other brain health problems to seek an early diagnosis from their doctor. Funding for FY 2016 will focus on expanding the new campaign to sub-populations that may not have been reached in prior years, which may require development of specific outreach materials and further analysis to determine if content and messaging are culturally competent.

A small portion of the funds will be used to maintain and develop the Caregivers campaign initially developed in 2012. These funds will be used to update the information currently available on the alzheimers.gov web site. Content on the web site will be refreshed and enhanced through a panel of subject matter experts.

Resource and Program Data:

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

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	2	4,102	2	4,058	2	4,058
Interagency Agreements	--	--	--	--	--	--
Program Support /1		98		142		142
Total Resources		4,200		4,200		4,200

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

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Limb Loss Resource Center

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Limb Loss Resource Center	$2,810,000	$2,800,000	$2,810,000	$10,000

Note: This program was funded at CDC through FY 2014 and was transferred to ACL in FY 2015.

Authorizing Legislation: Public Health Service Act Section 301 (a) and Section 317, as amended, 42U.S.C. 241 (a); 42 U.S.C. 247 (b)

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

Approximately 185,000 amputations occur in the United States each year[143], and hospital costs associated with amputation total more than $8.3 billion annually[144]. The Limb Loss program seeks to improve the health of people with limb loss (PWLL) and promote their well-being, improve quality of life, prevent disease, reduce unnecessary medical expenditures, and provide support to their families and caregivers.

Limb loss is the loss of all or part of an arm or leg due to trauma, infection, diabetes, heart diseases, cancer or other diseases. Approximately 2 million adults living in the U.S have limb loss, and approximately 58% of people living with limb loss are 65 or older[145]. The main causes of limb loss are vascular disease (54%) – including diabetes and peripheral arterial disease – trauma (45%) and cancer (less than 2%). The number of people with limb loss is expected to double by 2050, largely due to the rise of diabetes.[146]

The Limb Loss Program supports a national resource center and related activities that provides comprehensive information and resources to assist individuals and families dealing with Limb Loss. Program accomplishments also include a nationwide awareness campaign, highlighted by

[143] Owings M, Kozak LJ, National Center for Health S. Ambulatory and Inpatient Procedures in the United States, 1996. Hyattsville, Md.: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics; 1998

[144] HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality; 2009.

[145] Ziegler-Graham K, MacKenzie EJ, Ephraim PL, Travison TG, Brookmeyer R. Estimating the Prevalence of Limb Loss in the United States: 2005 to 2050. Archives of Physical Medicine and Rehabilitation, 2008;89(3):422-9

[146] HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). In. Rockville, MD: Agency for Healthcare Research and Quality; 2009.

Limb Loss Awareness Month in April. In 2012, 40 state governors acknowledged April as Limb Loss Awareness Month and President Obama recognized Limb Loss Awareness Month in a letter addressed to the public.

Funding History:

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

FY 2011 .....$2,836,000
FY 2012 .....$2,820,000
FY 2013 .....$2,788,000
FY 2014 .....$2,810,000
FY 2015 .....$2,800,000

Note: This program was funded at CDC through FY 2014 and transferred to ACL in FY 2015.

Budget Request:

The FY 2016 request is $2,810,000; an increase of +$10,000 above the FY 2015 enacted level. In FY 2014, limb loss funding supported the National Limb Loss Resource Center through a grant to the Amputee Coalition. The National Limb Loss Resource Center offers, at no cost, resources for people with limb loss, their families, friends, and the health care professionals involved in their lives. With the help of this information, people with limb loss can choose the best available options, discuss these options with their healthcare providers and caregivers, and plan for their future.

Resource and Program Data:

Limb Loss Resource Center
(Dollars in thousands)

	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	1	2,740
Continuations	1	2,100	1	2,730	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		710		70		70
Total Resources 2/		2,810		2,800		2,810

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

2/ Funding for this program was provided to the Centers for Disease Control and Prevention in FY 2014. It was transferred to ACL in FY 2015.

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Paralysis Resource Center

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Paralysis Resource Center	$6,683,000	$6,700,000	$6,700,000	--

Authorizing Legislation: Sections 311 and 317(k)(2) of the Public Health Service Act [42 U.S.C. 243 & 247b(k)(2)], as amended.

Allocation Method .....Competitive Grant

Program Description and Accomplishments:

The Paralysis Resource Center (PRC) promotes the health and well-being of people living with paralysis and supports their families and caregivers by providing comprehensive information and referral services. The PRC seeks to bridge a wide information gap experienced not only by newly-paralyzed individuals, but also by those who have lived for some time with paralysis. This information promotes better health, encourages community involvement, and improves quality of life.

The PRC provides information specialists fluent in English and Spanish to answer paralysis-related questions via a toll-free phone call or email. The PRC also operates an information clearinghouse that provides access to a variety of paralysis-related publications. Additionally, the PRC publishes and distributes a free Paralysis Resource Guide, as well as informational videos and training materials.

The PRC is operated via a cooperative agreement, currently with the Christopher and Dana Reeve Foundation. The Reeve Foundation is supported in its operation of the PRC by a network of 40 members of its "Paralysis Task Force." This task force is united in meeting the needs of people living with paralysis via research, information-gathering and dissemination, and advocacy efforts. The current cooperative agreement runs through May 2015.

With the formation of ACL, HHS has a new operating division focused on maximizing the independence, well-being, and health of older adults, people with disabilities, and their families and caregivers. Due to the natural synergies with the aims of the PRC, in FY 2014 funding and administrative responsibilities for the PRC were transferred from the Centers for Disease Control and Prevention to ACL. Under ACL, the PRC will benefit from extensive ties to ACL's

disability networks and will provide a valuable source of information as ACL continues to strengthen its policy and advocacy efforts in the field of disabilities.

Funding History:

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

FY 2011 .....$5,800,000
FY 2012 .....$6,700,000
FY 2013 .....$6,352,000
FY 2014 .....$6,683,000
FY 2015 .....$6,700,000

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

Budget Request:

The FY 2016 request is $6,700,000, the same as the FY 2015 enacted level. The work done by the PRC is vital for the support of the 6 million Americans currently living with paralysis. The average age of those reporting that they are paralyzed is 52 years old, and the average person reports having been paralyzed for 15.6 years.[147] Providing information, resources, and support to these individuals and their families is critical in avoiding adverse secondary health outcomes such as depression, infection, chronic pain issues, and upper extremity problems, all of which can seriously degrade quality of life and increase medical costs.

[147]http://www.christopherreeve.org/site/c.mtKZKgMWKwG/b.5184241/k.ACBD/Average_age_average_length_of_time_since_paralysis_and_SCI.htm

Resource and Program Data:

Paralysis Resource Center
(Dollars in thousands)

Mechanism	FY 2014 Final		FY 2015 Enacted		FY 2016 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	1	6530	--	--
Continuations	1	6,590	--	--	1	6,530
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		93		170		170
Total Resources 2/		6,683		6,700		6,700

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

2/ Funding for this program was provided to the Centers for Disease Control and Prevention in FY 2013. It was transferred to ACL in FY 2014.

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Program Administration

	FY 2014 Final	FY 2015 Enacted	FY 2016 President's Budget	FY 2016 +/- FY 2015
Program Administration	$37,476,000	$37,709,000	$40,063,000	$2,354,000
FTE[148]……..	181	191	198	+7

Note: Funding and FTEs for FY 2014 include estimated comparable funding for programs transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act. Funding for FY 2015 includes the estimated annualized amount transferred to ACL for program administration, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting these funds directly.

Authorizing Legislation: Older Americans Act of 1965 (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the Help America Vote Act (HAVA), the Assistive Technology Act of 1998, the Rehabilitation Act of 1973, the Public Health Services Act (PHSA), the Elder Justice Act (EJA), the Medicare Improvements for Patients and Providers Act (MIPPA), and the Omnibus Budget and Reconciliation Act of 1990.

FY 2016 Authorization ..... See Program Narratives

Allocation Method .....Direct Federal/Contract

Program Description and Accomplishments:

In FY 2012, the Administration for Community Living (ACL) was created by bringing together three existing entities: the Administration on Aging (AoA), an HHS operating division; the Administration on Developmental Disabilities (AIDD), then a part of the Administration for Children and Families (ACF); and the Office of Disability (OD), then a part of the HHS Office of the Secretary (OS). In FY 2014, Congress for the first time provided a consolidated Program Administration appropriation for ACL. (In prior years, funding was provided through a combination of direct appropriations to AoA and transfers from ACL's predecessor agencies). The FY 2014 appropriation also transferred the State Health Insurance Assistance Program (SHIP) and the Paralysis Resource Center program to ACL. Later in 2014, as part of the

[148] FTE numbers above for Program Administration only reflect those FTE funded from the Program Administration budget line. Not included are reimbursable FTE supported with HCFAC funds (7 FTE in 2014 and 8 FTE in each of FY 2015-FY 2016) and CMS CMMI funds (2 FTE in FY 2014 and 3 FTE in FY 2015-FY 2016); ADRC FTE supported with mandatory funds (3 in FY 2014); or FTE funded by programs (SHIP funds--2 FTE in FY 2014 and 8 FTE in each of FY 2015-FY 2016; Elder Justice-2 in FY 2015 and 4 in FY 2016). These FTE are included in the appropriate narrative tables in other sections of this document.

Workforce Innovation and Opportunity Act (WIOA), Congress transferred three complementary Department of Education programs—Independent Living, Assistive Technology, and the National Institute on Disability, Independent Living and Rehabilitation Research (NIDILRR)—to ACL. This budget incorporates resources that have been transferred from the Department of Education to ACL to support the ongoing operation of these programs.

Program Administration funds the direction and support of ACL programs established under the Older Americans Act (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the Help America Vote Act (HAVA), the Assistive Technology Act of 2004, the Rehabilitation Act of 1973, the Public Health Services Act (PHSA), the Elder Justice Act, the Medicare Improvements for Patients and Providers Act (MIPPA), and the Omnibus Budget and Reconciliation Act (OBRA) of 1990. The majority of these funds cover pay, rent and security and external shared services, all of which are relatively fixed in the short term. ACL's appropriation also includes language that allows Program Administration funds to be used for Department-wide coordination of policy and program activities that assist individuals with disabilities (consistent with the role previously performed by the Office of Disability), as ACL's Principal Deputy Administrator also serves as the Secretary's Senior Advisor on Disability Policy.

In FY 2015, Program Administration funding will support 191 of ACL's 212 FTE in both central office and in ACL's regional offices. Forty-six of these FTE represent the annualized level of FTE expected to provide program and administrative support for the three programs the Work Innovations and Opportunity Act transferred to ACL. Other sources of funding for ACL FTE included staff charged to program and reimbursable funding sources such as Elder Justice, Health Care Fraud and Abuse Control, and the State Health Insurance Assistance Program.

Funding History:

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

FY 2012	$29,558,000	145	FTE*
FY 2013	$28,064,000	135	FTE*
FY 2014	$37,476,263	181	FTE**
FY 2015	$37,709,263	191	FTE**

* Funding for FY 2012 and FY 2013 reflects actual funding and FTEs provided to ACL for Program Administration, not comparably adjusted for programs transferred to ACL from the Department of Education by the Workforce Innovation and Opportunity Act (WIOA).
** Funding and FTEs for FY 2014 includes estimated comparable funding for programs transferred by WIOA. Funding for FY 2015 includes the estimated annualized amount transferred to ACL for program administration, based on a determination order between the Department of Education and ACL. For FY 2016, ACL is requesting these funds directly.

Budget Request:

The FY 2016 request for Program Administration is $40,063,000, an increase of +$2,354,000 over the comparably adjusted FY 2015 enacted level. Of this increase, +$1,354,000 is needed to bring direct and administrative support staff for WIOA programs to 53 FTE and to provide the full level of administrative support these three new programs require. This includes an increase in salaries and benefits related to new FTE of $500,000, an increase of $290,000 for internal program IT needs, and an increase of $564,000 for additional shared/external services costs.

The remaining increase of $1,000,000 is needed for other ACL administrative needs. These include approximately $850,000 to cover the increased rent costs that will result from the relocation of ACL's Headquarters to the Switzer Building in the HHS Southwest complex. This increase reflects partial amortization of relocation costs through loan vehicles offered by the General Services Administration (GSA), which are repaid by tenants as part of their annual rent costs. The $850,000 increase will support the repayment of the Federal Acquisition Service (FAS) loans for furniture ($368,000) and for information technology and audiovisual equipment ($352,000) as well the GSA Consolidation Fund loan ($130,000) for construction and build out. The remaining increase would be applied to the 1.3% FY 2016 pay raise.

ACL Headquarters Lease Renewal Process

The ten-year lease on ACL's headquarters space ended on September 30, 2012, although ACL continues to occupy the same space under a temporarily extended lease at a higher monthly cost until renovations to the Mary E. Switzer building are complete. ACL is working with the HHS Facilities and Logistics Service (FLS) to refine the schedule and milestones and to ensure that cost estimates

are sufficient to cover all costs associated with the transition to Switzer, including build-out, moving, and rent. ACL's move is now estimated to occur in the Summer of 2015.

Budget Authority by Object Class

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

	FY 2015 Base	FY 2016 Request	FY 2016 +/- FY 2015
Personnel compensation:			
Full-time permanent (11.1)	18,291	24,174	5,883
Other than full-time permanent (11.3)	2,305	3,010	705
Other personnel compensation (11.5)	198	261	64
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	--	--
Subtotal personnel compensation	**20,794**	**27,446**	**6,652**
Civilian benefits (12.1)	6,014	7,965	1,950
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Total Pay Costs	**26,808**	**35,411**	**8,603**
Travel and transportation of persons (21.0)	567	781	214
Transportation of things (22.0)	4	5	2
Rental payments to GSA (23.1)	2,165	3,432	1,267
Rental payments to Others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	475	485	10
Printing and reproduction (24.0)	15	16	1
Other Contractual Services:			
Advisory and assistance services (25.1)	15,991	28,287	12,296
Other services (25.2)	800	2,414	1,614
Purchase of goods and services from government accounts (25.3)	4,961	5,884	923
Operation and maintenance of facilities (25.4)	81	84	3
Research and Development Contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	4	4	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal Other Contractual Services	**21,837**	**36,673**	**14,836**
Supplies and materials (26.0)	77	89	12
Equipment (31.0)	46	47	1
Land and Structures (32.0)	--	--	--
Investments and Loans (33.0)	--	--	--
Grants, subsidies, and contributions (41.0)	1,814,974	1,974,268	159,294
Interest and dividends (43.0)	--	--	--
Refunds (44.0)	--	--	--
Total Non-Pay Costs	**1,840,160**	**2,015,796**	**175,636**
Total Budget Authority by Object Class	**1,866,968**	**2,051,207**	**184,239**

Salaries and Expenses

Administration for Community Living
(Dollars in Thousands)

	FY 2015 Enacted	FY 2016 Budget	FY 2016 +/- FY 2015
Personnel compensation:			
Full-time permanent (11.1)	18,291	24,174	5,883
Other than full-time permanent (11.3)	2,305	3,010	705
Other personnel compensation (11.5)	198	261	64
Military personnel (11.7)	--	--	--
Special personnel services payments (11.8)	--	--	--
Subtotal personnel compensation	**20,794**	**27,446**	**6,652**
Civilian benefits (12.1)	6,014	7,965	1,950
Military benefits (12.2)	--	--	--
Benefits to former personnel (13.0)	--	--	--
Total Pay Costs	**26,808**	**35,411**	**8,603**
Travel and transportation of persons (21.0)	567	781	214
Transportation of things (22.0)	4	5	2
Rental payments to GSA (23.1)	2,165	3,432	1,267
Rental payments to Others (23.2)	--	--	--
Communication, utilities, and misc. charges (23.3)	475	485	10
Printing and reproduction (24.0)	15	16	1
Other Contractual Services:			
Advisory and assistance services (25.1)	15,991	28,287	12,296
Other services (25.2)	800	2,414	1,614
Purchase of goods and services from government accounts (25.3)	4,961	5,884	923
Operation and maintenance of facilities (25.4)	81	84	3
Research and Development Contracts (25.5)	--	--	--
Medical care (25.6)	--	--	--
Operation and maintenance of equipment (25.7)	4	4	--
Subsistence and support of persons (25.8)	--	--	--
Subtotal Other Contractual Services	**21,837**	**36,673**	**14,836**
Supplies and materials (26.0)	77	89	12
Total Non-Pay Costs	**25,140**	**41,481**	**16,341**
Total Salary and Expense	**51,948**	**76,892**	**24,944**
Direct FTE	193	202	9

Detail of Full-Time Equivalent Employment (FTE)

Administration for Community Living

	2014 Actual Civilian	2014 Actual Military	2014 Actual Total	2015 Est. Civilian	2015 Est. Military	2015 Est. Total	2016 Est. Civilian	2016 Est. Military	2016 Est. Total
Immediate Office of the Administrator									
Direct:	45		45	50		50	56		56
Reimbursable:	0		0	0		0	0		0
Total:	45	0	45	50	0	50	56	0	56
Administration on Aging									
Direct:	23		23	25		25	25		25
Reimbursable:	0		0	0		0	0		0
Total:	23	0	23	25	0	25	25	0	25
Administration on Intellectual & Developmental Disabilities									
Direct:	20		20	21		21	21		21
Reimbursable:	0		0	0		0	0		0
Total:	20	0	20	21	0	21	21	0	21
Center for Policy and Evaluation									
Direct:	23		23	24		24	25		25
Reimbursable:	0		0	0		0	0		0
Total:	23	0	23	24	0	24	25	0	25
Center for Management and Budget									
Direct:	34		34	38		38	39		39
Reimbursable:	1		1	1		1	1		1
Total:	35	0	35	39	0	39	40	0	40
Center for Consumer Access and Self Determination									
Direct:	10		10	11		11	12		12
Reimbursable:	9		9	12		12	12		12
Total:	19	0	19	23	0	23	24	0	24
Office of Regional Operations									
Direct:	26		26	26		26	26		26
Reimbursable:	4		4	4		4	4		4
Total:	30	0	30	30	0	30	30	0	30
FTE Total	**195**	**0**	**195**	**212**	**0**	**212**	**221**	**0**	**221**

Average GS Grade	
FY 2012	12.8
FY 2013	12.9
FY 2014	13.0
FY 2015	12.9
FY 2016	12.9

Detail of Positions

Administration for Community Living

	2014 Actual	2015 Enacted	2016 Budget
Executive level I			
Executive level II			
Executive level III			
Executive level IV	1	1	1
Executive level V			
Subtotal			
Total - Exec. Level Salaries	$155,500	$155,947	$155,947
ES-6			
ES-5	2	2	2
ES-4	2	2	2
ES-3	2	2	2
ES-2	1	1	1
ES-1	1	1	1
Subtotal	8	8	8
Total - ES Salary	$1,179,086	$1,303,076	$1,315,781
GS-15	33	32	32
GS-14	37	38	38
GS-13	64	74	83
GS-12	26	29	29
GS-11	9	12	12
GS-10	1	1	1
GS-9	4	4	4
GS-8	1	1	1
GS-7	3	4	4
GS-6	1	1	1
GS-5	0	0	0
GS-4	0	0	0
GS-3	1	1	1
GS-2	0	0	0
GS-1	0	0	0
Subtotal	180	197	206
Total - GS Salary			
Average ES level	3.4	3.4	3.4
Average ES salary	$147,386	$162,885	$164,473
Average GS grade	13.0	12.9	12.9
Average GS salary	$105,691	$100,665	$101,657
Average Special Pay categories			
Administratively Determined (AD)	$128,692	$129,667	$130,931

Programs Proposed for Elimination

Administration for Community Living

ACL does not have any programs proposed for elimination.

FTE Funded by the Affordable Care Act

Administration for Community Living
(Dollars in thousands)

Program	Section	FY 2012			FY 2013			FY 2014		
		Total	FTEs	CEs	Total	FTEs	CEs	Total	FTEs	CEs
Pre-existing programs funded by ACA (Mandatory)										
National Clearinghouse for Long-Term Care Information	Title VIII	$ 3,000	1	0	$ 86	0	0	$ -	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$25,000	0	0	$ -	0	0
New programs authorized and funded by ACA (Mandatory)										
Aging and Disability Resource Centers	Section 2405	$10,000	4	0	$ 9,490	4	0	$ 9,280	3	0
New programs funded from the PPHF under ACA (Discretionary)										
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ 6,000	0	0	$ 2,000	0	0	$ -	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$10,000	0	0	$ 7,086	1	0	$ 8,000	0	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ -	0	0	$ -	0	0	$10,500	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ 4,000	0	0	$ 150	0	0	$ 4,200	0	0
Falls Prevention--(PPHF)	Section 4002	$ -	0	0	$ -	0	0	$ 5,000	0	0
Programs authorized by ACA but funded by other sources (Discretionary)										
Elder Justice Initiative/Adult Protective Services	Subtitle H, Sections 6701-6703	$ -	0	0	$ -	0	0	$ -	0	0

Program	Section	FY 2015			FY 2016		
		Total	FTEs	CEs	Total	FTEs	CEs
Pre-existing programs funded by ACA (Mandatory)							
National Clearinghouse for Long-Term Care Information	Title VIII	$ -	0	0	$ 1,000	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$ -	0	0
New programs authorized and funded by ACA (Mandatory)							
Aging and Disability Resource Centers	Section 2405	$ -	0	0	$ -	0	0
New programs funded from the PPHF under ACA (Discretionary)							
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ -	0	0	$ -	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$ 8,000	0	0	$ 8,000	0	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ 10,500	0	0	$ 10,500	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ 4,200	0	0	$ 4,200	0	0
Falls Prevention--(PPHF)	Section 4002	$ 5,000	0	0	$ 5,000	0	0
Programs authorized by ACA but funded by other sources (Discretionary)							
Elder Justice Initiative/Adult Protective Services	Subtitle H, Sections 6701-6703	$ 4,000	2	0	$ 25,000	4	0

Significant Items in Appropriations Committee Reports

Administration for Community Living

Home and Community-Based Supportive Services: ACL is directed to work with States to prioritize innovative service models, like naturally occurring retirement communities, which help older Americans remain independent as they age.

Actions Taken or To Be Taken: The 2006 reauthorization of the Older Americans Act (OAA) included provisions for the Community Innovations for Aging in Place (CIAIP) program. In 2009, the program funded fourteen demonstration projects designed to assist communities in their efforts to enable older adults to sustain their independence and age in place in their homes and communities. The grantees, representing communities across the nation, implemented a wide variety of community assistance models including but not limited to Naturally Occurring Retirement Communities (NORCs). A Technical Assistance Grant (TAG) was also awarded to assist the grantees in their efforts. The TAG grantee was supported by a variety of experts with extensive experience in relation to aging in place, livable communities, naturally occurring retirement communities (NORCs), disability, community partnerships, evaluation, and models of sustainability.

Through the CIAIP program, grantees identified barriers to aging in place in their communities and developed strategies for making their communities more aging friendly, including providing older individuals with linkages to comprehensive and coordinated health care and social services that are critical to aging. Services provided under the program included care management, evidence-based disease prevention and health promotion programs, education, socialization, recreation, and civic engagement. In their initiatives, grantees collaborated with other community agencies, such as Aging and Disability Resource Centers (ADRCs), area agencies on aging (AAAs), local providers of health and social services, housing entities, community development organizations, philanthropic organizations, as well as foundations.

Despite the conclusion of the demonstration program period in 2012, experts continue to reference the successful program and taut the value of the implementation of strategies that facilitate aging in place. Most recently, in her December 14, 2014 Huffington Post Public Health Blog, former Assistant Surgeon General, Susan Blumenthal, M.D. provided an overview of the CIAIP program and stated that it "demonstrated several effective ways of helping older adults age in place."[149]

The success of the CIAIP program is validated by the sustained activities of a number of grantees, as well as the awards they received and continue to receive that relate to the activities

[149] http://www.huffingtonpost.com/susan-blumenthal/post_8756_b_6315082.html

conducted under the grant. Below are examples of continued program activities and the awards grantees received.

- With funding from the City of Austin, Texas, set to begin in October of 2015, CIAIP grantee Family Eldercare of Austin Texas is funding a collaborative modeled after their *Living Well!* CIAIP project. The 2015 project will include services to be delivered at eight affordable senior housing communities in the City of Austin.
- The New York City Department on Aging continues to demonstrate their commitment to supporting Aging in Place activities by dedicating their OAA Disease Prevention, Health Promotion Program resources to fund NORCs.
- In June of 2013, the Family Eldercare of Austin Texas Living Well! program was the third-place winner of the American Association of Service Coordinator's 2013 Innovations in Service Coordination Award sponsored by Critical Signal Technologies (CST).
- In August of 2012, CIAIP grantee Jewish Family Service of New Mexico and The Pueblo of Zuni! won the 2012 Grantmakers in Aging Diversity Award for their CIAIP partnership.
- In 2011, the Atlanta Regional Commission's Lifelong Mableton project received the U.S. Environmental Protection Agency's Building Healthy Communities for Active Aging Initiative Commitment Award.

Limb Loss: Funding and administrative responsibility for the Limb Loss Program is transferred from CDC to ACL in fiscal year 2015 because the program is better aligned with the ACL mission of increasing the independence and well-being of people with disabilities. ACL is directed to work with CDC on a smooth transition of the program, which ensures that support for current grantees is continued in fiscal year 2015.

Actions Taken or To Be Taken: ACL continues to work with CDC on a smooth transition of the Limb Loss program. The current grant award will expire March 31, 2015. Due to the recent transfer of the program, ACL will continue the grant for an additional year, develop a funding announcement in late summer 2015 that could include new priorities, openly recomplete the grant in the Fall of 2015, and issue the grant award prior to March 31, 2016.

Prevention and Public Health Fund

Administration for Community Living

In FY 2016, ACL is proposing the following funding from the Prevention and Public Health fund:

	FY 2014 Enacted	FY 2015 Enacted	FY 2016 President's Budget
Chronic Disease Self-Management Education……...	$8,000,000	$8,000,000	$8,000,000
Falls Prevention……...	$5,000,000	$5,000,000	$5,000,000
Alzheimer's Disease Initiative – Services……	$10,500,000	$10,500,000	$10,500,000
Alzheimer's Disease Initiative – Communications Campaign……	$4,200,000	$4,200,000	$4,200,000
Total	**$27,700,000**	**$27,700,000**	**$27,700,000**

A summary of each item requested in FY 2016 follows. More detailed requests are found in separate sections elsewhere in this volume.

Chronic Disease Self-Management Education (CDSME)

- $8,000,000 for Chronic Disease Self-Management Education (CDSME), requested again for FY 2016 from the Prevention and Public Health Fund (PPHF) appropriated under the Affordable Care Act. This would maintain the funding at the level enacted in FY 2014 and FY 2015. CDSME programs have proven effective in helping people to better self-manage their chronic conditions and reduce their need for more costly medical interventions. Funding for CDSME is awarded in the form of competitive grants to states.

Falls Prevention

- $5,000,000 for Falls Prevention Programs, unchanged from the FY 2014 and FY 2015 enacted budgets from PPHF. This FY 2016 funding would be used to fund a national resource center and competitive grants to States, Tribes, and other applicants who have experience in evidence-based falls prevention programs.

Alzheimer's Disease Initiative - Services

- $10,500,000 for services to individuals with Alzheimer's Disease (AD) and their families under the President's Alzheimer's Initiative, funded from the Prevention and Public Health Fund. For FY 2016, the request is at the same level as the FY 2014 and FY 2015 enacted budgets. Funds will be used to expand efforts to develop more AD-capable long-term services and supports systems designed to meet the needs of AD caregivers. Caregivers will be linked to interventions shown to decrease their burden and depression and thus improve their health outcomes. The funding is used to award cooperative agreements to States, tribes, or other localities, and these entities are charged with developing systems that coordinate or integrate access to a system-wide set of programs.

Alzheimer's Disease Initiative – Communications Campaign

- $4,200,000 for the Alzheimer's Disease Initiative Outreach Campaign to inform people caring for people with Alzheimer's disease about the federal, state, local, and nonprofit resources available to help them. For FY 2016, the request is at the same level as the FY 2014 and FY 2015 enacted budgets. This funding is proposed from the Prevention and Public Health Fund. The funding mechanism used is a contract.