DEPARTMENT of HEALTH and HUMAN SERVICES

Fiscal Year

2017

Administration for Community Living

Justification of Estimates for Appropriations Committees

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DEPARTMENT OF HEALTH & HUMAN SERVICES Administration for Community Living

Washington, DC 20201

I am pleased to present the Administration for Community Living's (ACL) FY 2017 President's Budget request, totaling $2.0 billion, a net increase of +$28 million. The vast majority of ACL's funding is allocated for grants that provide direct services and supports. ACL received modest increases in FY 2016 for many of these core services programs and our FY 2017 request maintains these increases while also requesting additional funding for three key areas. First, +$23.8 million is requested for nutrition and supportive services programs to help meet the needs of a growing senior population— and thereby reduce or delay the need for more expensive medical interventions and institutional services. Second, +$2 million is requested for Elder Justice/Adult Protective Services (APS). Historically, an absence of federal stewardship in APS has led to inconsistent data systems and no reporting requirements at the national level, and prevented APS programs from conducting meaningful program evaluations. The additional funding will further support states by providing significant, on-going technical assistance and resources for identifying promising and best practices, participating in national APS data collection efforts; and conducting research and evaluations to increase the knowledge base about effective APS programming and practices. Finally, +$3.6 million is requested for two cross-cutting programs—Lifespan Respite Care and Aging and Disability Resource Centers—to further develop more efficient, cost-effective and consumer responsive State-wide systems that support both seniors and those of all ages with disabilities, and their families and caregivers.

The FY 2017 request also incorporates a new proposal to use up to 1% of the funds appropriated to ACL's nutrition programs to develop innovative, evidence-based practices for senior nutrition. Examples of 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), new service models (testing variations and hybrid strategies) and other innovations to better serve older adults. These 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.

Finally, ACL continues to work towards the seamless integration of its recently transferred programs—including Traumatic Brain Injury, Limb Loss, and those programs transferred by the 2014 Workforce Innovation and Opportunity Act—having brought them all together under one roof in our recent move to the Mary E. Switzer building. These programs closely align with ACL's vision that all people, regardless of age and disability, live with dignity, make their own choices, and participate fully in society. The transfer of these programs is a significant step in the evolution of ACL. ACL's past few years have been a time of growth, learning, and a rededication of our efforts to ensure that all people, regardless of age or disability, can live and thrive in their communities. This budget will allow us to continue serving our populations and position us for greater successes on their behalf.

Kathy Greenlee
Administrator and Assistant Secretary for Aging

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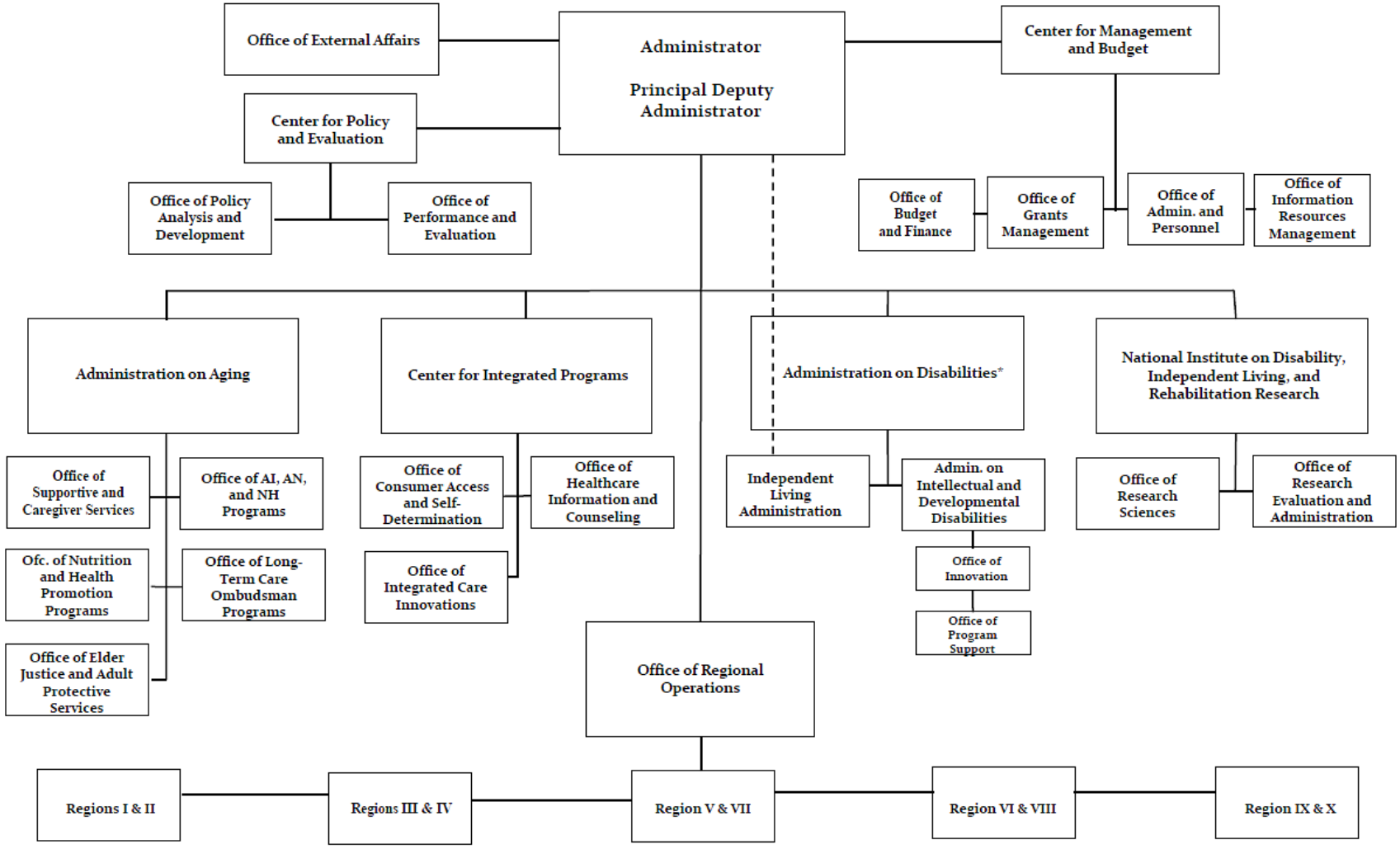
ADMINISTRATION FOR COMMUNITY LIVING ORGANIZATIONAL CHART



*The Administration on Disabilities is headed by a Commissioner, who reports directly to the Administrator, and a Deputy Commissioner/Director of Independent Living. In this dual role, the Deputy Commissioner/Director of Independent Living serves as a member of the Administrator's senior leadership and reports directly to the Administrator in carrying out the functions of the Director of Independent Living consistent with Section 701A of the Rehabilitation Act.

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Introduction and Mission

The Administration for Community Living (ACL) works 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.

ACL's programs provide community-based services and supports that help people to remain independent while reducing costs to other public programs such as Medicaid. This is critical given the growth in the segments of the population that these programs serve:

- 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]

- According to the U.S. Census Bureau, in 2010, there were 56.7 million Americans living with disabilities, 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 comprise between 1.2 and 1.65 percent of the U.S. population, or between 3.8 and 5.3 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]

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[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) (see http://www.acl.gov/Programs/AIDD/DDA_BOR_ACT_2000/p2_tI_subtitleA.aspx) and census estimates of U.S. Population, July 1, 2014

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 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.

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[4] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 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/2013CNP.html Accessed 10 January, 2016.

[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 Budget Request

The Administration for Community Living is committed to the fundamental principle that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and fully participate in their communities. ACL's programs provide home- and community-based services and supports, and invest in research and best practices, to make that principle a reality for millions of people.

The FY 2017 discretionary request for the Administration for Community Living is $1,993,294,000, an increase of $28,444,000 over the FY 2016 enacted level. The request maintains the modest increases received in FY 2016 and continues to focus on sustaining core programs that promote self-determination, independence, productivity and community integration for older adults and people of all ages with disabilities, allowing them to remain independent and involved in their communities. The budget requests additional funding for four priority investment areas – nutrition and supportive services for older adults, adult protective services and elder justice, respite care, and streamlined access to community-based services. The request also includes funding to cover increased costs associated with ACL's new headquarters location and external services. Finally the budget also reflects the transfer (consistent with the FY 2016 appropriation) of the Traumatic Brain Injury Program from the Health Resources and Services Administration to ACL.

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

ACL's community-based services and supports 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. Recognizing the growing need for these services, ACL proposes additional investments in three key programs:

- Home and Community-Based Supportive Services: ACL will invest an additional $10,000,000 in supportive services for older adults, for a total of $357,724,000. These services include information and assistance, transportation, case management, personal care services, chore services, senior centers and physical fitness programs. In combination with state and local funding, the budget will support over 31.8 million hours of assistance to seniors unable to perform daily activities of living such as bathing and dressing; 22.3 million rides for critical activities such as visiting the doctor, pharmacy, or grocery stores; and 7.8 million hours of adult day services, to name just a few.

- Nutrition Services: ACL will invest an additional $13,804,000 in nutrition programs (+$5,749,000 for meals provided in congregate settings such as community senior centers and +$8,055,000 for home-delivered meals), for a total of $848,557,000. These services

help older Americans, many of whom are low-income, to remain independent and in their own homes, delaying or preventing the need for more costly institutional services. Rising costs of providing meals are making it difficult for local programs to continue to serve as many existing clients. This increase in funding, leveraged further by state and local funding, will allow states to provide a total of 205 million meals to over 2 million older Americans nationwide.

- Lifespan Respite Care: ACL will invest an additional $1,640,000 in the Lifespan Respite Care program to increase access to, and improve the quality of respite support for family caregivers of older adults and people of all ages with disabilities. The support of informal caregivers – typically family and friends – is often the critical factor in enabling a person to live independently in his or her home A 2014 Rand Corporation study found that the care provided by informal caregivers of elderly adults has an estimated economic value of $522 billion.[6] Investments in services such as respite care that help people meet the physical, mental, emotional and financial challenges of caregiving enables them to continue to provide these services, which in turn delays or prevents the much higher costs – which often are government-funded – of the loved one needing institutional care.

Modernizing and Positioning Services for the Future

This budget also includes investments to modernize ACL's core services and improve 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 proposes to invest in the following areas:

- Modernizing Senior Nutrition Programs: The FY 2017 request incorporates a new proposal to use up to one percent of the funds appropriated to ACL's nutrition programs for modernization initiatives. These funds will support competitive grants to translate research into practice and expand evidence-based models for delivering services at the community level. Promising practices that enhance quality and effectiveness of nutrition programs range from relatively minor changes, such as adding service products that appeal to caregivers (for example, web-based ordering systems and carryout meals) and increased involvement of specialized volunteers (such as retired chefs) to implementation of significantly different service delivery models. These 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. This effort would increase the knowledge base of our

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

nutrition providers; drive improved health outcomes for program recipients by promoting higher service quality, and increase program efficiency through innovative service delivery models.

- Elder Rights Support Activities/National Adult Protective Services System: Historically, an absence of federal stewardship in APS has led to inconsistent data systems, and an absence of reporting requirements at the national level, and prevented APS programs from conducting meaningful program evaluations. In turn, this has made it nearly impossible to work across states to prevent and address elder abuse and exploitation. ACL's request includes an additional $2,000,000 in Elder Justice funding, for a total of $10,000,000, to build on work begun in 2015 to reduce abuse, neglect, and exploitation and prevent the damage they cause to the health and independence of seniors and adults with disabilities. With this funding, ACL will provide significant, on-going technical assistance and resources for: identifying promising and best practices; participating in national APS data collection efforts; and conducting research and evaluations to increase the knowledge base about effective APS programing and practices. In addition, 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 to enable 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 $2,000,000, for a total of $8,119,000, 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 in the community. Aging and Disability Resource Centers make it easier for Americans to learn about and obtain the long-term services and supports they need to remain living in their own homes and communities.

Enhancing Interagency Collaboration: The FY 2017 request includes new language (HHS General Provision 224) to facilitate collaboration with other Federal agencies both inside and outside the Department to address common priorities through joint grant making. This language would permit agencies to enter into reimbursable agreements to transfer funds from one agency to another for the purposes of making grants, such as allowing NIDILRR to collaborate with Departments such as Transportation and the Department of Veteran's Affairs on research projects to address the needs of disabled veterans. NIDILRR historically participated in this collaboration with VA, and this new general provision language is needed for NIDILRR to continue this collaboration with VA and other agencies now that the program has moved to HHS.

Other Programmatic Investments

Funding for core ACL programs under the Older Americans Act (OAA), the Developmental Disabilities Assistance and Bill of Rights Act, the Rehabilitation Act, the Assistive Technology Act, and other legislation would otherwise be maintained in this request.

The FY 2017 budget request includes $27,700,000 from the Prevention and Public Health Fund authorized by the Affordable Care Act. Of this, $8,000,000 will continue to fund Chronic Disease Self-Management Education programs, $5,000,000 will support Senior Falls Prevention programs, and the remaining $14,700,000 will 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 for people with Alzheimer's Disease and their caregivers.

Also included is an estimated $18 million in funding for the Senior Medicare Patrol program, financed by the Health Care Fraud and Abuse Control (HCFAC) account. Finally, ACL's program level includes $37,500,000 for activities related to the Medicare Improvements for Patients and Providers Act.

No funding is requested for the Assistive Technology (AT) Alternative Financing Program, a one-year competitive-grant program no longer authorized under current law, which was funded at $2 million through appropriations in FY 2016.

Enhancing Program Integrity and Oversight

ACL's request includes $41,063,000 for Program Administration, an increase of +$1,000,000 over the FY 2016 enacted level. This increase is necessary to fund higher occupancy and external services costs projected as a result of ACL's headquarters move to the Switzer building. Prior increases for additional administrative resources have been provided to fund the costs related to ACL's headquarters relocation and to meet the needs of programs transferred in from other agencies.

Because prior administrative increases have been fully consumed by the increased costs associated with operating new programs and headquarters relocation, ACL has not been able to make the necessary investments in the people and systems needed to ensure the integrity of our core programs. These programs comprise over 80% of ACL's budget, awarded through 15 programs as formula grants to states and tribes, making it critical that we provide our grantees with the support they need to effectively and efficiently serve older adults and people with disabilities, as well as their families and caregivers.

Therefore, beginning in FY 2017, ACL will add an additional 18 FTE to conduct program monitoring and oversight and to provide technical assistance to its formula grantees. These new FTE will be responsible for performing oversight, conducting program evaluations, and providing technical assistance to enhance program performance and systems development for the core formula grant programs. With the addition of these FTE, ACL will be able to increase the resources devoted to program monitoring and integrity activities from approximately 23 FTE to 41 FTE. When fully implemented in FY 2017, these added resources will allow ACL to adequately staff both its central and regional office teams to engage more effectively with staff at the tribal, state and local levels to ensure programs are operating effectively and meeting the needs of the populations ACL serves.

Conclusion

The populations served by ACL are growing. 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.[7] The total number of Americans living with disabilities in 2010 was 56.7 million people, 12 million of whom require assistance with tasks like dressing, eating, and performing household chores.[8]

Most of these people can live in their own homes, with family, or in other independent settings, if they have access to the help they need. For many, this help comes through the community-based services and supports provided by ACL's programs. In most cases, providing these services and supports are significantly less expensive than the cost of institutional care, which is often borne by Medicaid. This budget will allow ACL to continue to provide services and supports to people with disabilities and older adults so that they can live where they choose, with the people they choose, and fully participate in their communities.

[7] 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.

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

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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 continue the integration of ACL's newest programs that serve the aging and disability communities (e.g. the Independent Living Programs, Assistive Technology Program, National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), Traumatic Brain Injury Program etc.). The 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: Administration on Aging (AoA)

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 of performance goals 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 AoA's performance trends shows that, through FY 2014 most outcome indicators have been maintained or steadily improved. While service counts are declining due to funding and inflationary factors, AoA outcome indicators demonstrate that services are continuing to be effective. Following are some key successes that are indicative of the performance of AoA programs and the Aging Network to meet demographic and fiscal challenges.

- OAA programs help older Americans remain independent and in the community: Older adults that have three or more impairments in Activities of Daily Living (ADL) are at a high risk for nursing home entry. Measures of the 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 2014 the proportion grew to 42%, a 26% increase.

- The FY 2017 performance budget also includes eleven core performance indicators supporting AoA's commitment to improving client outcomes and four indicators related to 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.

- OAA programs are efficient: The National Aging Services Network is providing high quality services to the neediest elders and doing so in a very prudent and cost-effective manner. AoA has significantly increased the number of clients served per million dollars of AoA Title III funding by nearly 20% over the last decade. In FY 2014, the Aging Network served 8,930 people per million dollars of OAA Title III funding. Since this measure's introduction in FY 2005, AoA and the Aging Network have met or exceeded efficiency targets. For FY 2017, there are two efficiency indicators for AoA program activities, both of which consistently meet or exceed targets.

- OAA programs are high quality: OAA clients report that services contribute in an essential way to maintaining their independence and they express a high level of satisfaction with these services. In 2014, over 95 percent of transportation clients and nearly 94% of 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 FY 2017.

Overview of Performance: Disability Programs

ACL works with our 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). For developmental disability programs, our 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. The following highlights the Developmental Disabilities (DD) Network's accomplishments in these three 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 for 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. AIDD 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 2017.

Given limited resources and economic pressures that create barriers to systems change and capacity building, the efficient use of federal funds is paramount. AIDD illustrates the DD Network's efficiency tied to outcomes through measuring the number of individuals reached who are independent, self-sufficient and integrated into the community per thousand dollars of federal funding. This measure has shown an increasing trend since FY 2008. Targets have been reached or exceeded for the last six 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. In FY 2014, over 86 percent of consumers had their complaint corrected. While this result missed the ambitious target of 87.5 percent, the success rate is well over 80 percent.

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 2014 exceeded the target at 41.5 percent. Since FY 2009 this measure has steadily increased.

Independent Living; National Institute on Disability, Independent Living, and Rehabilitation Research; and Assistive Technology Programs

ACL is continuing the process of transferring several programs from the Department of Education (National Institute on Disability, Independent Living, and Rehabilitation Research; Independent Living Programs; and Assistive Technology Programs). As that process is completed and these programs become fully integrated into ACL, program performance is being reviewed and a set of meaningful measures will be adopted to manage the 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.

A few examples of these programs' contribution to improving the lives of people with disabilities include:

- Publication of groundbreaking research on disorders of consciousness. This work calls for a reconsideration of currently appropriate models of care and has practical implications for the timing and duration of rehabilitation services. The full collection of articles can be accessed at http://www.sciencedirect.com/science/journal/00039993/94/10.
- Utilization of NIDILRR/ACL longitudinal data bases in areas of spinal cord injury, traumatic brain injury, and burn injury are fostering collaboration and research focusing on long-term outcomes and community integration of individuals who have experienced these traumatic injuries.
- NIDILRR's grant to the University of Richmond resulted in a rigorous return on investment model that estimated the long-term impacts of Vocational Rehabilitation (VR) services on likelihood of employment, subsequent earnings, and receipt of SSI and SSDI for VR applicants.

In that same period, the Independent Living Programs provided services to hundreds of thousands of individuals with disabilities in their respective communities that included:

- Nearly 1.5 million requests for information and referral services;
- Core and related services to over 280,000 people;
- Independent living and life skills training provided to over 90,000 people;
- Peer counseling services to nearly 50,000 people; and
- Advocacy and legal services for over 80,000 people.

Program Evaluation and Performance Management

Program Evaluation and Research:
In addition 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 AoA's nutrition and caregiver programs as well as AIDD's efforts regarding employment systems change. Following are brief descriptions of the array of evaluation activities underway at ACL.

- The OAA Title III-C Elderly Nutrition Services program (ENSP) evaluation is designed to determine the effectiveness and efficiency of the OAA ENSP (Title III-C) in preventing the need for more costly interventions through the provision of healthy meals, social interaction, health promotion, and linking older adults to other appropriate services. Data about program operations have been collected from all State Units on Aging (SUA) and a sample of Area Agencies on Aging (AAA) and local service providers and a report is available at: http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx. These local service providers were also asked to participate in a cost study, the primary objective of which was to determine the average costs of a congregate and home-delivered meal provided under the Elderly Nutrition Services Program and whether these average costs vary by how meals are prepared or by other program characteristics. The cost study report is available at: http://www.aoa.acl.gov/Program_Results/docs/Program_Eval/III_C_Assessment/NSP-Meal-Cost-Analysis.pdf. Data will also be collected from a sample of consumers and members of a comparison group matched through Medicare records. An Inter-Agency Agreement with Centers for Medicare & Medicaid Services (CMS) will enhance this evaluation to include prospective analysis of healthcare utilization and cost. Consumer data will be collected three times over a one-year period. This outcome study is expected to be completed by the Fall of 2017.

- The evaluation of the Title III-E National Family Caregiver Support Program (NFCSP) is the first comprehensive federal evaluation of the NFCSP, which serves over 800,000 family caregivers. The NFCSP process and outcome evaluations were designed to benefit policy and program decision-making; collect and analyze information on program processes and site operations; evaluate program efficiency and cost issues for approaches best suited to specific contexts; and evaluate the effectiveness of the program's contribution to family caregivers in terms of three areas —of maintaining their health and well-being; improving their caregiving skills, and avoiding or delaying institutional care. Process data collection from SUAs, AAAs, and local service providers is completed and a report is expected in March 2016. Consumer-level data collection is pending OMB review with an outcome evaluation report anticipated for September 2018.

- An evaluability assessment of the OAA Title VI Tribal Grant Program was conducted in FY 2015 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. The assessment included working with an advisory group of Tribal leaders and interviews with grantees on each of the three program areas. A final report was completed in September 2015 and is available at: http://www.aoa.acl.gov/Program_Results/docs/EA-of-TitleVI-v2.pdf. ACL will use this information to design an evaluation approach including identification of the most promising program components and potential sites for a future evaluation.

- In October 2014, ACL initiated a three-year project with funding support from the HHS Office on Women's Health to identify and promote vetted, low-cost, community-based oral health services for older adults. The cross-Federal initiative will examine the existing fragmentation across Federal programs that result in a lack of oral health prevention and treatment services for older adults. The project goals is to determine what community-based oral health programs for older adults and programs serving other populations which could be translated to older adults in community-based settings exist. Project deliverables include: an environmental scan of existing community-based oral health programs for older adults and programs serving other populations which could be translated to older adult community-based settings; a guide of promising practices identified through this project that also includes a user-friendly evaluation template for evaluating programs that are implemented; and a dissemination plan to promote the new guide widely among community stakeholders.

- 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 about how to best work to support competitive, integrated employment systems for individuals with intellectual and developmental disabilities. The 2015 project update found grantee outcomes that include: California's creation and launch in June 2015 of an employment data monitoring tool integrated into the new Senior and Disabilities Services (SDS) data system which builds an expectation of employment into the plan of care; passage of the Mississippi Competitive Employment Act (March 2015); increased cross-system and cross-agency collaboration, such as the California Works! Blueprint - a cross-agency framework to support school to integrated, competitive employment (ICE) transition; and reductions in barriers to employment, such as significant increases in the number of Certified Employment Services Professionals (CESP) across New York.

- An external evaluation of NIDILRR and its grantees conducted under contract by the National Academy of Sciences (NAS) was released in 2012 (http://www.acl.gov/Programs/NIDILRR/Grant-Funding/Programs/nidrr/external.aspx). The committee concluded that NIDILRR grants have produced valuable research, tools, and other outputs for advancing the field of disability and rehabilitation research in line with the agency's mandate. An outgrowth of the evaluation is a ten-year evaluation plan completed under contract in 2013. The plan includes a set of research questions aimed at assessing the effectiveness and efficiency of NIDILRR's operations as well as the quality and impacts of NIDILRR-funded activities and products. As part of the plan, a schedule of evaluation activities was developed which identifies the programmatic focus for each year's analysis, and identifies specific questions to be addressed and the data source. The current phase of the contract is the development of the tools for collecting the data.

ACL's Internal Performance Management Plan

ACL's programs provide grants to States, local governments, universities, Tribal organizations, and non-profit entities that comprise the Aging and 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 Disability Networks, technical assistance, and senior leadership's involvement in performance management) that are expected to yield performance improvements.

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 that 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 other partners toward this end, the Aging Services and Disability Networks have demonstrated solid performance over the past ten years.

All Purpose Table

Administration for Community Living

(dollars in thousands)

Program	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Health & Independence for Older Adults				
Home & Community-Based Supportive Services	347,724	347,724	357,724	10,000
Nutrition Services	814,657	834,753	848,557	13,804
Congregate Nutrition Services (non-add)	*438,191*	*448,342*	*454,091*	*5,749*
Home-Delivered Nutrition Services (non-add)	*216,397*	*226,342*	*234,397*	*8,055*
Nutrition Services Incentive Program (non-add)	*160,069*	*160,069*	*160,069*	--
Preventive Health Services	19,848	19,848	19,848	--
Chronic Disease Self-Management Education [PPHF]	*8,000*	*8,000*	*8,000*	--
Elder Falls Prevention [PPHF]	*5,000*	*5,000*	*5,000*	--
Native American Nutrition & Supportive Services	26,158	31,158	31,158	--
Aging Network Support Activities	9,961	9,961	9,961	--
Holocaust Survivor Assistance {non-add}	*2,500*	*2,500*	*2,500*	--
Subtotal, Health & Independence for Older Adults	1,231,348	1,256,444	1,280,248	23,804
Caregiver & Family Support Services				
Family Caregiver Support Services	145,586	150,586	150,586	--
Native American Caregiver Support Services	6,031	7,531	7,531	--
Alzheimer's Disease Supportive Services Program	3,800	4,800	4,800	--
Alzheimer's Disease Initiative -- Specialized Supportive Services [PPHF]	*10,500*	*10,500*	*10,500*	--
Lifespan Respite Care	2,360	3,360	5,000	1,640
Subtotal, Caregiver & Family Support Services	168,277	176,777	178,417	1,640
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 /1 [HCFAC beginning FY 2016]	*8,910*	*8,910*	*8,910*	--
Health Care Fraud and Abuse Control [HCFAC] /2	*8,710*	*8,710*	*8,710*	--
Elder Rights Support Activities	7,874	11,874	13,874	2,000
Elder Justice {non-add}	*4,000*	*8,000*	*10,000*	*2,000*
Subtotal, Protection of Vulnerable Adults	46,152	50,152	52,152	2,000
Disability Programs, Research & Services				
State Councils on Developmental Disabilities	71,692	73,000	73,000	--
Developmental Disabilities Protection and Advocacy	38,734	38,734	38,734	--
University Centers for Excellence in Developmental Disabilities	37,674	38,619	38,619	--
Projects of National Significance	8,857	10,000	10,000	--
National Institute on Disability, Independent Living, and Rehab. Research /3	103,970	103,970	103,970	--
Independent Living /3	101,183	101,183	101,183	--
Limb Loss Resource Center	2,800	2,810	2,810	--
Paralysis Resource Center	6,700	7,700	7,700	--
Traumatic Brain Injury 6/	9,321	9,321	9,321	--
Subtotal, Disability Programs, Research & Services	380,931	385,337	385,337	--

Consumer Information, Access & Outreach				
Aging and Disability Resource Centers	6,119	6,119	8,119	2,000
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 /3	33,000	34,000	32,000	(2,000)
Alzheimer's Disease Initiative--Communications Campaign [PPHF]	*4,200*	*4,200*	*4,200*	--
Medicare Improvements for Patients and Providers Act [TRA/BBA] /4	*25,000*	*37,500*	*37,500*	--
Subtotal, Consumer Information, Access & Outreach	125,397	138,897	138,897	--
Program Administration /5	37,709	40,063	41,063	1,000
Subtotal, Program Level	1,989,814	2,047,670	2,076,114	28,444
Less: Funds From Mandatory Sources				
HCFAC Wedge Funds /2	*(8,710)*	*(8,710)*	*(8,710)*	--
HCFAC Funds for Senior Medicare Patrol Program /1	--	*(8,910)*	*(8,910)*	--
Prevention & Public Health Fund (ACA)	(27,700)	(27,700)	(27,700)	--
Medicare Improvements for Patients and Providers Act /4	(25,000)	(37,500)	(37,500)	--
Total, Discretionary Budget Authority	1,928,404	1,964,850	1,993,294	28,444

1/ The FY 2016 enacted appropriation states that it "fully funds" SMP through HCFAC appropriations to the Centers for Medicare & Medicaid Services, but it does not specify a number. This amount serves as a placeholder for FY 2016 and FY 2017 pending final decisions on the amounts by the Secretary of HHS.

2/ $8,710,146 is a placeholder amount in FY 2016 and 2017. The Secretary and Attorney General will determine the final amount.

3/ Funding for FY 2015 reflects the annualized amount transferred to ACL from the Department of Education, based on a determination order between the Department of Education and ACL. For FY 2016 and FY 2017, ACL is requesting funding for these programs directly.

4/ Includes funding for four MIPPA programs: SHIPs, ADRCs, AAAs, and the National Center for Benefits Outreach Enrollment. Of these, funding for MIPPA SHIPs ($7.5 million in FY 2015, $13 million in FY 2016 and FY 2017), is currently appropriated to the Centers for Medicare and Medicaid Services (CMS) directly and transferred to ACL via an Intra-Departmental Delegation of Authority (IDDA).

5/ Program Administration funding for FY 2015 includes the annualized amount transferred to ACL from the Department of Education, based on a determination order between the Department of Education and ACL. For FY 2016 and FY 2017, ACL is requesting these funds directly.

6/ Funding is displayed comparably for FY 2015. Funding will be transferred from HRSA to ACL beginning in FY 2016 and is requested directly by ACL in the FY 2017 request.

Appropriations Language

AGING AND DISABILITY SERVICES PROGRAMS

(INCLUDING TRANSFER OF FUNDS)

For carrying out, to the extent not otherwise provided, the Older Americans Act of 1965 ("OAA"), titles III and XXIX of the PHS Act, sections 1252 and 1253 of the PHS Act, section 119 of the Medicare Improvements for Patients and Providers Act of 2008, 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, $1,941,179,000, 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: Provided further, That of amounts made available under this heading to carry out sections 311, 331, and 336 of the OAA, up to one percent of such amounts shall be available for developing and implementing evidence-based practices for enhancing senior nutrition: Provided further*, That notwithstanding any other provision of this Act, funds made available under this heading to carry out section 311 of the OAA may be transferred to the Secretary of Agriculture in accordance with such section: **[***Provided further*, That $2,000,000 shall be for competitive grants to support alternative financing programs that provide for the purchase of assistive technology devices, such as a low-interest loan fund; an interest buy-down program; a revolving loan fund; a loan guarantee; or an insurance program: *Provided further*, That applicants shall provide an assurance that, and information describing the manner in which, the alternative financing program will expand and emphasize consumer choice and control: *Provided further*, That State agencies and community-based disability organizations that are directed by and operated for individuals with disabilities shall be eligible to compete: *Provided further*, That in addition, the unobligated balance of amounts previously made available for the Health Resources and Services Administration to carry out functions under sections 1252 and 1253 of the PHS Act shall be transferred to this account, except for such sums as may be necessary to provide for an orderly transition of such functions to the Administration for Community Living: *Provided further*, That none of the funds made available under this heading may be used by an eligible system (as defined in section 102 of the Protection and Advocacy for Individuals with Mental Illness Act

(42 U.S.C. 10802)) to continue to pursue any legal action in a Federal or State court on behalf of an individual or group of individuals with a developmental disability (as defined in section 102(8)(A) of the Developmental Disabilities and Assistance and Bill of Rights Act of 2000 (20 U.S.C. 15002(8)(A)) that is attributable to a mental impairment (or a combination of mental and physical impairments), that has as the requested remedy the closure of State operated intermediate care facilities for people with intellectual or developmental disabilities, unless reasonable public notice of the action has been provided to such individuals (or, in the case of mental incapacitation, the legal guardians who have been specifically awarded authority by the courts to make healthcare and residential decisions on behalf of such individuals) who are affected by such action, within 90 days of instituting such legal action, which informs such individuals (or such legal guardians) of their legal rights and how to exercise such rights consistent with current Federal Rules of Civil Procedure: *Provided further*, That the limitations in the immediately preceding proviso shall not apply in the case of an individual who is neither competent to consent nor has a legal guardian, nor shall the proviso apply in the case of individuals who are a ward of the State or subject to public guardianship.**]** *(Department of Health and Human Services Appropriations Act, 2016.)*

Appropriations Language Analysis

Administration for Community Living

Language Provision	Explanation
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
Provided further, That of amounts made available under this heading to carry out sections 311, 331, and 336 of the OAA, up to one percent of such amounts shall be available for developing and implementing evidence-based practices for enhancing senior nutrition:	Authorizes ACL to use up to one percent of the total appropriations for the Nutrition Services Incentives Program, Congregate Nutrition Services and Home-Delivered Nutrition Services on demonstration grants to develop and implement innovative, evidence-based practices for enhancing senior nutrition programs.

Amounts Available for Obligation

Administration for Community Living

	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget
General Fund Discretionary Appropriation:			
Appropriation (L/HHS)	1,621,141,000	1,912,735,000	1,941,179,000
Across-the-board reductions (L/HHS)	--	--	--
Subtotal, Appropriation (L/HHS, Ag, or Interior)	1,621,141,000	1,912,735,000	1,941,179,000
Secretary's Transfer	--	--	--
Subtotal, adjusted appropriation	1,621,141,000	1,912,735,000	1,941,179,000
Transfer of Funds to Department of Agriculture 1/	-2,549,334	-2,214,429	--
Comparable transfer from Health Resources Svcs Admin 2/	9,321,000		--
Comparable transfer from Department of Education 3/	233,252,566	--	--
Subtotal, adjusted general fund discr. appropriation	1,861,165,232	1,910,520,571	1,941,179,000
Total, Discretionary Appropriation	**1,861,165,232**	**1,910,520,571**	**1,941,179,000**
Mandatory Appropriation:			
Appropriation (PPACA) Prevention Funds	27,700,000	27,700,000	27,700,000
Appropriation (TRA/MACRA) MIPPA	17,500,000	24,500,000	24,500,000
Subtotal, adjusted mandatory. appropriation	45,200,000	52,200,000	52,200,000
Offsetting collections from:			
Trust Funds: HCFAC	8,612,728	8,710,146	8,710,146
Trust Funds: SMP	--	8,910,000	8,910,000
Trust Funds: SHIPs HI/SMI	52,020,978	52,115,000	52,115,000
Subtotal, spending authority from offsetting collections	60,633,706	69,735,146	69,735,146
Unobligated balance, lapsing	968,821	--	--
Total obligations	**1,967,967,759**	**2,032,455,717**	**2,063,114,146**

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 the Health Resources Services Administration (HRSA) for the Traumatic Brain Injury (TBI) transferred to ACL in FY 2016.

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)

2016	
Total estimated budget authority	1,964,850
(Obligations)	
2017	
Total estimated budget authority	1,993,294
(Obligations)	
Net Change	28,444

	FY 2017 PB FTE	FY 2017 PB BA	FY 2017 +/- FY 2016 FTE	FY 2017 +/- FY 2016 BA
Increases:				
A. Built-in:				
1. Program Administration	185	41,063	8	1,000
Subtotal, Built-in Increases			8.0	1,000
B. Program:				
1. Home & Community Based Supportive Services	2	357,724	2	10,000
2. Nutrition Services	6	848,557	6	13,804
3. Preventive Health Services	0.7	19,848	0.7	--
4. Family Caregiver Support	2	150,586	2	--
5. Long-Term Care Ombudsman Program	0.7	15,885	0.7	--
6. Prevention of Elder Abuse and Neglect	0.3	4,773	0.3	--
7. Lifespan Respite Care		5,000		1,640
8. Elder Rights Support Activities	4	13,874	1	2,000
9. Developmental Disabilities Programs	4.4	155,316	4.4	--
11. Independent Living	1	101,183	1	--
12. Aging and Disability Resource Centers		8,119		2,000
13. Medicare Improvement for Patients and Providers Act	6	37,500	1	-
Subtotal, Program Increases			19.1	29,444
Total Increases			27.1	30,444
Decreases:				
A. Program:				
1. Assistive Technology	0.9	32,000	0.9	(2,000)
Subtotal, Program Decreases	0.9	32000	0.9	(2,000)
Total Decreases			0.9	(2,000)
Net Change			28	28,444

Budget Authority by Activity

Administration for Community Living
(Dollars in Thousands)

	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget
Health & Independence for Older Adults			
Home & Community-Based Supportive Services	347,724	347,724	357,724
Nutrition Services	814,657	834,753	848,557
Preventive Health Services	19,848	19,848	19,848
Native American Nutrition & Supportive Services	26,158	31,158	31,158
Aging Network Support Activities	9,961	9,961	9,961
Subtotal, Health & Independence for Older Adults	1,218,348	1,243,444	1,267,248
Caregiver & Family Support Services			
Family Caregiver Support Services	145,586	150,586	150,586
Native American Caregiver Support Services	6,031	7,531	7,531
Alzheimer's Disease Supportive Services Program	3,800	4,800	4,800
Lifespan Respite Care	2,360	3,360	5,000
Subtotal, Caregiver & Family Support Services	157,777	166,277	167,917
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/1	8,910	--	--
Elder Rights Support Activities	7,874	11,874	13,874
Subtotal, Protection of Vulnerable Adults	37,442	32,532	34,532
Disability Programs, Research & Services			
State Councils on Developmental Disabilities	71,692	73,000	73,000
Developmental Disabilities Protection and Advocacy	38,734	38,734	38,734
University Centers for Excellence in Developmental Disabilities	37,674	38,619	38,619
Projects of National Significance	8,857	10,000	10,000
National Institute on Disability, Independent Living, and Rehab. Research 3/	103,970	103,970	103,970
Independent Living 3/	101,183	101,183	101,183
Limb Loss Resource Center	2,800	2,810	2,810
Paralysis Resource Center	6,700	7,700	7,700
Tramatic Brain Injury 6/	9,321	9,321	9,321
Subtotal, Disability Programs, Research & Services	380,931	385,337	385,337

Consumer Information, Access & Outreach			
Aging and Disability Resource Centers [Discretionary]	6,119	6,119	8,119
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 3/	33,000	34,000	32,000
Subtotal, Consumer Information, Access & Outreach	96,197	97,197	97,197
Program Administration 5/	37,709	40,063	41,063
Total, Discretionary Budget Authority	**1,928,404**	**1,964,850**	**1,993,294**
HCFAC Funds for Senior Medicare Patrol Program/1		8,910	8,910
HCFAC Wedge Funds/ 2	8,710	8,710	8,710
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 - Specialized Supportive Services {non-add}	*10,500*	*10,500*	*10,500*
Alzheimer's Disease Initiative - Communications Campaign {non-add}	*4,200*	*4,200*	*4,200*
Medicare Improvements for Patients and Providers Act/4	25,000	37,500	37,500
Aging and Disability Resource Centers {non-add}	*5,000*	*5,000*	*5,000*
Area Agencies on Aging {non-add}	*7,500*	*7,500*	*7,500*
National Center for Benefits Outreach and Enrollment {non-add}	*5,000*	*12,000*	*12,000*
State Health Insurance Assistance Program {non-add}	*7,500*	*13,000*	*13,000*
Total, Program Level	**1,989,814**	**2,047,670**	**2,076,114**

1/ The FY 2016 enacted appropriation states that it "fully funds" SMP through HCFAC appropriations to the Centers for Medicare & Medicaid Services, but it does not specify a number. The amounts in FY 2016 and FY 2017 serve as placeholders pending final decisions on amounts by the Secretary of HHS.

2/ $8,710,146 is a placeholder amount in FY 2016 and 2017. The Secretary and Attorney General will determine the final amount.

3/ Funding for FY 2015 reflects the annualized amount transferred to ACL from the Department of Education, based on a determination order between the Department of Education and ACL. For FY 2016 and FY 2017, ACL is requesting funding for these programs directly.

4/ Includes funding for four MIPPA programs: SHIPs, ADRCs, AAAs, and the National Center for Benefits Outreach Enrollment. Of these, funding for MIPPA SHIPs ($7.5 million in FY 2015, $13 million in FY 2016 and FY 2017), is currently appropriated to the Centers for Medicare and Medicaid Services (CMS) directly and transferred to ACL via an Intra-Departmental Delegation of Authority (IDDA).

5/ Program Administration funding for FY 2015 includes the annualized amount transferred to ACL from the Department of Education, based on a determination order between the Department of Education and ACL. For FY 2016 and FY 2017, ACL is requesting these funds directly.

6/ Funding is displayed comparably for FY 2015. Funding will be transferred from HRSA to ACL beginning in FY 2016 and is requested directly by ACL in the FY 2017 request.

Authorizing Legislation

Administration for Community Living

	FY 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
1) Home and Community-Based Supportive Services: OAA Section 321	Expired	347,724,000	Expired	357,724,000
2) Nutrition Services OAA Sections 311, 331, and 336	Expired	834,753,000	Expired	848,557,000
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	150,586,000	Expired	150,586,000
5) Native American Nutrition and Supportive Services: OAA Sections 613 and 623	Expired	31,158,000	Expired	31,158,000
6) Native American Caregiver Support Program: OAA Section 631	Expired	7,531,000	Expired	7,531,000
7) Long-Term Care Ombudsman Program: OAA Section 712	Expired	15,885,000	Expired	15,885,000
8) Prevention of Elder Abuse and Neglect: OAA Section 721	Expired	4,773,000	Expired	4,773,000
9) Elder Rights Support Activities OAA Sections 201, 202, and 411, 751, and 752, as amended. Social Security Act, Title XX-B, Section 2042	Expired	11,874,000	Expired	13,874,000
10) Aging Network Support Activities: OAA Sections 202, 215 and 411	Expired	9,961,000	Expired	9,961,000
11) Alzheimer's Disease Demonstration Grants Public Health Services Act Section 398	Expired	4,800,000	Expired	4,800,000
12) Lifespan Respite Care Lifespan Respite Care Act of 2006 and Public Health Service Act Title XXIX	Expired	3,360,000	Expired	5,000,000

	FY 2016 Amount Authorized	FY 2016 Appropriations Act	FY 2017 Amount Authorized	FY 2017 President's Budget
13) Program Administration:				
OAA Section 205	Expired	40,063,000	Expired	41,063,000
14) Aging and Disability Resource Centers				
OAA Sections 202b and 411	Expired	6,119,000	Expired	8,119,000
15) State Health Insurance Assistance Program:				
Omnibus Budget Reconciliation Act of 1990 Section 4360	Expired	52,115,000	Expired	52,115,000
16) State Councils on Developmental Disabilities				
DD Act Section 129(a)	Expired	73,000,000	Expired	73,000,000
17) Protection and Advocacy				
DD Act Section 145	Expired	38,734,000	Expired	38,734,000
18) University Centers for Excellence in Developmental Disabilities				
DD Act Section 156	Expired	38,619,000	Expired	38,619,000
19) Projects of National Significance				
DD Act Section 163	Expired	10,000,000	Expired	10,000,000
20) Voting Assistance for People with Disabilities				
Help America Vote Act Section 291	Expired	4,963,000	Expired	4,963,000
21) Paralysis Resource Center				
Public Health Services Act Sections 311 and 317(k)(2)	N/A	7,700,000	N/A	7,700,000
22) 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	103,970,000
23) Independent Living				
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	78,305,000
24) Assistive Technology				
Assistive Technology Act of 1998	Expired	34,000,000	Expired	32,000,000
25) Limb Loss Resource Center				
Public Health Services Act, Title III	N/A	2,810,000	N/A	2,810,000
26) Traumatic Brain Injury				
Traumatic Brain Injury Reauthorization Act of 2014	N/A	9,321,000	N/A	9,321,000
Total Request Level		$1,964,850,000		$1,993,294,000

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
General Fund Appropriation:				
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
Subtotal.....				1,413,435,235
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
Subtotal.....				1,591,343,000
FY 2010 /3	1,491,343,000	1,530,881,000	1,495,038,000	1,516,297,000
FY 2010 Transfer				-224,298
Subtotal.....				1,516,072,702
FY 2011	1,624,733,000	1,651,178,000	1,659,383,000	1,500,323,000
FY 2011 Rescission				-3,000,646
Subtotal.....				1,497,322,354
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
Subtotal.....				1,470,917,701
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
Subtotal.....				1,553,100,029
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 9/	2,104,976,000	1,944,358,000	1,861,089,000	1,964,850,000
FY 2017	1,993,294,000			

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.
9/ Includes $2,214,429 in FY 2016 budget authority appropriated to AoA and transferred to the Department of Agriculture for commodities purchases pursant to Public Law 114-113.

Appropriations Not Authorized by Law

Appropriations in FY 2016

Program	Last Year of Authorization	Authorization Level	Appropriations in Last Year of Authorization	Appropriations in FY 2017
Alzheimer's Disease Supportive Services: PHSA Section 398	FY 2002	Such Sums	$11,483,000	$4,800,000
Older Americans Act	FY 2011	Such Sums	$1,927,486,000	$1,480,275,000
Lifespan Respite Care: Lifespan Respite Care Act of 2006	FY 2011	$94,810,000	$2,495,000	$3,360,000
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	$160,353,000
Voting Access for People with Disabilities:				
Help America Vote Act - Section 291	FY 2005	$17,410,000	$13,879,000	$4,963,000
Elder Justice / Adult Protective Services: Social Security Act, Title XX-B	FY 2014	$129,000,000	$0	$8,000,000
The Assistive Technology Act of 2004	FY 2010	Such Sums	$25,000,000	$34,000,000

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Health and Independence for Older Adults

Summary of Request

The Administration on Aging's Health and Independence for Older Adults 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.

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.[9] In addition, the number of seniors age 65 and older with severe disabilities (defined as 3 or more limitations in activities of daily living), who are at greatest risk of nursing home admission, is projected to increase by more than 20 percent over the same period.[10] Health and Independence for Older Adults programs are vital to helping seniors remain in their homes and communities for as long as possible. For example, 61 percent of congregate and 92 percent of home-delivered meal recipients reported that the meals allowed them to continue living in their own homes. Additionally, 51 percent of seniors using transportation services rely on them for the majority of their trips to doctors' offices, pharmacies, meal sites, and other critical daily activities that help them to remain in the community.[11]

ACL's FY 2017 funding request for Health and Independence for Older Adults programs is $1,280,248,000, an increase of +$23,804,000 above the comparable FY 2016 enacted level. For FY 2017, specific program requests include:

- $357,724,000 for Home and Community-Based Supportive Services (HCBSS), an increase of $10,000,000 over the FY 2016 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

[9] 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.

[10] Ibid and Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population Data from the 2013 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/2013CNP.html. Accessed 10 January 2016.

[11] 2015 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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

- $848,557,000 for three Nutrition Services programs (Congregate Nutrition Services, Home-Delivered Nutrition Services and the Nutrition Services Incentives Program). This amount is an increase of +$13,804,000 above the FY 2016 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 2017, these funds will support more than 205 million meals.

- $19,848,000 for Preventive Health Services, the same as the FY 2016 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) from the Prevention and Public Health Fund (PPHF) authorized under the Affordable Care Act. This would continue funding at the FY 2016 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, from the PPHF, authorized under the Affordable Care Act. This would continue funding at the FY 2016 enacted level. Falls are the leading cause of both fatal and nonfatal injuries for those 65 and over. 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.

- $31,158,000 for Native American Nutrition and Supportive Services, the same as the FY 2016 enacted level. These funds will provide approximately 6.1 million meals and 760,000 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 2016 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 and Outputs Table:

Health and Independence for Older Adults

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
1.1 For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Efficiency)	FY 2014: 8,930 clients Target: 8,600 clients (Target Exceeded)	8,700 clients	9,000 clients	+300 clients
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 2014: 63.8 weighted average Target: 62 weighted average (Target Exceeded)	63 weighted average	63.25 weighted average	+0.25 weighted average
3.3 The percentage 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 2014: 36.5% Target: 26.2% (Target Exceeded)	26.2%	26.2%	Maintain
3.6 The percentage of OAA clients served who live in poverty is 150% greater than the percent of all U.S. elders living below the poverty level. (Outcome)	FY 2014: 32.44% Target: 24.85% (Target Exceeded)	24.75%	25.78%	+1.03

Home and Community-Based Supportive Services

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Home and Community-Based Supportive Services	$347,724,000	$347,724,000	$357,724,000	+$10,000,000
FTE	0	0	2	+2

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

FY 2017 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 formula 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 HCBSS 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, 56 percent are unable to perform one or more critical activities of daily living and require long-term support. Data also show that over 92 percent of seniors have at least

one chronic condition and 76 percent have at least two.[12] 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.

Services provided by the HCBSS program in FY 2014 (the most recent available data) include:

- *Transportation Services* provided 22.2 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 36.5 million hours of assistance to seniors unable to perform activities of daily living (such as eating, dressing, or bathing) or instrumental activities of daily living (such as shopping or light housework) (Output D).

- *Adult Day Care/Day Health* provided 8.5 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 3.3 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 49 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.[13] Many of these individuals cannot safely drive a car, as nearly 77 percent of transportation riders have at least one of the following chronic conditions that could impair their ability to navigate safely:[14]

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

- 15 percent have had a stroke;

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[12] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 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/2013CNP.html. Accessed 10 January 2016.

[13] 2015 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[14] Id.

- 10 percent have Alzheimer's or dementia;
- 4 percent have epilepsy;
- 3 percent have Multiple Sclerosis; and
- 3 percent have Parkinson's disease.

Of the transportation participants, 96 percent take daily medications, with over 19 percent taking 10 to 20 medications daily.[15] 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, they were better able to care for themselves.[16] 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.[17]

Funding History:

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

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 .....$347,724,000
FY 2016 .....$ 347,724,000

[15] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[16] Id.

[17] 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.

Budget Request:

The FY 2017 request for Home and Community-Based Supportive Services is $357,724,000, an increase of $10,000,000 over the FY 2016 enacted level. HCBSS funding has not kept pace with demand in recent years. Additionally, service levels have been declining due to inflation and stable or declining State, and local funding for these programs. Although most HCBSS have had a downward trend in the provision of service units since at least 2007, the budget requested in FY 2017 would help to slow the decline of or maintain these service unit measures of performance for home and community-based services. This funding will allow ACL to provide services to the increasing population in need, which can significantly reduce the risk of nursing home admission. At this level, the overall budget request will support 7.8 million hours of adult day care for older adults; 22.3 million rides for critical daily activities such as visiting the doctor, the pharmacy, or grocery stores; and 31.8 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 six seniors, serving nearly 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.[18] Nationally, 25 percent of individuals 60 and older live alone[19], and in FY 2014, 68 percent of the OAA transportation users were 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

[18] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. [Table 1.2 Demographic and Socioeconomic Characteristics of Medicare Beneficiaries, by Age and by Gender and Age, 2013]. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 10 January 2016.

[19] 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 (2013), accessed January, 10, 2016.

who live in a State with higher home and community-based service expenditures had significantly lower risk of nursing home admissions.[20]

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

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

Outputs and Outcomes Table:

Home and Community-Based Supportive Services

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.1 For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Efficiency)	FY 2014: 8,930 clients Target: 8,600 clients (Target Exceeded)	8,700 clients	9,000 clients	+300 clients
2.9b Maintain at 90% or higher the percentage of transportation clients who rate services good to excellent. (Outcome)	FY 2014: 95.1% 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 2014: 63.8 weighted average Target: 62 weighted average (Target Exceeded)	63 weighted average	63.25 weighted average	+0.25 weighted average
2.11 Increase the percentage of transportation clients who live alone. (Outcome)	FY 2014: 67.6% Target: 67% (Target Exceeded)	67.5%	Discontinued	N/A
3.3 The percentage 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 2014: 36.5% Target: 26.2% (Target Exceeded)	26.2%	26.2%	Maintain

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
3.6 The percentage of OAA clients served who live in poverty is 150% greater than the percent of all U.S. elders living below the poverty level. (Outcome)	FY 2014: 32.44% Target: 24.85% (Target Exceeded)	24.75%	25.78%	+1.03

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output C: Transportation Service Units *(Output)*	FY 2014: 22.2 M	22.0 M	22.3 M	+0.3 M
Output D: Personal Care, Homemaker and Chore Services units *(Output)*	FY 2014: 36.5 M	31.8 M	31.8 M	Maintain
Output E: Adult Day Care/Day Health units *(Output)*	FY 2014: 8.5 M	7.8 M	7.8 M	Maintain
Output F: Case Management Services units *(Output)*	FY 2014: 3.3 M	3.9 M	3.9 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 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	56	56	56
Average Award	$6,147,264	$6,147,264	$6,324,049
Range of Awards	$215,155 - $34,081,746	$215,155 - $34,081,746	$221,342 - $34,578,882

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	5,325,874	5,325,874	5,403,560	77,686
Alaska	1,721,234	1,721,234	1,770,734	49,500
Arizona	6,478,530	6,478,530	7,006,205	527,675
Arkansas	3,450,663	3,450,663	3,500,996	50,333
California	34,081,746	34,081,747	34,578,882	497,135
Colorado	4,095,054	4,095,054	4,761,264	666,210
Connecticut	4,341,017	4,341,017	4,404,337	63,320
Delaware	1,721,234	1,721,234	1,770,734	49,500
District of Columbia	1,721,234	1,721,234	1,770,734	49,500
Florida	24,898,663	24,898,663	25,261,848	363,185
Georgia	7,795,519	7,795,519	8,605,854	810,335
Hawaii	1,721,234	1,721,234	1,770,734	49,500
Idaho	1,721,234	1,721,234	1,770,734	49,500
Illinois	14,316,068	14,316,068	14,524,890	208,822
Indiana	6,827,801	6,827,801	6,927,395	99,594
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	4,741,271	68,164
Louisiana	4,726,948	4,726,948	4,795,898	68,950
Maine	1,721,234	1,721,234	1,770,734	49,500
Maryland	5,773,227	5,773,227	5,857,438	84,211
Massachusetts	8,091,074	8,091,074	8,209,095	118,021
Michigan	11,093,893	11,093,893	11,255,715	161,822
Minnesota	5,420,599	5,420,599	5,499,667	79,068
Mississippi	3,225,660	3,225,660	3,272,711	47,051
Missouri	7,016,089	7,016,089	7,118,429	102,340
Montana	1,721,234	1,721,234	1,770,734	49,500
Nebraska	2,261,944	2,261,944	2,294,938	32,994
Nevada	2,426,000	2,426,000	2,715,355	289,355
New Hampshire	1,721,234	1,721,234	1,770,734	49,500

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	10,115,423	10,115,423	10,262,972	147,549
New Mexico	2,036,483	2,036,483	2,109,453	72,970
New York	23,934,312	23,934,312	24,283,431	349,119
North Carolina	9,234,231	9,234,231	9,829,657	595,426
North Dakota	1,721,234	1,721,234	1,770,734	49,500
Ohio	13,618,168	13,618,168	13,816,810	198,642
Oklahoma	4,216,778	4,216,778	4,278,286	61,508
Oregon	4,074,931	4,074,931	4,320,274	245,343
Pennsylvania	17,622,920	17,622,920	17,879,977	257,057
Rhode Island	1,721,234	1,721,234	1,770,734	49,500
South Carolina	4,722,656	4,722,656	5,114,676	392,020
South Dakota	1,721,234	1,721,234	1,770,734	49,500
Tennessee	6,663,028	6,663,028	6,760,219	97,191
Texas	20,033,849	20,033,848	21,324,835	1,290,987
Utah	1,839,934	1,839,934	2,020,899	180,965
Vermont	1,721,234	1,721,234	1,770,734	49,500
Virginia	7,751,887	7,751,887	7,864,960	113,073
Washington	6,357,321	6,357,321	6,827,964	470,643
West Virginia	2,733,663	2,733,663	2,773,538	39,875
Wisconsin	6,298,516	6,298,516	6,390,390	91,874
Wyoming	1,721,234	1,721,234	1,770,734	49,500
Subtotal, States	337,532,792	337,532,792	347,307,417	9,774,625
American Samoa	465,527	465,527	472,317	6,790
Guam	860,617	860,617	885,367	24,750
Northern Mariana Islands	215,155	215,155	221,342	6,187
Puerto Rico	4,312,052	4,312,052	4,374,950	62,898
Virgin Islands	860,617	860,617	885,367	24,750
Subtotal, States and Territories	344,246,760	344,246,760	354,146,760	9,900,000
Undistributed 1/	3,477,240	3,477,240	3,577,240	100,000
TOTAL	**347,724,000**	**347,724,000**	**357,724,000**	**10,000,000**

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

Nutrition Services

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Congregate Nutrition	$438,191,000	$448,342,000	$454,091,000	+5,749,000
Home Delivered	$216,397,000	$226,342,000	$234,397,000	+$8,055,000
Nutrition Services Incentive Program	$160,069,000	$160,069,000	$160,069,000	--
Total	$814,657,000	$834,753,000	$848,557,000	$13,804,000
FTE	--	--	6	+6

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

FY 2017 Older Americans Act Authorization ..... Expired

Allocation Method ..... Formula Grant

Program Description and Accomplishments:

Nutrition Services help older Americans 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 older adults who are homebound due to illness, disability, or geographic isolation. These services occur in all 50 states, the District of Columbia, and five territories through a network of more than 5,000 local nutrition service providers. Nutrition Services include:

- Congregate Nutrition Services (Title III-C1): Provides funding for the provision of meals and other related services in a variety of congregate settings (e.g. senior centers, community centers, congregate dining facilities, school cafeterias, restaurants, farmers markets, hospital cafeterias, etc.) which helps to keep older individuals healthy and prevents the need for more costly medical interventions. Established in 1972, the program also presents opportunities for social engagement, health promotion activities, nutrition education, nutrition counseling and meaningful volunteer roles, all of which contribute to participants' 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 are often the 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 State administrative costs. 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 older adults. States and tribes elected to spend nearly $2.2 million on commodities, including $130,374 assessed by USDA as administrative expenses, in FY 2016.

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 (NSIP) grants are provided to states, territories, and eligible tribal organizations based on the number of meals served in the prior fiscal year. The meals provided through these programs fulfill the standards set by the current Dietary Guidelines for Americans and provide a minimum of 33 percent of the dietary reference DRIntake, as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences.

Nutrition services assist approximately 2.4 million (2014) diverse participants with characteristics that place them at higher risk for health care interventions as well as institutionalization. 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 older individuals avoid more serious medical care. 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.

Multiple chronic diseases and conditions negatively affect quality of life, contribute to declines in functioning and the ability to remain in the community, adversely impact individuals' health, and contribute to increased hospitalizations and health care costs.[21] 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.[22]

Data from ACL's National Survey of OAA Participants indicate that about 44 percent of congregate and 62 percent of home-delivered participants have 6 or more chronic health conditions. About 30 percent of congregate and 53 percent of home-delivered participants take over six medications per day and some take as many as 20 medications.[23] 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.[24] Data from the National Survey of OAA Participants indicate that about 19 percent of congregate and 39 percent of home-delivered program participants stayed overnight in the hospital or a nursing home in the past year and thus might be at risk of malnutrition.[25] 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 OAA Participants indicate that 10 percent of congregate and over 43 percent of home-delivered

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[21] 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

[22] *Id.*

[23] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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

[25] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

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 19 percent of congregate and 52 percent of home-delivered participants need help in getting outside the house, thus limiting their ability to shop for food themselves.[26] Although many of these older adults may rely on family and friends for assistance, about 44 percent of congregate and 59 percent of home-delivered participants live alone.[27] 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 78 percent of congregate and 83 percent of home-delivered meal participants say they eat healthier meals due to the programs, and 61 percent of congregate and 92 percent of home-delivered meal recipients say that the meals enable them to continue living in their homes.[28] 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.[29] 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.[30]

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-eight percent of home-delivered meal clients rate service as good to excellent (Outcome 2.9a). Also, the percentage of home-delivered meal recipients with severe disabilities (3+ ADL) was 42 percent in 2014 (Outcome 3.5). This level of disability is frequently associated with nursing home admission, and demonstrates the extreme frailty of a significant number of home-delivered meal clients. The most recent data on how these nutrition programs, in combination with state and local funding for nutrition, are helping seniors remain healthy and independent in their homes include:

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[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 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
[30] *Id.*

- *Home-Delivered Nutrition Services* provided nearly 138 million meals to over 837,000 individuals in FY 2014 (Output G).

- *Congregate Nutrition Services* provided over 80.3 million meals to nearly 1.6 million seniors in a variety of community settings in FY 2014 (Output H).

Funding History:

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

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
FY 2016 .....$834,753,000

Budget Request:

The FY 2017 request for Nutrition Services is $848,557,000, an increase of +$13,804,000 above the FY 2016 enacted level. At this level, the budget request combined with state and local contributions will support an estimated 205 million home-delivered and congregate meals to more than 2.2 million elderly individuals in a variety of community settings. The FY 2017 request also incorporates a new proposal to add appropriations language that would allow the use of up to 1 percent of the funds appropriated to ACL's nutrition programs for development of innovative, evidence-based practices for senior nutrition aimed at enhancing the quality and effectiveness of the nutrition programs' services.

Nutrition Services need to be funded because they, like HCBSS, help to delay much more expensive medical and institutional services. Consistent with ACL's commitment to target services to those most in need, approximately 67 percent of home-delivered meal recipients have annual incomes at or below $20,000.[31] Meals are especially critical for the survival of the nearly

[31] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

60 percent of Home-delivered recipients (52 percent of Congregate 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 by these programs.[32] 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. While the funding request is nearly $14 million above the FY 2016 enacted level this increase represents a 1.7% increase for the program overall when considering state and local contributions. These programs also have strong partnerships with State and local governments, philanthropic organizations, and private donors that contribute funding. In FY 2014, State and local funding comprised approximately 64 percent of all the funding for home-delivered meals and congregate meals. The increased federal contribution will help to mitigate the effect of inflation and likely provide more than 1.3 million additional meals than would be served with stable funding and serve an estimated 13,000 additional older adults.

In FY 2017, 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, continued cost increases that exceed increases in resources may result in some providers looking 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 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.

As such, the FY 2017 budget would, through appropriations language, allow for up to 1 percent of the appropriations provided for nutrition to be invested in evidence-based innovation projects. 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),

[32] Id

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. These funds could 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 grants of up to $1 million each. 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

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
1.1 For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Efficiency)	FY 2014: 8,930 clients Target: 8,600 clients (Target Exceeded)	8,700 clients	9,000 clients	+300 clients
2.9a Maintain at 90% or higher the percentage of clients receiving home delivered meal who rate services good to excellent. (Outcome)	FY 2014: 88% Target: 90% (Target Not Met)	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 2014: 63.8 weighted average Target: 62 weighted average (Target Exceeded)	63 weighted average	63.25 weighted average	+0.25 weighted average
3.3 The percentage 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 2014: 36.5% Target: 26.2% (Target Exceeded)	26.2%	26.2%	Maintain

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
3.5 Increase the percentage of older persons with severe disabilities who receive home-delivered meals. (Outcome)	FY 2014: 42% Target: 44.3% (Target Not Met)	45%	45.1%	+0.1
3.6 The percentage of OAA clients served who live in poverty is 150% greater than the percent of all U.S. elders living below the poverty level. (Outcome)	FY 2014: 32.44% Target: 24.85% (Target Exceeded)	24.75%	25.78%	+1.03

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output G: Number of Home-Delivered meals served (Output)	FY 2014: 138 M	130.6 M	129 M	-1.6
Output H: Number of Congregate meals served (Output)	FY 2014: 80.3 M	77.5 M	76 M	-1.5
Outputs G & H: Total Number of Meals (Output)	FY 2014: 218 M	208.1 M	205 M	-3.1

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	56	56	56
Average Award	$7,746,591	$7,926,046	$7,946,593
Range of Awards	$271,131 - $43,329545	$277,412 - $45,080,599	$278,131 - $45,263,224

Home-Delivered Nutrition Programs Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	56	56	56
Average Award	$3,825,590	$4,001,403	$4,101,948
Range of Awards	$133,896 - $22,178,956	$140,049 - $23,373,557	$143,568 - $23,960,874

Nutrition Services Incentive Program Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards[33]	317	317	317
Average Award[34]	$499,734	$489,479	$499,900
Range of Awards[35]	$139 - $16,839,155	$140 - $16,762,659	$140 - $16,589,163

[33] Number of awards includes 261 awards to Tribal organizations.

[34] If the 261 awards to Tribal organizations are excluded from the "average award" calculation, the average award to States, DC, and the territories is $2,761,365 in FY 2015, $2,761,641 in FY 2016, and $2,733,057 in FY 2017.

[35] If the 261 award to Tribal organizations are excluded from the "range of awards" calculation, the smallest award to States, DC, and the territories is $57,977 in FY 2015, $57,983 in FY 2016, and $57,383 in FY 2017.

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	6,448,535	6,630,459	6,657,320	26,861
Alaska	2,169,045	2,219,293	2,225,046	5,753
Arizona	8,927,511	9,321,402	9,359,164	37,762
Arkansas	4,163,564	4,163,564	4,163,564	-
California	43,329,545	45,080,599	45,263,224	182,625
Colorado	6,058,702	6,334,621	6,360,283	25,662
Connecticut	5,241,452	5,241,452	5,241,452	-
Delaware	2,169,045	2,219,293	2,225,046	5,753
District of Columbia	2,169,045	2,219,293	2,225,046	5,753
Florida	30,882,211	32,045,414	32,175,233	129,819
Georgia	11,007,936	11,449,654	11,496,038	46,384
Hawaii	2,169,045	2,219,293	2,225,046	5,753
Idaho	2,169,045	2,219,293	2,225,046	5,753
Illinois	17,286,541	17,286,541	17,286,541	-
Indiana	8,266,359	8,499,079	8,533,510	34,431
Iowa	5,081,501	5,081,501	5,081,501	-
Kansas	4,089,903	4,089,903	4,089,903	-
Kentucky	5,744,377	5,907,747	5,931,680	23,933
Louisiana	5,645,998	5,774,297	5,797,690	23,393
Maine	2,169,045	2,219,293	2,225,046	5,753
Maryland	7,240,922	7,466,055	7,496,301	30,246
Massachusetts	9,780,267	9,780,267	9,780,267	-
Michigan	13,443,686	13,819,524	13,875,509	55,985
Minnesota	6,846,987	7,072,298	7,100,949	28,651
Mississippi	3,891,114	3,891,114	3,891,114	-
Missouri	8,467,047	8,467,047	8,467,047	-
Montana	2,169,045	2,219,293	2,225,046	5,753
Nebraska	2,738,802	2,738,802	2,738,802	-
Nevada	3,446,533	3,612,643	3,627,278	14,635
New Hampshire	2,169,045	2,219,293	2,225,046	5,753

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey.....	12,190,488	12,190,488	12,190,488	-
New Mexico.....	2,718,255	2,806,521	2,817,891	11,370
New York.....	28,963,855	28,963,855	28,963,855	-
North Carolina.....	12,624,403	13,077,861	13,130,841	52,980
North Dakota.....	2,169,045	2,219,293	2,225,046	5,753
Ohio.....	16,393,785	16,393,785	16,393,785	-
Oklahoma.....	5,080,736	5,080,736	5,080,736	-
Oregon.....	5,533,521	5,747,906	5,771,192	23,286
Pennsylvania.....	21,279,716	21,279,716	21,279,716	-
Rhode Island.....	2,169,045	2,219,293	2,225,046	5,753
South Carolina.....	6,536,987	6,804,818	6,832,385	27,567
South Dakota.....	2,169,045	2,219,293	2,225,046	5,753
Tennessee.....	8,555,440	8,820,689	8,856,423	35,734
Texas.....	27,192,651	28,371,616	28,486,552	114,936
Utah.....	2,581,502	2,688,704	2,699,596	10,892
Vermont.....	2,169,045	2,219,293	2,225,046	5,753
Virginia.....	10,031,513	10,366,665	10,408,661	41,996
Washington.....	8,734,066	9,084,261	9,121,062	36,801
West Virginia.....	3,305,947	3,305,947	3,305,947	-
Wisconsin.....	7,665,166	7,900,689	7,932,696	32,007
Wyoming.....	2,169,045	2,219,293	2,225,046	5,753
Subtotal, States.....	425,615,109	435,489,049	436,611,794	1,122,745
American Samoa.....	594,843	594,843	594,843	-
Guam.....	1,084,523	1,109,646	1,112,523	2,877
Northern Mariana Islands...	271,131	277,412	278,131	719
Puerto Rico.....	5,158,961	5,277,984	5,299,366	21,382
Virgin Islands.....	1,084,523	1,109,646	1,112,523	2,877
Subtotal, States and Territories	433,809,090	443,858,580	445,009,180	1,150,600
Undistributed 1/.....	4,381,910	4,483,420	9,081,820	4,598,400
TOTAL.....	**438,191,000**	**448,342,000**	**454,091,000**	**5,749,000**

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

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	3,300,791	3,437,785	3,524,168	86,383
Alaska	1,071,165	1,120,393	1,148,545	28,152
Arizona	4,569,698	4,832,995	4,954,435	121,440
Arkansas	2,048,767	2,123,029	2,176,375	53,346
California	22,178,956	23,373,557	23,960,874	587,317
Colorado	3,101,249	3,284,398	3,366,926	82,528
Connecticut	2,477,235	2,565,047	2,629,500	64,453
Delaware	1,071,165	1,120,393	1,148,545	28,152
District of Columbia	1,071,165	1,120,393	1,148,545	28,152
Florida	15,807,579	16,615,026	17,032,516	417,490
Georgia	5,634,597	5,936,459	6,085,626	149,167
Hawaii	1,071,165	1,120,393	1,148,545	28,152
Idaho	1,071,165	1,120,393	1,148,545	28,152
Illinois	8,052,146	8,373,552	8,583,956	210,404
Indiana	4,231,275	4,406,634	4,517,361	110,727
Iowa	2,180,137	2,260,928	2,317,739	56,811
Kansas	1,856,324	1,932,025	1,980,572	48,547
Kentucky	2,940,356	3,063,071	3,140,037	76,966
Louisiana	2,865,596	2,993,879	3,069,107	75,228
Maine	1,082,445	1,131,578	1,160,012	28,434
Maryland	3,706,388	3,871,028	3,968,297	97,269
Massachusetts	4,526,417	4,708,313	4,826,620	118,307
Michigan	6,881,377	7,165,199	7,345,240	180,041
Minnesota	3,504,745	3,666,872	3,759,010	92,138
Mississippi	1,914,158	1,993,637	2,043,731	50,094
Missouri	4,134,686	4,298,337	4,406,342	108,005
Montana	1,071,165	1,120,393	1,148,545	28,152
Nebraska	1,211,914	1,260,729	1,292,407	31,678
Nevada	1,764,166	1,873,096	1,920,162	47,066
New Hampshire	1,071,165	1,120,393	1,148,545	28,152

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	5,839,280	6,062,752	6,215,092	152,340
New Mexico	1,391,385	1,455,136	1,491,699	36,563
New York	12,931,863	13,395,710	13,732,308	336,598
North Carolina	6,462,013	6,780,659	6,951,038	170,379
North Dakota	1,071,165	1,120,393	1,148,545	28,152
Ohio	8,056,613	8,368,820	8,579,105	210,285
Oklahoma	2,499,780	2,594,510	2,659,703	65,193
Oregon	2,832,426	2,980,196	3,055,080	74,884
Pennsylvania	9,442,665	9,781,330	10,027,108	245,778
Rhode Island	1,071,165	1,120,393	1,148,545	28,152
South Carolina	3,346,067	3,528,187	3,616,841	88,654
South Dakota	1,071,165	1,120,393	1,148,545	28,152
Tennessee	4,379,246	4,573,384	4,688,301	114,917
Texas	13,919,016	14,710,222	15,079,849	369,627
Utah	1,321,385	1,394,049	1,429,078	35,029
Vermont	1,071,165	1,120,393	1,148,545	28,152
Virginia	5,134,799	5,374,947	5,510,005	135,058
Washington	4,470,679	4,710,042	4,828,392	118,350
West Virginia	1,475,026	1,523,328	1,561,605	38,277
Wisconsin	3,923,544	4,096,379	4,199,310	102,931
Wyoming	1,071,165	1,120,393	1,148,545	28,152
Subtotal, States	210,250,769	219,941,541	225,468,067	5,526,526
American Samoa	136,498	140,049	143,568	3,519
Guam	535,583	560,196	574,273	14,077
Northern Mariana Islands	133,896	140,049	143,568	3,519
Puerto Rico	2,640,701	2,736,549	2,805,311	68,762
Virgin Islands	535,583	560,196	574,273	14,077
Subtotal, States and Territories	214,233,030	224,078,580	229,709,060	5,630,480
Undistributed 1/	2,163,970	2,263,420	4,687,940	2,424,520
TOTAL	**216,397,000**	**226,342,000**	**234,397,000**	**8,055,000**

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

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	3,265,986	3,266,312	3,232,505	(33,807)
Alaska	464,911	464,958	460,145	(4,813)
Arizona	1,823,404	1,823,587	1,804,712	(18,875)
Arkansas	2,607,066	2,607,326	2,580,339	(26,987)
California	12,917,914	12,919,205	12,785,487	(133,718)
Colorado	1,381,437	1,381,575	1,367,276	(14,299)
Connecticut	1,508,605	1,508,756	1,493,140	(15,616)
Delaware	691,298	691,367	684,211	(7,156)
District of Columbia	653,678	653,743	646,977	(6,766)
Florida	6,337,801	6,338,435	6,272,830	(65,605)
Georgia	2,632,180	2,632,443	2,605,196	(27,247)
Hawaii	445,222	445,266	440,657	(4,609)
Idaho	713,417	713,488	706,103	(7,385)
Illinois	6,024,391	6,024,992	5,962,632	(62,360)
Indiana	1,568,917	1,569,074	1,552,833	(16,241)
Iowa	1,834,344	1,834,527	1,815,539	(18,988)
Kansas	2,249,113	2,249,338	2,226,057	(23,281)
Kentucky	1,714,897	1,715,069	1,697,317	(17,752)
Louisiana	3,477,559	3,477,907	3,441,909	(35,998)
Maine	597,153	597,213	591,031	(6,182)
Maryland	1,580,901	1,581,059	1,564,695	(16,364)
Massachusetts	6,414,572	6,415,213	6,348,814	(66,399)
Michigan	7,437,452	7,438,195	7,361,208	(76,987)
Minnesota	1,898,489	1,898,678	1,879,027	(19,651)
Mississippi	1,623,075	1,623,237	1,606,436	(16,801)
Missouri	4,016,600	4,017,002	3,975,425	(41,577)
Montana	1,202,948	1,203,069	1,190,617	(12,452)
Nebraska	1,135,537	1,135,651	1,123,897	(11,754)
Nevada	1,299,820	1,299,950	1,286,495	(13,455)
New Hampshire	1,281,198	1,281,326	1,268,064	(13,262)

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	3,780,589	3,780,967	3,741,833	(39,134)
New Mexico	2,275,381	2,275,609	2,252,055	(23,554)
New York	16,760,990	16,762,659	16,589,163	(173,496)
North Carolina	3,310,293	3,310,624	3,276,358	(34,266)
North Dakota	822,673	822,756	814,240	(8,516)
Ohio	5,725,528	5,726,100	5,666,833	(59,267)
Oklahoma	2,093,814	2,094,023	2,072,350	(21,673)
Oregon	1,932,983	1,933,177	1,913,168	(20,009)
Pennsylvania	6,169,349	6,169,965	6,106,104	(63,861)
Rhode Island	426,018	426,061	421,651	(4,410)
South Carolina	1,524,809	1,524,961	1,509,178	(15,783)
South Dakota	895,832	895,921	886,648	(9,273)
Tennessee	1,552,490	1,552,645	1,536,575	(16,070)
Texas	11,351,786	11,352,920	11,235,414	(117,506)
Utah	1,249,371	1,249,496	1,236,563	(12,933)
Vermont	833,703	833,786	825,156	(8,630)
Virginia	2,038,493	2,038,696	2,017,595	(21,101)
Washington	2,167,497	2,167,713	2,145,277	(22,436)
West Virginia	1,653,699	1,653,864	1,636,746	(17,118)
Wisconsin	2,753,336	2,753,611	2,725,110	(28,501)
Wyoming	867,601	867,688	858,707	(8,981)
Subtotal, States	150,986,120	151,001,203	149,438,298	(1,562,905)
American Samoa	20,621	20,623	20,410	(213)
Guam	355,916	355,952	352,268	(3,684)
Northern Mariana Islands	57,977	57,983	57,383	(600)
Puerto Rico	3,027,895	3,028,198	2,996,855	(31,343)
Virgin Islands	187,913	187,931	185,986	(1,945)
Subtotal, States and Territories	154,636,442	154,651,890	153,051,200	(1,600,690)
Grants to Tribes	3,779,127	3,816,420	3,816,420	-
Undistributed 1/	1,653,431	1,600,690	3,201,380	1,600,690
TOTAL	**160,069,000**	**160,069,000**	**160,069,000**	**-**

1/ The undistributed line reflects the amount reserved from the NSIP appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. 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

Preventive Health Services

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Preventive Health Services……	$19,848,000	$19,848,000	$19,848,000	--
FTE	--	--	.7	+.7

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

FY 2017 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 nation's population aged 60 and over. These funds support evidence-based programs 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 evidence-based preventive health activities to best meet local needs. Priority has been given to providing access to programs for 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. On average, an American turning age 65 today can expect to live an additional 19.3 years.[36] 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.[37] One consequence of this increased longevity is the higher incidence of chronic diseases such as obesity, arthritis, diabetes, osteoporosis, and

[36] Murphy SL, Kochanek, KD, Xu JQ, Arias, E. Mortality in the United States, 2014. NCHS data brief, no 229, Hyattsville, MD: National Center for Health Statistics 2015

[37] 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.

depression, as well as the greater probability of injury from a fall, which quickly limits physical activity.

To help address the increase in multiple chronic conditions and ensure the best use of limited funds, in FY 2012 ACL requested and Congress enacted appropriations language requiring states and territories to use their Preventive Health funds only on evidence-based programs that have been proven to enhance the wellness and fitness of older adults. The same language has been included in each subsequent year's appropriation's language. Other health services, such as health screenings, can be funded under the Home and Community-Based Supportive Services program.

Evidence-based programs are interventions that have been proven through randomized control trials 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:

- *Self-Management Programs*: Chronic Disease Self-Management Education (CDSME) programs are low-cost, evidence-based disease prevention models that use state-of-the-art techniques and leaders in the community to help individuals with chronic disease address issues related to the management and treatment of their condition, improve their health status, and reduce their need for more costly medical care. CDSME programs have been shown repeatedly, through multiple studies, to be effective at helping participants adopt healthy behaviors and improve their psychological and physical health status. Some evidence suggests that CDSME programs may also significantly reduce the use of hospital care and physician services, as well as reduce health care costs.

- *Physical Activity Programs*: Physical activity programs are multi-component group exercise programs designed for community-based organizations and intended to promote physical activity among older adults. Components may include strength training using soft wrist and ankle weights; cardiovascular workouts using dancing, aerobics, or walking; and balance and posture exercises. Becoming more physically active has many positive benefits such as increased mobility and function, decreased pain and depression, and lower risk of type 2 diabetes, hypertension, coronary heart disease, obesity, and some cancers.

- *Medication Management Programs*: 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.

- *Falls Prevention Programs:* Falls prevention programs help participants achieve improved strength, balance, and mobility; provide education on how to avoid falls and reduce fall risk factors; involve medication reviews and modifications; provide referrals for medical care management for fall risk factors; and provide home assessments to identify and reduce environmental hazards. Many people limit their activity after a fall, which can reduce strength, physical fitness, and mobility.

- *Depression Care Management:* Depression is not a normal part of aging, yet it is a prevalent and disabling condition among older adults. Older adults with depression frequently visit the doctor and emergency room, use more medication, stay longer in the hospital, and have substantially higher total health care costs than those without depression. Cost-effective, evidence-based interventions have been shown to reduce depressive symptoms and improve quality of life in older adults.

Funding History:

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

FY 2012 .....$20,944,000
FY 2013 .....$19,848,825
FY 2014 .....$19,848,000
FY 2015 .....$19,848,000
FY 2016 .....$19,848,000

Budget Request:

The FY 2017 request for Preventive Health Services is $19,848,000, the same as the FY 2016 enacted level. ACL currently reserves 1% of Preventive Health Services funds at the beginning of the year to pay for statutory related activities, contingencies and for program support, allocating any funds unused for these purposes to States at the end of the year.

ACL continues to request appropriations language that 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/CPE/OPE/ADEPP.aspx and a link to the page is one resource on the Title III-D 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 III-D webpage contains definitions of evidence-based interventions, frequently asked questions, and program examples.[38] Grantees can use the Title III-D Highest-Tier Criteria Evidence-Based Disease Prevention and Health Promotion Programs Cost Chart[39] on the site to search the 45+ highest-level criteria programs listed.

Underscoring the need for these programs, the 2015 National Survey of OAA Participants found that between 70 and 89 percent of clients across OAA services take three or more different prescription medications every day. In addition, between 19 and 42 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. Four to sixteen percent of respondents, representing over 200,000 OAA clients, reported that they learned through a group class.[40]

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 by providing benefits to individuals and 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

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

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

[40] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/

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

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output AB: The number of people served with health and disease prevention programs. *(Output)*	FY 2014: 2.2 M	2.0 M	2.0 M	Maintain

Grant Awards Tables:

Preventive Health Services Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 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

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	311,357	311,357	311,357	-
Alaska	98,248	98,247	98,247	-
Arizona	378,742	378,742	378,742	-
Arkansas	197,733	197,733	197,733	-
California	1,992,449	1,992,462	1,992,462	-
Colorado	239,401	239,401	239,401	-
Connecticut	244,076	244,076	244,076	-
Delaware	98,248	98,247	98,247	-
District of Columbia	98,248	98,247	98,247	-
Florida	1,455,604	1,455,604	1,455,604	-
Georgia	455,734	455,734	455,734	-
Hawaii	98,248	98,247	98,247	-
Idaho	98,248	98,247	98,247	-
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	648,561	648,561	-
Minnesota	316,895	316,895	316,895	-
Mississippi	183,404	183,404	183,404	-
Missouri	395,543	395,543	395,543	-
Montana	98,248	98,247	98,247	-
Nebraska	116,724	116,724	116,724	-
Nevada	141,827	141,827	141,827	-
New Hampshire	98,248	98,247	98,247	-

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
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	98,247	98,247	-
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	98,247	98,247	-
South Carolina	276,092	276,092	276,092	-
South Dakota	98,248	98,247	98,247	-
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	98,247	98,247	-
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	98,247	98,247	-
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 1/	198,480	198,480	198,480	-
TOTAL	**19,848,000**	**19,848,000**	**19,848,000**	**-**

1/ The undistributed line reflects the amount reserved from the Preventive Health appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

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Chronic Disease Self-Management Education

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
CDSME……...	$8,000,000	$8,000,000	$8,000,000	--

Note: Funding in FY 2015 and FY 2016 was provided from the Prevention and Public Health Fund, and FY 2017 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 2017 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 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. Proven CDSME programs include the Stanford University Chronic Disease Self-Management Program (CDSMP) which is appropriate for any type of chronic conditions, Enhance Wellness, 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 (ASMP), Cancer Thriving and Surviving, and online versions of the CDSMP, ASMP, and DSMP.

In the United States, over 76 percent of Medicare beneficiaries have multiple (2 or more) chronic conditions,[41] placing them at greater risk for premature death, poor functional status,

[41] 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 4 March, 2015.

unnecessary hospitalizations, adverse drug events, and nursing home placement.[42] Chronic conditions also impact health care costs, as 93 percent of Medicare expenditures are for beneficiaries with chronic conditions. [43]

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.[44] Some evidence suggests that CDSME programs may also significantly reduce the use of hospital care and physician services and reduce health care costs.[45]

The in-person programs emphasize an individual's role in managing though 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, YWCAs, YMCAs, 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 two to three years. In FY 2010, AoA funded 47 state grants for CDSME programs using funding provided under the Recovery Act. The Recovery Act grants concluded in March 2013 with over 101,000 people completing CDSME courses, well exceeding the programmatic goal to reach 50,000 people.

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[42] 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. Also, Parekh, A.K., et al. 2011. Managing Multiple Chronic Conditions: a Strategic Framework for Improving Health Outcomes and Quality of Life, Public Health Rep. 126(4):460–71.

[43] 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/

[44] 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

[45] Sobel, DS, Lorig,KR, Hobbs,M. Chronic Disease Self-Management Program: From Development to Dissemination. Permanente Journal; Spring 2002. Also Ory, M. G., et al. 2013. "Successes of a National Study of the Chronic Disease Self-Management Program: Meeting the Triple Aim of Health Care Reform." Medical Care 51(11), 992-998.

A 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 allowed states to provide CDSME programs to approximately 80,000 adults to help them better manage chronic conditions. The funding not only increased access to CDSME programs, but also fostered the development of comprehensive, integrated delivery systems to embed and sustain these programs within the long-term supports and services and health care systems. ACL also funded a Resource Center through a grant to the National Council on Aging. In addition, competitive contracts were awarded to support a database, and related activities. Another round of two-year grants (8 total) were issued at the end of FY 2015.

Funding History:

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

FY 2012 .....$10,000,000
FY 2013 .....$7,086,000
FY 2014 .....$8,000,000
FY 2015 .....$8,000,000
FY 2016 .....$8,000,000

Budget Request:

The FY 2017 request for CDSME is $8,000,000 from the Prevention and Public Health Fund, the same as the enacted level for FY 2016. 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.[46] 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, reduction in depression and quality of life), and reduced health care utilization (lower emergency room visits and hospitalizations),

[46] 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

resulting in potential cost savings.[47] This continued investment of resources will allow ACL, in coordination with its existing HHS partners and private philanthropists, 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.

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.[48] 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 2014 alone, nearly 35,000 individuals with chronic conditions completed the CDSME program through ACL's network (Output CD1). Fifty-seven percent of participants reporting relevant data indicate that they have multiple chronic conditions, with the most common conditions being hypertension (38.5 percent), arthritis (33 percent), and diabetes (32.4 percent). Over one-third of the participants are minority elders, including 22.2 percent African-Americans and over 17 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 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

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[47] 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

[48] Centers for Disease Control and Prevention. National Diabetes Fact Sheet.

http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf,Accessed May 4, 2013.

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.

Outcomes and Outputs Table:

Chronic Disease Self-Management Education

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
CD2 Increase the percentage of individuals who complete the CDSME program. (Outcome)	FY 2014: 74% Target: 74% (Target Met)	75%	75%	Maintain

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output CD1: Total number of individuals with chronic conditions completing the CDSME program. *(Output)*	FY 2014: 34,905	20,000	20,000	Maintain

Grant Awards Table:

Chronic Disease Self-Management Education Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	9	9	9
Average Award	$830,763	$830,183	$830,183
Range of Awards	$711,510 - $1,000,000	$711,510 - $1,000,000	$711,510 - $1,000,000

Resource and Program Data:

Chronic Disease Self-Management Education
(Dollars in Thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	8	6,477	9	--	--	--
Continuations	1	1,000	--	7,472	9	7,472
Contracts	2	311	2	288	2	288
Interagency Agreements	1	6	--	--	--	--
Program Support /1		206		240		240
Total Resources		8,000		8,000		8,000

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

Falls Prevention

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Falls Prevention……..	$5,000,000	$5,000,000	$5,000,000	--

Note: Funding in FY 2015 and FY 2016 was provided from the Prevention and Public Health Fund, and FY 2017 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 2017 Older Americans Act Authorization.....Expired

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.[49] One in three adults aged 65 and older falls each year.[50] In 2013, fall-related injuries resulted in 2.5 million emergency room visits, over 734,000 hospitalizations, about 25,500 deaths, and an estimated $34 billion in direct medical costs.[51] Of those who fall, 20 to 30 percent will experience serious injuries, such as brain trauma, broken bones, or hip fractures.[52] 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.[53] 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.[54] Many people limit their activity after a fall, which may

[49] 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.

[50] 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.

[51] Centers for Disease Control and Prevention, Falls Among Older Adults: An Overview. http://www.cdc.gov/HomeandRecreationalSafety/Falls/adultfalls.html. Accessed March 23, 2015.

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

[53] 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

[54] 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.

reduce strength, physical fitness, and mobility.[55] The importance of preventing falls is underscored by the inclusion of falls prevention screening in the annual Medicare wellness visit.

Falls can result in significant loss of independence and often trigger the onset of a series of growing needs. Americans over age 75 who fall are more than four times more likely to be admitted to a skilled nursing facility.[56] 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 35,000 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.

Evidence-based, community Falls Prevention/Management programs have clearly demonstrated a reduction in falls through randomized controlled trials. For example, when compared with control groups, the risk of falling for participants in the Tai Chi: Moving for Better Balance intervention decreased by 55 percent;[57] and the Stepping On program reduction was 31 percent.[58] 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.[59]

In addition to reducing falls; these community-based interventions are proven to be cost-effective. 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

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[55] 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.

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

[57] 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.

[58] 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.

[59] 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.

settings. Participation was associated with a -$938 decrease in total medical costs per year. This finding includes a -$517 reduction in unplanned hospitalization costs, a -$234 reduction in skilled nursing facility costs, and an -$81 reduction in home health costs.[60] Additionally, a 2014 cost-benefit analysis found that the benefits from community-based falls prevention interventions covered their implementation costs and exceeded direct medical costs, resulting in a return on investment (ROI) of 64% for Stepping On, and an ROI of 509% for Tai Chi: Moving for Better Balance.[61]

Funding History

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

FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$5,000,000
FY 2015 .....$5,000,000
FY 2016 .....$5,000,000

Budget Request:

ACL is requesting $5,000,000 from the Prevention and Public Health Fund in FY 2017, the same as the enacted level for FY 2016. Falls Prevention activities received their first dedicated funding in FY 2014, which was used to fund a national resource center and provide grants to States, Tribes, and other applicants to implement evidence-based falls prevention programs through ACL's network of community-based provider organizations.

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-

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

[61] Carande-Kulis, V., et al., A cost–benefit analysis of three older adult fall prevention interventions, Journal of Safety Research (2015), http://dx.doi.org/10.1016/j.jsr.2014.12.007. Accessed March 23, 2015.

management education, falls prevention, diabetes self-management training, physical activity, nutrition education, and depression management programs.

Grants for Falls Prevention programs 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 are 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 other program support activities, such as 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	9	10	9
Average Award	$529,946	$476,214	$529,127
Range of Awards	$300,000 - $695,040	$300,000 - $695,040	$300,000 - $695,040

Resource and Program Data:

Falls Prevention
(Dollars in Thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	2	700	10	4,762	9	4,162
Continuations	7	4,070	--	--	--	600
Contracts	2	223	--	200	--	200
Interagency Agreements	--	--	--	--	--	--
Program Support /1		7		38		38
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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Native American Nutrition & Supportive Services……..	$26,158,000	$31,158,000	$31,158,000	--

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

FY 2017 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 803,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[62] Over 295,000 of those elders identify as Native American or Alaskan Native with no other racial group.[63]

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 28 percent of eligible Native American seniors in participating Tribal organizations, home-delivered meals reach 20 percent of such persons, and supportive services reach 46 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.

[62] U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origen for the United States: April 1, 2010 to July 1 2014 Released June, 2015, accessed 25 August 2015.

[63] 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 (2013), accessed 25 August, 2015.

Services provided by this program in FY 2014 (the most recent year for which data are available) include:

- *Transportation Services*, which provided 754,441 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 42,454 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 2.5 million meals to 60,836 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 905,521 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, website, 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 2015, grants were awarded to 264 Tribal organizations (representing 400 Tribes), including one organization serving Native Hawaiian elders.

Funding History:

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

FY 2012 .....$27,601,000
FY 2013 .....$26,157,052
FY 2014 .....$26,158,000
FY 2015 .....$26,158,000
FY 2016 .....$31,158,000

Budget Request:

The FY 2017 request for Native American Nutrition and Supportive Services is $31,158,000, the same as the FY 2016 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 postpone 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 2017 request level, these services will provide 769,000 rides (Output L), 3.2 million meals at home (Output M), and 2.9 million meals at congregate sites (Output N) to over 100,000 Native American seniors. 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 they desire.

In FY 2017, 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 305, a 39 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.

Outcomes and Outputs Table:

Native American Nutrition & Supportive Services

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.3 For Title VI Services, increase the number of units of service provided to Native Americans per thousand dollars of AoA funding. (Efficiency)	FY 2014: 307 Target: 300 (Target Exceeded)	304	305	+1

Indicator	Year and Most Recent Result /	FY 2016 Projection	FY 2017 Projection	FY 2017 Projection +/-FY 2016 Projection
Output L: Transportation Services units *(Output)*	FY 2014: 754,441	800,000	769,000	-31,000
Output M: Home-Delivered Nutrition meals *(Output)*	FY 2014: 2.6 M	3.2 M	3.2 M	Maintain
Output N: Congregate Nutrition meals *(Output)*	FY 2014: 2.5 M	2.9 M	2.9 M	Maintain
Output O: Information, Referral and Outreach units *(Output)*	FY 2014: 905,521	1.1 M	1.1 M	Maintain

Grant Awards Table:

Native American Nutrition & Supportive Services Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	264	264	264
Average Award	$96,567	$115,647	$115,647
Range of Awards	$63,870 - $1,505,000	$77,290 - $1,505,000	$77,290 - $1,505,000

Resource and Program Data:

Native American Nutrition and Supportive Services
(Dollars in Thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	264	25,526	264	30,496	264	30,496
New Discretionary	1	11	--	--	1	150
Continuations	1	150	1	150	--	--
Contracts	2	420	1	428	1	428
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		51		83		83
Total Resources		26,158		31,158		31,158

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

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Aging Network Support Activities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Aging Network Support Activities	$9,961,000	$9,961,000	$9,961,000	--

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

FY 2017 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

The Aging Network Support Activities programs provide competitive grants and contracts to support ongoing activities of national significance that help seniors and their families to obtain information about their care options and benefits and 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, tribal organizations, States, Area Agencies on Aging (AAAs), institutions of higher learning, and other organizations representing and/or serving older people, including faith-based organizations. Grantees are generally asked 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 2015, Aging Network Support Activities funded 29 grants with an average award of $337,278.

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 754,430 individuals in 2014.

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 assists 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 July 31, 2015, the National Alzheimer's Call Center handled over 319,000 calls through its national and local partners, and its on-line message board community recorded over 6.6 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 Master's 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 individuals with Alzheimer's, 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 30 states. In 2014, data for the program show that:

- Pension Counseling projects have successfully recovered over $206 million in client benefits, representing a return of more than nine 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 in 1998, the Center has conducted approximately 200 workshops per year on strategies to access financial and retirement planning information. 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 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 curriculum 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 Education (CDSME) workshops, and a 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 developed and implemented a program to provide supportive services for aging Holocaust survivors living in the United States. One cooperative agreement (amount: $2,467,500) was awarded to a national organization with demonstrated expertise in working with Holocaust survivors to advance the development and delivery of person-centered, trauma-informed supportive services. The program is focusing efforts on two fronts: 1) expanding the capacity of community-based agencies to provide direct services to Holocaust survivors in a person-centered, trauma-informed manner; and 2) developing and implementing a national technical assistance center devoted to expanding the aging services network's capacity to deliver person-centered, trauma-informed services.

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 2012 .....$7,873,000
FY 2013 .....$7,431,864
FY 2014 .....$7,406,000
FY 2015 .....$9,961,000
FY 2016 .....$9,961,000

Budget Request:

The FY 2017 request for Aging Network Support Activities is $9,961,000, the same as the FY 2016 enacted level. Within this budget, $2,500,000 is specifically for Holocaust Survivors,

the same amount of funding for this purpose as the FY 2016 enacted level. 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 unique services, – such as the National Alzheimer's Call Center and the National Eldercare Locator –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 for Older Adults and Caregiver and Family Support Services.

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

Activity	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Aging Network Support Activities:			
National Eldercare Locator and Engagement	$2,038	$2,038	$2,038
National Alzheimer's Call Center	945	945	945
Pension Counseling and Retirement Information	1,858	1,858	1,858
National Resource Centers on Native Americans	655	655	655
National Minority Aging Organizations	1,165	1,165	1,165
Holocaust Survivor Assistance	2,500	2,500	2,500
Program Performance and Technical Assistance	799	799	799
Total, Aging Network Support Activities	**$9,961**	**$9,961**	**$9,961**

Grant Awards Table:

Aging Network Support Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	29	29	29
Average Award	$337,278	$334,629	$334,629
Range of Awards	$189,650 - $2,467,500	$189,650 - $2,467,500	$189,650 - $2,467,500

Resource and Program Data:

Aging Network Support Activities
(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	13	4,817	4	741	2	359
Continuations	16	4,965	25	8,963	27	9,345
Contracts	3	74	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		105		257		257
Total Resources		9,961	29	9,961	29	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 determine whether an older person can remain in his or her home. In 2013, approximately 34.2 million adult caregivers provided uncompensated care to those 50 years of age and older.[64] The economic cost of replacing unpaid caregiving of elderly adults is estimated to be between $470 billion[65] and $522 billion annually,[66] higher than that of *all* Medicaid spending in FY 2014 (Federal and state: $476 billion).[67]

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.[68] 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-four percent of the caregivers

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[64] National Alliance for Caregiving, and AARP Public Policy Institute. *Caregiving in the US, 2015 report. June 2015 Washington DC.*

[65] S. C. Reinhard, L. Feinberg, R. Choula, and A. Houser, *Valuing the Invaluable: 2015 Update, Undeniable Progress, but Big Gaps Remain* (Washington, DC: AARP Public Policy Institute, July 2015). http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf. Accessed 01/13/2016

[66] *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

[67] "Total Medicaid Spending," The Henry J. Kaiser Family Foundation, 2014. http://kff.org/medicaid/state-indicator/total-medicaid-spending/.

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

served by OAA programs report that these services allow them to provide care longer than they otherwise could.[69]

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.[70] To address these caregiver-related needs, ACL requests a total of $178,417,000, an increase of $1,640,000 above the FY 2016 enacted level. The request includes:

- $150,586,000 for Family Caregiver Support Services, the same as the FY 2016 enacted level. This program makes a range of support services available to family and informal caregivers—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.

- $7,531,000 for Native American Caregiver Support Services, the same as the FY 2016 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.

- $4,800,000 for Alzheimer's Disease Supportive Services, the same as the FY 2016 enacted level. This program focuses specifically on supportive services for those with Alzheimer's Disease (AD) and their caregivers. One critical focus of this program is to support the family caregivers who provide countless hours of unpaid care, thereby enabling their family members with dementia to continue living in the community. Another focus is to expand the availability of evidence-based diagnostic and support services to those with Alzheimer's.

[69] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[70] 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.

- $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 as in FY 2016. Funds will be used to expand efforts to develop more AD-capable long-term services and support 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 $1,640,000 above the FY 2016 enacted level. This increase is to further develop more efficient, cost-effective methods that improve the quality of 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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Family Caregiver Support Services	$145,586,000	$150,586,000	$150,586,000	--
FTE	--	--	2	+2

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

FY 2017 Older Americans Act Authorization ..... Expired

Allocation Method ..... Formula Grant

Program Description and Accomplishments:

The National Family Caregiver Support Program provides formula 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 that caregivers can access on behalf of themselves and the seniors for whom they provide care. Based on FY 2014 data, the most recent available, services included:

- *Access Assistance Services* provided nearly 1.4 million contacts to caregivers assisting them in locating services from a variety of public and private agencies (Output I).

- *Counseling and Training Services* provided 125,134 caregivers with counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J).

- *Respite Care Services* provided nearly 67,000 caregivers with approximately 6.2 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. The economic cost of replacing unpaid caregiving is estimated to be between $470[71] and $522 billion annually is potentially higher than that of *all* Medicaid spending in FY 2014 (Federal and state: $476 billion).[72] 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, nearly 20 percent of caregivers are assisting two or more individuals. Over 70 percent of Title III caregivers are 60 or older, making them more vulnerable to a decline in their own health, and 29 percent describe their own health as fair to poor.[73] 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 National Family Caregiver Support 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.[74]

Additionally, data from ACL's National Surveys of caregivers of elderly clients also shows that OAA services, including those provided through the National Family Caregiver Support Program, are effective in helping caregivers keep their loved ones at home. Approximately 74 percent of caregivers of program clients reported that services enabled them to provide care longer than otherwise would have been possible.[75] Caregivers receiving services were also asked

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[71] S. C. Reinhard, L. Feinberg, R. Choula, and A. Houser, *Valuing the Invaluable: 2015 Update, Undeniable Progress, but Big Gaps Remain* (Washington, DC: AARP Public Policy Institute, July 2015). http://www.aarp.org/content/dam/aarp/ppi/2015/valuing-the-invaluable-2015-update-new.pdf. Accessed 01/13/2016

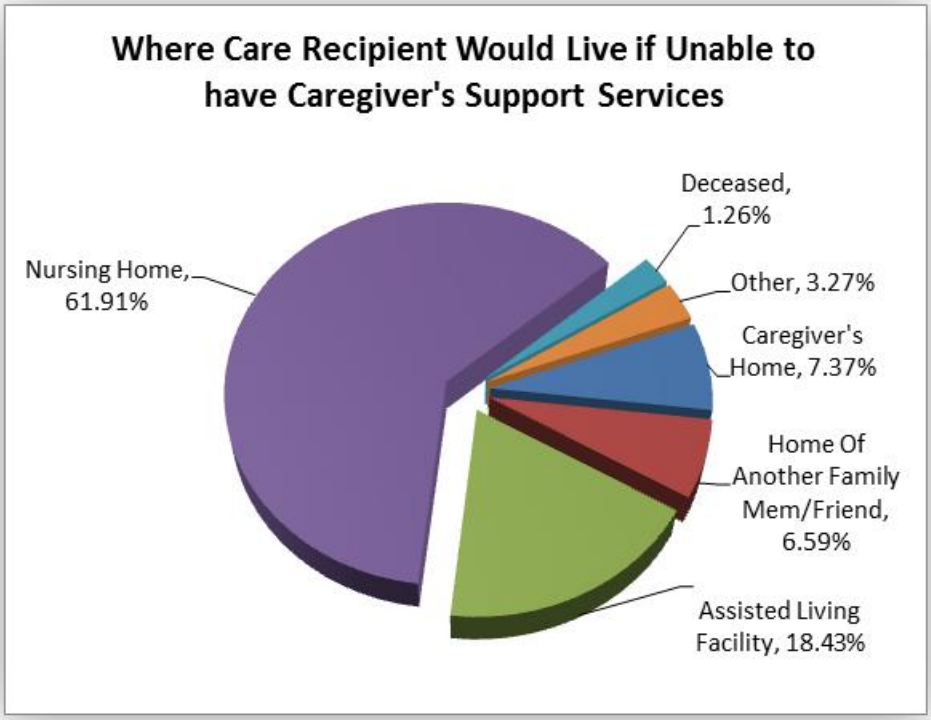
[72] "Total Medicaid Spending," The Henry J. Kaiser Family Foundation, 2013. http://kff.org/medicaid/state-indicator/total-medicaid-spending/.

[73] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

[74] *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.

[75] 2014 National Survey of Older Americans Act Participants. http://www.agid.acl.gov/.

whether the care recipient would have been able to live in the same residence if the services had not been available. Nearly 40 percent of caregivers indicated that the care recipient would be unable to remain at home without the support services. Those respondents were then asked to identify where the care recipient would be living without services. A significant majority of those caregivers, 80 percent, indicated that the care recipient would most likely be living in a nursing home or assisted living (see below).



Funding History:

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

FY 2012 .....$153,621,000
FY 2013 .....$145,585,801
FY 2014 .....$145,586,000
FY 2015 .....$145,586,000
FY 2016 .....$150,586,000

Budget Request:

The FY 2017 request for Family Caregiver Support Services is $150,586,000, the same as the enacted level for FY 2016. Funding for Family Caregiver Support Services will allow ACL to provide services that give caregivers the assistance often needed to help them sustain their caregiving and provide care longer. Funding at this level will allow 900,000 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 120,000 caregivers will also have the opportunity to participate in counseling, peer support groups, and training to help them better cope with the stresses of caregiving (Output J.

In FY 2017, ACL expects the aging services network to meet or exceed the target of only 26.8 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 2014, that rate had been reduced to 36 percent of caregivers reporting difficulty getting services.

For FY 2017, 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

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
1.1 For Home and Community-based Services including Nutrition and Caregiver services increase the number of clients served per million dollars of Title III OAA funding. (Efficiency)	FY 2014: 8,930 clients Target: 8,600 clients (Target Exceeded)	8,700 clients	9,000 clients	+300 clients
2.6 Reduce the percentage of caregivers who participate in the National Family Caregiver Support Program who report difficulty in obtaining services. (Outcome)	FY 2014: 36% Target: 28% (Target Not Met)	27%	26.8%	-0.2
2.9c Maintain at 90% or higher the percentage of National Family Caregiver Support Program clients who rate services good to excellent. (Outcome)	FY 2014: 93.6% 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 2014: 63.8 weighted average Target: 62 weighted average (Target Exceeded)	63 weighted average	63.25 weighted average	+0.25 weighted average
3.1 Increase the number of caregivers served through the National Family Caregiver Support Program.	FY 2014: 934,096 caregivers Target: 790,000 caregivers (Target Exceeded)	825,000 caregivers	900,000 caregivers	+75,000 caregivers

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target +/-FY 2016 Target**
(Outcome)				
Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection +/-FY 2016 Projection**
Output I: Caregivers access assistance units of service. *(Output)*	FY 2014: 1.4 M	1.3 M	1.3 M	Maintain
Output J: Caregivers receiving counseling and training. *(Output)*	FY 2014: 125,134	122,000	120,600	-1,400
Output K: Caregivers receiving respite care services. *(Output)*	FY 2014: 66,703	68,300	68,300	Maintain

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.

Grant Awards Table:

Family Caregiver Supportive Services Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	56	56	56
Average Award	$2,573,753	$2,662,145	$2,662,145
Range of Awards	$93,175 - $14,733,109	$93,175 - $15,350,031	$93,175 - $15,350,031

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	2,201,423	2,273,071	2,273,071	-
Alaska	720,651	745,400	745,400	-
Arizona	3,157,996	3,337,314	3,337,314	-
Arkansas	1,400,893	1,442,327	1,442,327	-
California	14,733,109	15,350,031	15,350,031	-
Colorado	1,906,838	2,000,285	2,000,285	-
Connecticut	1,710,575	1,746,825	1,746,825	-
Delaware	720,651	745,400	745,400	-
District of Columbia	720,651	745,400	745,400	-
Florida	11,646,384	12,143,608	12,143,608	-
Georgia	3,508,461	3,681,543	3,681,543	-
Hawaii	720,651	745,400	745,400	-
Idaho	720,651	745,400	745,400	-
Illinois	5,435,283	5,564,836	5,564,836	-
Indiana	2,832,791	2,906,110	2,906,110	-
Iowa	1,549,356	1,575,411	1,575,411	-
Kansas	1,279,583	1,310,132	1,310,132	-
Kentucky	1,926,002	1,983,860	1,983,860	-
Louisiana	1,865,313	1,920,451	1,920,451	-
Maine	720,651	745,400	745,400	-
Maryland	2,411,157	2,496,960	2,496,960	-
Massachusetts	3,082,374	3,160,073	3,160,073	-
Michigan	4,603,309	4,726,419	4,726,419	-
Minnesota	2,372,201	2,442,543	2,442,543	-
Mississippi	1,273,578	1,311,331	1,311,331	-
Missouri	2,836,149	2,914,714	2,914,714	-
Montana	720,651	745,400	745,400	-
Nebraska	841,954	859,814	859,814	-
Nevada	1,113,372	1,182,221	1,182,221	-
New Hampshire	720,651	745,400	745,400	-

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	4,017,923	4,110,299	4,110,299	-
New Mexico	912,601	950,483	950,483	-
New York	8,878,615	9,061,944	9,061,944	-
North Carolina	4,234,276	4,417,061	4,417,061	-
North Dakota	720,651	745,400	745,400	-
Ohio	5,486,056	5,598,512	5,598,512	-
Oklahoma	1,693,980	1,744,261	1,744,261	-
Oregon	1,830,342	1,907,586	1,907,586	-
Pennsylvania	6,662,545	6,779,539	6,779,539	-
Rhode Island	720,651	745,400	745,400	-
South Carolina	2,157,172	2,264,508	2,264,508	-
South Dakota	720,651	745,400	745,400	-
Tennessee	2,870,144	2,976,353	2,976,353	-
Texas	8,907,980	9,329,589	9,329,589	-
Utah	861,930	898,325	898,325	-
Vermont	720,651	745,400	745,400	-
Virginia	3,324,345	3,458,673	3,458,673	-
Washington	2,835,182	2,964,871	2,964,871	-
West Virginia	983,253	1,001,946	1,001,946	-
Wisconsin	2,669,204	2,739,575	2,739,575	-
Wyoming	720,651	745,400	745,400	-
Subtotal, States	141,382,112	146,223,604	146,223,604	-
American Samoa	90,081	93,175	93,175	-
Guam	360,325	372,700	372,700	-
Northern Mariana Islands	90,081	93,175	93,175	-
Puerto Rico	1,847,216	1,924,786	1,924,786	-
Virgin Islands	360,325	372,700	372,700	-
Subtotal, States and Territories	144,130,140	149,080,140	149,080,140	-
Undistributed 1/	1,455,860	1,505,860	1,505,860	-
TOTAL	**145,586,000**	**150,586,000**	**150,586,000**	**-**

1/ The undistributed line reflects the amount reserved from the Family Caregiver Support Services appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to State.

Native American Caregiver Support Services

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Native American Caregiver Support Services	$6,031,000	$7,531,000	$7,531,000	--

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

FY 2017 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 populations 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 2012 .....$6,364,000
FY 2013 .....$6,031,076
FY 2014 .....$6,031,000
FY 2015 .....$6,031,000
FY 2016 .....$7,531,000

Budget Request:

The FY 2017 request for Native American Caregiver Support Services is $7,531,000, the same as the enacted level for FY 2016. 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 803,000 persons age 60 and over identify themselves as Native American or Alaska Native alone or in combination with another racial group.[76] Over 295,000 of those elders identify as Native American or Alaskan Native with no other racial group[77]. 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.

[76] U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Single Year of Age, Race Alone or in Combination, and Hispanic Origin for the United States: April 1, 2010 to July 1, 2014 Released June 2015, accessed 25 August 2015.

[77] 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 (2013), accessed 25 August, 2015.

Performance data indicates that these programs are an efficient means to help Native American Elders remain independent and in the community. In FY 2017, 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 2017 more than 450,000 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

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
3.1 Increase the number of caregivers served through the National Family Caregiver Support Program. (Outcome)	FY 2014: 934,096 caregivers Target: 790,000 caregivers (Target Exceeded)	825,000 caregivers	900,000 caregivers	+75,000 caregivers

Grant Awards Table:

Native American Caregivers Supportive Services Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	233	231	231
Average Award	$25,882	$32,430	$32,430
Range of Awards	$1,639 - $47,263	$1,639 - $47,263	$1,639 - $47,263

Resource and Program Data:

Native American Caregiver Support Services
(Dollars in thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	231	6,016	231	7,491	231	7,491
New Discretionary	2	14	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		1		40		40
Total Resources		6,031		7,531		7,531

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
ADSSP……	$3,800,000	$4,800,000	$4,800,000	--

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

FY 2017 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 services that support persons with Alzheimer's disease and related dementias (ADRD) and their family caregivers, and create state-wide, person-centered, dementia-capable home and community-based service (HCBS) systems. These systems are able to identify persons with ADRD and their family caregivers, understand their unique circumstances, communicate appropriately with them, help them identify and 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 and in the community. The primary components of the ADSSP program include the translation and implementation of evidence-based supportive services for persons with ADRD and their caregivers at the community level; development and delivery of statewide person-centered, dementia-capable HCBS systems; and incorporation of evidence-based research in the formulation of innovative projects.

Twelve states funded in prior program years continue to offer seven dementia specific evidence-based interventions. One example of an evidence-based intervention implemented through the ADSSP program is the New York University Caregiver Intervention (NYUCI), a spousal caregiver support program that, in a randomized-control trial, delayed institutionalization of persons with Alzheimer's Disease by an average of 557 days.[78] The state of Minnesota has

[78] 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.

translated this intervention and results are consistent with the original study.[79] Due to the success of the translation of the NYUCI program in their states, Minnesota, California, and Georgia continue to offer it well beyond the program funding period.

In recent years, ADSSP grant projects have been designed to ensure that states provide people with dementia and their family caregivers with access to a sustainable HCBS system that is dementia-capable. While projects funded since 2011 continue to focus on the use of evidence-based and evidence-informed caregiver interventions, more recent programs are designed around the development of sustainable and person-centered, dementia-capable state HCBS systems. There are presently 15 states engaged in projects dedicated to the development and delivery of dementia-capable service systems.

Family caregivers remain the major source of support for most people with ADRD. The nature of the disease – a slow loss of cognitive and functional/physical independence – means that most people with Alzheimer's disease are dependent upon family and HCBS for years. 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 ADRD, and their family caregivers. Overall, these ADSSP programs offer direct services and other supports to thousands of persons with ADRD and their caregivers. Programs ensure continuous quality improvement and evaluation of the state systems providing necessary services as beneficiaries access a variety of services from many different systems including aging, medical, and mental health. As the number of people with Alzheimer's disease grows, it is increasingly important that health and HCBS systems effectively coordinate and are responsive to persons with ADRD and their caregivers.

Funding History:

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

FY 2012 .....$4,010,000
FY 2013 .....$3,785,653
FY 2014 .....$3,772,000
FY 2015 .....$3,800,000
FY 2016 .....$4,800,000

[79] 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.

Budget Request:

The FY 2017 request for the Alzheimer's Disease Supportive Services Program is $4,800,000, the same as the enacted level for FY 2016.

The need for cutting edge approaches that serve those with Alzheimer's and their caregivers continues to grow as the incidence of and population 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.[80]

The FY 2017 funding request will allow ACL to expand efforts to create statewide dementia-capable systems designed to ensure the people with dementia and their caregivers have access to dementia-capable home and community-based services (HCBS). Dementia-capable systems in states will foster better quality, enhance care coordination and improve population health at lower cost. 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 the 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 9 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.

ACL released a joint analysis of results from a six-state translation effort of the New York University Caregiver Intervention in FY 2015, 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.

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[80] 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

Outcome and Outputs Table:

Alzheimer's Disease Supportive Services Program

Measure	**Year and Most Recent Result /** **Target for Recent Result /** **(Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target** **+/-FY 2016 Target**
ALZ.2 Increase number of individuals served with evidence-based interventions - cumulative. (Outcome)	FY 2014: 21,450 Target: 19,000 (Target Exceeded)	21,957	22,000	+43

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output AC: Number of individuals served – cumulative[81] *(Output)*	FY 2014: 46,860	52,900	54,700	+1,800
Output AD: Percent of individuals served that are of a racial/ethnic minority *(Output)*	FY 2014: 21%	22%	Discontinued	N/A

Grant Awards Table:

[81] Cumulative count began in 2008.

Alzheimer's Disease Supportive Services Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	5	8	8
Average Award	$458,978	$478,172	$478,172
Range of Awards	$312,904-$600,000	$312,904-$600,000	$312,904-$600,000

Resource and Program Data:

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	5	2,295	8	3,825	8	3,825
Continuations	--	--	--	--	--	--
Contracts	3	1,314	3	824	3	824
Interagency Agreements	--	--	--	--	--	--
Program Support /1		191		150		150
Total Resources		3,800		4,800		4,800

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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alzheimer's Disease Initiative – Services (Prevention Fund)	$10,500,000	$10,500,000	$10,500,000	--

Note: Funding in FY 2015 and FY 2016 was provided from the Prevention and Public Health Fund, and FY 2017 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 2017 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

An estimated 5.2 million individuals in the United States are living with Alzheimer's disease and related dementias (ADRD), and that number is expected to increase about 40% by 2025.[82] The anticipated increase is attributed to individuals living longer and is correlated to advances in medicine and technology, and social and environmental conditions.[83] The Alzheimer's Disease Initiative - Specialized Supportive Services (ADI-SSS) - is designed to fill gaps in existing dementia-capable home and community-based service (HCBS) systems for persons living with ADRD and their family caregivers.

The effects of ADRD are devastating for individuals living with the disease and their family caregivers, generally requiring significant levels of health care and the availability and provision of intensive HCBS. As the number of people with ADRD grows, it is increasingly important that effectively coordinated service delivery and health care systems are responsive to these individuals and their caregivers. Of the community dwelling individuals with ADRD,

[82] Alzheimer's Association. *2014 Alzheimer's Disease Facts and Figures.* Accessed April 14, 2014 at http://www.alz.org/alzheimers_disease_facts_and_figures.asp .

[83] Vincent, GK, Velkof, VA. *The Next Four Decades: The Older Population in the United States: 2010-2050*. Washington, DC. US Census Bureau, 2010.

approximately one-third live alone, exposing them to numerous risks, including unmet needs, malnutrition and injury and various forms of neglect and exploitation.[84]

The complexity of care of persons with advanced dementia, defined by the severity of functional and cognitive impairment, reliance on surrogate decision-making, and inability to live alone results in tremendous family/caregiver burden.[85] Behavioral symptoms such as repetitive speech, wandering, and sleep disturbances are core clinical features of ADRD. If untreated, these behaviors can accelerate disease progression, worsen functional decline and quality of life, cause significant caregiver distress, and result in earlier nursing home placement.[86]

Enhanced dementia capable HCBS systems designed to meet the needs of formal and informal caregivers of individuals with ADRD is critical to helping these individuals continue to provide care. The ADI-SSS provides funding for the development and implementation of specialized, person-centered services that help individuals remain independent and safe in their communities, while providing much needed supports to their caregivers. Through this program, ACL is working with public and private entities to identify and address the special needs of persons with ADRD and their caregivers.

In an effort to fill some identified existing gaps in systems that service people with ADRD and their family caregivers, the ADI-SSS program dedicates resources toward the provision of both services and training to targeted special populations. Specifically, the program requires that funded programs do at least one of the following:

- Develop and deliver supportive services to persons living alone with ADRD in communities;
- Prepare individuals living with moderate to severe impairment and their caregivers for the future;
- Improve the quality and effectiveness of programs and services provided to aging individuals with intellectual disabilities who have ADRD or who are at high risk of developing ADRD; and
- Deliver behavioral symptom management training and expert consultation to family caregivers.

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[84] Gould, E., Maslow, K., Yuen, P., Wiener, J. *Providing Services for People with Dementia Who Live Alone: Issue Brief.* Accessed April 14, 2014 at *http://www.adrc-tae.acl.gov/tiki-index.php?page=adsspkey&filter=key* .

[85] National Alzheimer Project Act Advisory Council on Alzheimer's Research, Care, and Services Meeting #15: Advanced Dementia Expert Panel Summary and Key Recommendations. (2015, January 26). *January 26, 2015 In-Person Meeting*. Retrieved from http://aspe.hhs.gov/daltcp/napa/012615/Mtg15-Slides4.shtml.

[86] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. *JAMA.* 2012;308(19):2020-2029. doi:10.1001/jama.2012.36918.

Funding History:

FY 2012 .....$0
FY 2013 .....$0
FY 2014 .....$10,500,000
FY 2015 .....$10,500,000
FY 2016 .....$10,500,000

Budget Request:

The FY 2017 request for ADI-SSS is $10,500,000 from the Prevention Public Health Fund, the same as the enacted level for FY 2016. Funds will enable ACL to continue the development and expansion of specialized supportive services for those impacted by the disease.

At the FY 2017 funding level, ACL will expand its focus on strengthening dementia-capability through development of specialized supportive services in a handful of States, tribal entities, and/or localities. A dementia-capable LTSS system is able to identify those with dementia and their caregivers, understand their unique circumstances, communicate appropriately with them, help them choose services that meet their needs, and provide supports to ease the burden on caregivers.

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 continue. ACL awarded 10 grants in September 2014 to begin this work.

Grant Awards Table:

Alzheimer's Disease Initiative – Specialized Supportive Services

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	11	10	10
Average Award	$941,522	$980,331	$980,331
Range of Awards	$796,712 - $995,890	$796,712 - $995,890	$796,712 - $995,890

Resource and Program Data:

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	11	10,357	10	9,803	10	9,803
Continuations	--	--	--	--	--	--
Contracts	2	114	2	639	2	639
Interagency Agreements	--	--	--	--	--	--
Program Support /1		29		58		58
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 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Lifespan Respite Care	$2,360,000	$3,360,000	$5,000,000	+$1,640,000

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

FY 2017 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 2015, AARP and the National Alliance for Caregiving estimated that 43.5 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: nineteen percent report high levels of physical strain; eighteen percent experience high levels of financial strain; and thirty-eight percent of all family caregivers indicated they experienced high levels of emotional stress.[87] Many caregivers report difficulty managing both physical and emotional stress and balancing work and family responsibilities.

Numerous studies have shown respite to be among the most frequently requested supportive service for family caregivers.[88] Respite is second only to direct financial assistance as a key policy priority of surveyed family caregivers.[89] Even though respite services are often the preferred mode of family caregiver support, they are often under-used, difficult to find and

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[87] *National Alliance for Caregiving and AARP. Caregiving in the U.S. 2015 – Focused Look at Caregivers of Adults Age 50+*. http://www.caregiving.org/wp-content/uploads/2015/05/2015_CaregivingintheUS_Care-Recipients-Over-50_WEB.pdf

[88] 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

[89] National Alliance for Caregiving and AARP, 2009

access, unaffordable, or in short supply. As a result, nearly 90 percent of family caregivers receive no respite at all.[90] The barriers to accessing and using respite services are often significant for specific populations such as family caregivers of individuals with Multiple Sclerosis, persons with intellectual and developmental disabilities, and for caregivers of veterans and individuals with Alzheimer's disease, spinal cord injuries, autism, and serious emotional disorders. [91]

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 the 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 funded 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, 33 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;

[90] National Alliance for Caregiving and AARP, 2009.
[91] National Alliance for Caregiving. (2012). *Multiple Sclerosis Caregivers.* Washington, DC: Author; The Arc, 2011.

- Integration and Sustainability grants in FY 2012 and FY 2013 have been awarded to a total of fifteen states (seven in 2012 and eight in 2013) enabling them to more fully embed the concept of respite and family support into statewide home and community-based services 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;

- Three Technical Assistance Resource Center cooperative agreements (the first awarded in FY 2009, the second awarded in FY 2012, and the third awarded in FY 2015), 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. In addition, ACL awarded a Lifespan Respite grant to Florida.

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.

State grantees work in collaboration with Aging and Disability Resource Centers/No Wrong Door Systems 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 2012 .....$2,490,000
FY 2013 .....$2,350,722
FY 2014 .....$2,342,000
FY 2015 .....$2,360,000
FY 2016 .....$3,360,000

Budget Request:

The FY 2017 request for Lifespan Respite is $5,000,000, an increase of +$1,640,000 above the FY 2016 enacted level. At this level, ACL will continue to make 19 new competitive grants available to support a range of possible activities to build or enhance Lifespan Respite Care Programs; further integrate and sustain Lifespan Respite activities into broader long-term services and supports in the State; and/or 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 supporting 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.[92]

The resources requested for FY 2017 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 in two new state 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.

[92] 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

Indicator	Year and Most Recent Result /	FY 2016 Projection	FY 2017 Projection	FY 2017 Projection +/-FY 2016 Projection
Output AJ The number of states that have participated in the Lifespan Respite Care program. *(Output)*	FY2014: 33	35	37	+2

Grant Awards Table:

Lifespan Respite Care Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	18	26	20
Average Award	$127,648	$125,462	$242,500
Range of Awards	$73,000 - $259,000	$73,000 - $259,000	$120,000 - $300,000

Resource and Program Data:

Lifespan Respite Care Program
(Dollars in thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	2	440	9	1,160	19	4,600
Continuations	16	1,858	17	2,102	1	250
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		62		98		150
Total Resources		2,360		3,360		5,000

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

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Protection of Vulnerable Adults
Summary of Request

Protection of Vulnerable Adults consists of several distinct but complementary programs designed to prevent, detect, and respond to elder abuse, neglect, and exploitation. As the population of older Americans increases, the problem of elder abuse, neglect, and exploitation continues to grow. While there is no single set of national elder abuse prevalence data, evidence indicates that 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.[93] 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.[94] 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.[95]

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.[96] 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.[97] 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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[93] 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

[94] 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

[95] 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

[96] 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.

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

PROTECTION OF VULNERABLE ADULTS

The total FY 2017 program level request for Protection of Vulnerable Adults is $52,152,000, an increase of +$2 million above the comparable FY 2016 enacted level. For FY 2017, specific program requests include:

- $15,885,000 for the Long-Term Care Ombudsman Program, the same as the FY 2016 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 2016 enacted level. This program provides formula grants to states to train, educate, and promote public awareness of elder abuse prevention efforts.

- $17,620,136 for the Senior Medicare Patrol Program, and related activities the same as the FY 2016 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 activity will be funded in FY 2016 and FY 2017 from the Health Care Fraud and Abuse Control (HCFAC) account. The SMP program is also supported by mandatory 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, and pays for infrastructure that supports States' Senior Medicare Patrols, as well as expansion grants to SMPs targeted to high-fraud states.

- $10,000,000 for Elder Rights Support Activities, an increase of +$2 million above the FY 2016 enacted level. The request will expand ACL's Elder Justice/Adult Protective Services activities 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. This program also provides funding for resource centers and activities that provide information, training, and technical assistance on elder rights issues to the national Aging Services Network.

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

Long-Term Care Ombudsman Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Long-Term Care Ombudsman Program	$15,885,000	$15,885,000	$15,885,000	--
FTE	--	--	.7	+0.7

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

FY 2017 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 3 million individuals who reside in 71,561 long-term care facilities.[98] 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 9,500 ombudsmen (both staff and designated volunteers) who resolve complaints with and on behalf of these residents, advocate for systemic improvement of long-term services and supports, 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 long-term services and supports, and educating the general public about issues related to long-term services and supports policies and regulations.

[98] National Ombudsman Reporting System (NORS) – Federal Fiscal 2014.

Much of the efficiency of the ombudsman program is due to a strong reliance on volunteers who make up the bulk of those who resolve resident issues.[99] All but three states have volunteer ombudsman programs. These trained and designated volunteer ombudsmen donated over 786,861 hours in FY 2014. In FY 2014, output data for the Long-Term Care Ombudsman Program highlights the accomplishments achieved by this program and the important role that ombudsmen play in ensuring that the rights of long-term care facility residents are respected:

- 1,294 paid and which represents 8,155 designated volunteer ombudsmen regularly visited residents in 27,913 facilities, more than 69 percent of all nursing home facilities and nearly 29 percent of all licensed board and care facilities (Output S). At least another 4,000 volunteers support these paid staff and volunteer ombudsmen.

- Ombudsmen investigated and worked to resolve 191,553 complaints (Output Q).

- Ombudsmen provided over 491,373 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 services and supports are increasingly choosing to live in 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 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-Based Service (HCBS) revised regulations, and Medicaid managed care, to name a few. These evolving services and supports continue 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 individuals 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, the newly published LTC Ombudsman rule will help bring needed

[99] 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.

consistency and strengthen LTC Ombudsman programs and the effectiveness of their services to individuals living in long-term care facilities.

Funding History:

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

FY 2012 .....$16,761,000
FY 2013 .....$15,885,000
FY 2014 .....$15,885,000
FY 2015 .....$15,885,000
FY 2016 .....$15,885,000

Budget Request:

The FY 2017 request for the LTC Ombudsman Program is $15,885,000, the same as the enacted level for FY 2016.

Funds will continue 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 75 percent,[100] demonstrating both the efficiency of the program and its ability to produce positive outcomes for residents. The FY 2014 average number of complaints per facility, at 2.62, 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

[100] National Ombudsman Reporting System (NORS) 2014 – Complaint resolution: 11% needing no further action; 4% withdrawn; 4.5% not resolved to the satisfaction of the resident; 5% referred to other agency for resolution.

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 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

Measure	**Year and Most Recent Result / Target for Recent Result / (Summary of Result)**	**FY 2016 Target**	**FY 2017 Target**	**FY 2017 Target +/-FY 2016 Target**
2.12 Decrease the average number of complaints per LTC facility. (Outcome)	FY 2014: 2.6 Target: 3 (Target Exceeded)	2.8	2.8	Maintain
2.14 Decrease the number of complaints not resolved to the satisfaction of the resident. (Outcome)	FY 2014: 8,675 Target: 10,700 (Target Exceeded)	9,700	9,000	-700

Indicator	Year and Most Recent Result /	FY 2016 Projection	FY 2017 Projection	FY 2017 Projection +/-FY 2016 Projection
Output Q: The Number of Complaints *(Output)*	FY 2014: 191,553	192,000	193,000	+1,000
Output R: Number of Ombudsman Consultations *(Output)*	FY 2014: 491,373	490,000	490,000	Maintain
Output S: Facilities regularly visited not in response to a complaint *(Output)*	FY 2014: 27,913	27,600	27,600	Maintain

Grant Awards Table:

Long-Term Care Ombudsman Program Formula Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 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 - $1,640,388	$9,829 - $1,640,388

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	242,304	241,269	241,269	-
Alaska	78,631	78,631	78,631	-
Arizona	335,451	339,187	339,187	-
Arkansas	150,395	148,997	148,997	-
California	1,628,106	1,640,388	1,640,388	-
Colorado	227,656	230,504	230,504	-
Connecticut	181,848	180,019	180,019	-
Delaware	78,631	78,631	78,631	-
District of Columbia	78,631	78,631	78,631	-
Florida	1,160,398	1,166,066	1,166,066	-
Georgia	413,623	416,629	416,629	-
Hawaii	78,631	78,631	78,631	-
Idaho	78,631	78,631	78,631	-
Illinois	591,090	587,668	587,668	-
Indiana	310,608	309,264	309,264	-
Iowa	160,039	158,675	158,675	-
Kansas	136,268	135,592	135,592	-
Kentucky	215,845	214,971	214,971	-
Louisiana	210,357	210,115	210,115	-
Maine	79,460	79,416	79,416	-
Maryland	272,077	271,674	271,674	-
Massachusetts	332,274	330,436	330,436	-
Michigan	505,146	502,864	502,864	-
Minnesota	257,275	257,346	257,346	-
Mississippi	140,514	139,916	139,916	-
Missouri	303,518	301,663	301,663	-
Montana	78,631	78,631	78,631	-
Nebraska	88,964	88,480	88,480	-
Nevada	129,503	131,457	131,457	-
New Hampshire	78,631	78,631	78,631	-

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	428,648	425,492	425,492	-
New Mexico	102,138	102,123	102,123	-
New York	949,298	940,130	940,130	-
North Carolina	474,362	475,876	475,876	-
North Dakota	78,631	78,631	78,631	-
Ohio	591,417	587,335	587,335	-
Oklahoma	183,503	182,086	182,086	-
Oregon	207,922	209,154	209,154	-
Pennsylvania	693,164	686,467	686,467	-
Rhode Island	78,631	78,631	78,631	-
South Carolina	245,627	247,613	247,613	-
South Dakota	78,631	78,631	78,631	-
Tennessee	321,470	320,966	320,966	-
Texas	1,021,763	1,032,384	1,032,384	-
Utah	96,999	97,836	97,836	-
Vermont	78,631	78,631	78,631	-
Virginia	376,934	377,221	377,221	-
Washington	328,182	330,557	330,557	-
West Virginia	108,278	106,909	106,909	-
Wisconsin	288,018	287,490	287,490	-
Wyoming	78,631	78,631	78,631	-
Subtotal, States	15,434,014	15,435,807	15,435,807	-
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	193,848	192,055	192,055	-
Virgin Islands	39,315	39,315	39,315	-
Subtotal, States and Territories	15,726,150	15,726,150	15,726,150	-
Undistributed 1/	158,850	158,850	158,850	-
TOTAL	**15,885,000**	**15,885,000**	**15,885,000**	**-**

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

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Prevention of Elder Abuse and Neglect

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Prevention of Elder Abuse & Neglect…...	$4,773,000	$4,773,000	$4,773,000	--
FTE	--	--	.3	+0.3

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

FY 2017 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 2014, over $30 million of the Elder Abuse Prevention services expenditures was leveraged from non-OAA funds, a ratio of approximately $6.50 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, distributed informational cards for law enforcement officers to have in the patrol cars which contain crucial resource information for victims of elder abuse, conducted 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 State 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 2012 .....$5,036,000
FY 2013 .....$4,773,000
FY 2014 .....$4,773,000
FY 2015 .....$4,773,000
FY 2016 .....$4,773,000

Budget Request:

The FY 2017 request for the Prevention of Elder Abuse and Neglect program is $4,773,000, the same as the FY 2016 enacted level. The FY 2017 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.

Elder Abuse Prevention activities are important elements of ACL's continued focus in FY 2017 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 respond to 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 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

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
Output U: Elder Abuse prevention non-OAA service expenditures *(Output, dollars in thousands)*	FY 2014: $30,897	$30,500	$30,500	Maintain

Grant Awards Table:

Prevention of Elder Abuse, Neglect, and Exploitation Grant Awards

	FY 2015 Operating	**FY 2016 President's Budget**	**FY 2017 Request**
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 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
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 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
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 1/	41,000	41,000	41,000	-
TOTAL	**4,773,000**	**4,773,000**	**4,773,000**	**-**

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

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Senior Medicare Patrol Program

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
Senior Medicare Patrol Program 1/…….	$8,910,000	$8,910,000	$8,910,000	--
HCFAC Expansion Grants (mandatory funding) 2/……..	5,331,814	5,331,814	5,331,814	--
HCFAC Infrastructure mandatory Funds 2/.	3,378,322	3,378,322	3,378,322	--
Total……..	17,620,136	17,620,136	17,620,136	--
FTE……	7	7	7	--

1/ In FY 2015, $8.91M in ACL's discretionary budget authority funded the SMP program. Beginning in FY 2016, direct funding will no longer be provided or requested for SMP. Instead, based on FY 2016 appropriations language, funding levels are determined by the Secretary of HHS and made available from discretionary appropriations for the Health Care Fraud and Abuse (HCFAC) account within the Centers for Medicare & Medicaid Services (CMS). The amounts shown for FY 2016 and FY 2017 are placeholders pending final funding level decisions by the Secretary. These funds are separate from current ACL funding for mandatory HCFAC funding which comes from "Wedge" dollars (see footnote 2, below).

2/ Authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HCFAC Base Infrastructure funds and HCFAC Expansion Grants (provided to SMP program grantees) are funded from the mandatory HCFAC "Wedge" funds following decisions by the Secretary and the Attorney General. Mandatory HCFAC amounts in FY 2016 and FY 2017 are placeholders.

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

FY 2017 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 2014 shows that SMP projects:

- Maintained 5,194 active volunteers who worked over 117,300 hours to educate beneficiaries about how to prevent Medicare and Medicaid fraud;
- Educated 450,720 beneficiaries in 14,618 group education sessions and held 202,064 one-on-one counseling sessions with or on behalf of beneficiaries;
- Conducted 12,290 community outreach education events; and
- Resolved 91,422 inquiries for information or assistance from beneficiaries.

In addition, the Senior Medicare Patrol program's data show that since the program's inception 18 years ago, SMP projects have educated nearly 4.9 million beneficiaries in 138,441 group education sessions and 1,643,744 one-on-one counseling sessions, and conducted 196,225 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). These funds are utilized 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.

In the past six 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. ACL received $3.2 million from HCFAC funds for this same purpose in FY 2014 and $5.3 million in FY 2015.

Funding History:

Comparable funding for the SMP discretionary appropriations is as follows:

FY 2012 .....$9,402,000
FY 2013 .....$8,875,000
FY 2014 .....$8,888,000
FY 2015 .....$8,910,000
FY 2016 ..... $8,910,000*

*Beginning in FY 2016, direct funding will no longer be provided or requested for SMP. Instead, based on FY 2016 appropriations language, funding levels are determined by the Secretary of HHS and made available from discretionary appropriations for the Health Care Fraud and Abuse (HCFAC) account within the Centers for Medicare & Medicaid Services (CMS). The amount shown for FY 2016 is a placeholder pending final funding level decisions by the Secretary.

Budget Request:

No discretionary budget authority funding is requested by ACL for the Senior Medicare Patrol program in FY 2017. Since FY 2016, based on FY 2016 appropriations language, SMP funding levels are determined by the Secretary of HHS, and made available from discretionary appropriations for the HCFAC account within the Centers for Medicare & Medicaid Services (CMS). Funding levels for FY 2016 and FY 2017 represent placeholders pending these final decisions. Additional funds may also be provided for SMP's infrastructure and expansion grants through mandatory HCFAC funding.

Since the program's inception, SMP projects have educated over 4.9 million beneficiaries and received nearly 34,643 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.

Output Table:

Senior Medicare Patrol Program

Indicator	**Year and Most Recent Result /**	**CY 2016 Projection**	**CY 2017 Projection**	**CY 2017 Projection** **+/-CY 2016 Projection**
Output W: Beneficiaries Educated and Served (Output)	CY 2014: 769,846	650,000	650,000	Maintain

Grant Awards Table:

Senior Medicare Patrol Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	54	0	0
Average Award	$165,000	$0	$0
Range of Awards	$72,600-$169,950	NA	NA

Resource and Program Data:

Senior Medicare Patrols
(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted 2/		FY 2017 President's Budget 2/	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	54	8,910	--	--	--	--
Continuations	--	--	--	--	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		--		--		--
Total Resources		8,910		--		--

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

2 No discretionary budget authority funding is requested by ACL for the Senior Medicare Patrol program in FY 2017. Since FY 2016, based on FY 2016 appropriations language, SMP funding levels are determined by the Secretary of HHS, and made available from discretionary appropriations for the HCFAC account within the Centers for Medicare & Medicaid Services (CMS).

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Elder Rights Support Activities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
Elder Rights Support Activities	$7,874,000	$11,874,000	$13,874,000	+$2,000,000
FTE	2	3	4	+1

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 2017 Older Americans Act Authorization.....Expired

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

Program Description and Accomplishments:

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

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 provide 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. The Elder Rights Support Activities described below are essential components of ACL's ongoing elder rights programs.

Adult Protective Services

Unlike Child Protective Services, which has been in existence for decades, a federal infrastructure to support basic programmatic standards for Adult Protective Services (APS) is just beginning. Historically, an absence of federal stewardship in APS 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. APS programs and administrators have lacked reliable information and guidance on best practice and standards for conducting case investigations and for staffing and managing APS programs. Additionally, GAO has identified challenges faced by APS programs across the country in collecting, maintaining, and reporting statewide, case-level data. These challenges include chronic underfunding, unprecedented budget reductions, and increasing caseloads and --have impaired States' ability to assess client outcomes and the effectiveness of the services they are providing.[101] They have also given rise to systems that are less equipped to respond in an effective and timely way to reports of elder abuse, neglect and exploitation.

In FY 2015, ACL received its first dedicated appropriation to support states in enhancing their APS systems statewide. Through ACL's continued investment in the APS program in FY 2016, states will receive additional funding to test innovations and improvements in APS practice, services, data collection, and reporting, and to support the development and implementation of ACL's National Adult Maltreatment Reporting System (NAMRS) effort. The APS program supports states by providing significant, on-going technical assistance to identify promising and best practices, participate in national APS data collection efforts; and conduct research and evaluations to increase the knowledge base about effective APS programming and practices. Through the APS program, ACL encourages states to seek system transformations that reflect a "person-centered approach" (i.e., practices and services that are based on people's strengths, assets, goals, culture, and expectations, along with their needs) and that aim to improve the experiences, health, well-being, and outcomes of the individuals served by APS.

Legal Assistance and Support

Legal Assistance and Support provides funding for two different activities. Model Approaches help States develop and implement cost-effective, replicable approaches for integrating low-cost legal assistance mechanisms related to APS into the broader tapestry of State legal service delivery networks, such as senior legal helplines, law school clinics, and volunteer attorneys. Model Approaches projects ensure strong leadership at the State level, thereby enhancing the

[101] 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.

state's overall capacity for legal service delivery and creating linkages between legal assistance providers and professionals in the broader community-based aging/disability and elder rights networks. These linkages include Areas Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), State Long-Term Care Ombudsmen, and Adult Protective Services, and leverage the strengths and resources of both elder rights and aging/disability service networks for the provision of quality legal service on priority issues to older adults most in need.

Recently, Model Approaches – Phase II grants were awarded that promote legal service delivery systems that are optimally responsive to complex legal issues emerging from cases of elder abuse, neglect, and financial exploitation. In addition, these new projects are expanding outreach efforts and implementing legal data collection/reporting systems that demonstrate the beneficial impact of legal services on the independence, health, and financial security of older adults.

In addition to Model Approaches, 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. Through this funding, the National Legal Resource Center (NLRC) supports the leadership, knowledge, and systems capacity development 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. The audience targeted to receive support services through the NLRC includes a broad range of legal, elder rights, and aging/disability services professionals and advocates. These include Home and Community-Based Services legal providers, legal assistance developers, long-term care ombudsmen, Area Agency on Aging and Aging and Disability Resource Center staff, senior legal helplines, Adult Protective Services workers, and others involved in protecting the rights of older persons.

In FY 2015, ACL funded four projects as collaborators under the NLRC. These projects provide core legal support functions for aging and legal networks, including case consultation, training, technical assistance on legal and aging systems development, and information development and dissemination. Recent expansions for the NLRC include greater focus on elder abuse prevention, advance care planning, and supported decision-making.

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 developments. NCEA also facilitates the exchange of strategies for uncovering and prosecuting fraud in areas such as telemarketing and sweepstakes scams. In 2014, the NCEA:

- Continued its outreach by serving subscribers to its newsletter as well as 2,037 members of the Elder Abuse Listserv, and created and managed a new social media platform for the NCEA Clearinghouse that included over 1,643 followers on Facebook.

- Responded to over 350 individual public inquiries and requests for information regarding elder abuse.

- Provided cost-effective trainings to professionals though live Webcast forums on issues relevant to elder justice, trained 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 17 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.

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. The 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; and, Advocacy in Assisted Living. The Center's website continues to experience high utilization (over 40,000 monthly visits) by ombudsmen, consumers, and agencies.

Funding History:

Comparable funding for Elder Rights Support Activities is as follows:

FY 2012 .....$4,088,000
FY 2013 .....$3,859,000
FY 2014 .....$3,845,000
FY 2015 .....$7,874,000
FY 2016 .....$11,874,000

Budget Request:

The FY 2017 request for the four Elder Rights Support Activities is $13,874,000, an increase of +$2,000,000 from the FY 2016 enacted level, the entirety of which will be used to increase support for Elder Justice/Adult Protective Services. FY 2017 funding for Elder Rights Support Activities would be used as described below.

Elder Justice/Adult Protective Services:

The FY 2017 request for Elder Justice/Adult Protective Services is $10 million, an increase of +$2 million over the FY 2016 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 $10 million request would be used as follows:

- *Demonstration Grants to Enhance State APS Systems ($6 million)*

  In FY 2015 as recommended by the GAO, ACL, in partnership with ASPE, undertook an effort to develop the technology infrastructure for a national APS data collection system, the National Adult Maltreatment Reporting System (NAMRS). The NAMRS tool is a process where all states can voluntarily report data collected through APS investigations. The NAMRS tool was pilot-tested and finalized in September 2015, and ACL now is engaged in the next phase of implementing the NAMRS tool nationwide.

  Similarly to what GAO found with the National Child Abuse and Neglect Data System (NCANDS), states will need significant assistance to improve their technological capacity to a level where they will be able to participate in national data collection efforts, like NAMRS. In FY 2015, ACL issued $3 million in competitive grants to assist states in improving and enhancing their APS programs and systems so that they can collect data in a manner consistent with national data collection efforts, such as NAMRS.

In FY 2016, ACL invested an additional $4 million to continue facilitating the improvement of state APS systems, as well as the phased implementation of the NAMRS begun in FY 2015. FY 2016 funds will support the expansion of participation in NAMRS to 20 additional states, bringing approximately two-thirds of the APS jurisdictions on-line in the second year of implementation. In FY 2017, ACL plans to continue supporting states in enhancing their programs, services, and data collection with a $6 million investment in grants to states.

- *NAMRS Operation and Maintenance, and Technical Assistance ($1.2million)*

  GAO recommended significant, on-going technical assistance to states to facilitate their participation in a national APS data collection effort, as states previously needed with the NCANDS system.[102] In FY 2015, ACL funded a new contract to support state APS programs and NAMRS: the National APS Technical Assistance Resource Center. Funding in FY 2016 will expand ACL's ability to provide technical assistance to states in participating with NAMRS, as well as to conduct an evaluation of APS practices. FY 2017 funding will support the continued operation and maintenance of the NAMRS system, provide technical assistance to states using NAMRS, facilitate the analysis of the NAMRS data collected in 2016, and provide programmatic technical assistance to states. This activity supports and implements Recommendation 3 of the EJCC, "Develop a National Adult Protective Services System."

- *Research ($2.05 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 is also 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.

  In FY 2016, ACL will invest $2.15 million in support of efforts aimed at increasing knowledge about effective prevention and intervention of abuse, neglect, and exploitation of older adults, native elders, adults with disabilities, people who self-neglect, guardianship abuse, and in support of the Elder Justice Coordinating Council. In FY 2017, ACL will continue to invest in areas that build the foundational knowledge essential for understanding the problem and the best ways to prevent and address it.

[102] *Id.*

- *Program Implementation and Oversight ($0.75 million)*

  The FY 2017 request includes $750,000 for salaries and overhead costs supporting four FTE carrying out the Elder Justice initiative and supporting the ongoing work of the EJCC.

Other Elder Rights Support Activities:

The FY 2017 request for the remaining three Elder Rights Support Activities is $3,874,000 in total, the same as the FY 2016 enacted levels for these activities. This would maintain current funding levels for Legal Assistance and Support activities (Statewide Model Approaches and Legal Assistance programs), the National Center on Elder Abuse, and the National Long-Term Care Ombudsman Resource Center.

These programs provide the technical assistance, information, resources, referrals, and legal systems development and assistance activities that support the efforts of the entire spectrum of Protection of Vulnerable Adults programs. These activities, along with the Elder Justice and APS program, 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):

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Elder Rights Support Activities			
Elder Justice & APS	$4,000	$8,000	$10,000
Legal Assistance and Support	$2,593	$2,593	$2,593
National Center on Elder Abuse	$765	$765	$765
LTC Ombudsman Resource Center	$516	$516	$516
Total, Elder Rights Support Activities	$7,874	$11,874	$13,874

Grant Awards Table:

Elder Rights Support Activities Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	33	36	42
Average Award	$206,179	$236,707	$250,510
Range of Awards	$70,312 - $723,752	$70,312 - $723,752	$70,312 - $723,752

Resource and Program Data:

Elder Rights Support Activities
(Dollars in thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	18	3,702	32	7,068	11	2,516
Continuations	15	3,102	4	1,453	31	8,005
Contracts	4	965	3	2,347	3	2,347
Interagency Agreements	--	--	--	--	--	--
Program Support 1/		105		1,005		1,005
Total Resources		7,874		11,874		13,874

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 ensure 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. These programs seek to promote self-determination, independence, productivity, and integration and inclusion in all facets of community life.

The total FY 2017 request for Disability Programs, Research, and Services is $385,337,000, the same as the enacted FY 2016 level. For FY 2017, specific program requests include:

- $73,000,000 to continue funding for State Councils on Developmental Disabilities (DD Councils) in each state and territory, the same as the FY 2016 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 2016 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), the same as the FY 2016 enacted level. UCEDDs in each state and territory undertake 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.

- $10,000,000 for Projects of National Significance, the same as the FY 2016 enacted level. Projects of National Significance fund grants, cooperative agreements, and contracts to explore innovative opportunities for individuals with developmental disabilities to directly and fully contribute to, and participate in, all facets of community life.

- $103,970,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), the same as the FY 2016 enacted level. 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.

- $101,183,000 for Independent Living, the same as the FY 2016 enacted level. The Independent Living program 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 integrate these individuals into the mainstream of American society.

- $2,810,000 for the Limb Loss Resource Center, the same as the FY 2016 enacted level. The program supports a national resource center and related activities that provide comprehensive information and resources to assist individuals and families dealing with limb loss.

- $7,700,000 for the Paralysis Resource Center (PRC), the same as the FY 2016 enacted level. The PRC provides comprehensive information and referral services for people living with paralysis and their families and caregivers.

- $9,321,000 for the Traumatic Brain Injury (TBI) program, the same as the comparable FY 2016 enacted level. TBI, transferred to ACL in FY 2016 from the Health Resources and Services Administration (HRSA), provides increased access to comprehensive, coordinated family and person-centered service systems for individuals who have sustained a traumatic brain injury. The TBI program has two components: an aforementioned state grant program to support state-level infrastructure and service delivery system; and a protection and advocacy services program for individuals with TBI.

State Councils on Developmental Disabilities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
State Councils on Developmental Disabilities	$71,692,000	$73,000,000	$73,000,000	--
FTE	--	--	1.3	+1.3

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

FY 2017 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. Established in 1970, 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 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 DD Councils have a significant impact on promoting self-sufficiency and community living for persons with developmental disabilities. In FY 2014, DD Councils reported that 14.58 percent of individuals nationwide with developmental disabilities were independent, self-sufficient, and integrated into the community as a result of their efforts, exceeding the target of 14.43 percent. Examples of DD 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.[103] 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 were established in 2014. Kansas has expanded the number of sites from six locations in the first year to 11 in eight communities as of September, 2015. Currently Project SEARCH sites are: University of Kansas in Lawrence; Lawrence Memorial Hospital; Butler Community College in El Dorado; Susan B. Allen Memorial Hospital in El Dorado; Sedgwick County Government

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

in Wichita; Via Christi Hospital in Wichita; Newton Medical Center; Salina Regional Medical Center; McConnell Air Force Base in Derby; Hampton Inn in Mulvane; and Johnson County Government in Olathe. The Council also plans to expand the program to include a non-school program targeted towards young adults.

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"). There are 56 Councils. Council members are appointed by the Governor and serve in a volunteer capacity. Under current law, not less than 60 percent of the Council membership must be composed of persons with developmental disabilities and/or their family members.

Funding History:

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

FY 2012 .....$74,774,000
FY 2013 .....$70,555,000
FY 2014 .....$70,692,000
FY 2015 .....$71,692,000
FY 2016 .....$73,000,000

Budget Request:

The FY 2017 request for State Councils on Developmental Disabilities (DD Councils) is $73,000,000, the same as the FY 2016 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 2017, 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. In FY 2017, ACL will also provide Technical Assistance to State Councils from Projects of National Significance dollars.

It is crucial to continue funding for DD Councils 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 DD 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:

State Councils on Developmental Disabilities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
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 2014: 14.58% Target: 14.43% (Target Exceeded)	Prior Result + 0.1%	Prior Result + 0.1%	N/A
8E Increase the number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community per $1,000 of federal funding to the Councils. (Efficiency)	FY 2014: 9.73 Target: 9.72 (Target Exceeded)	Prior Result + 1%	Prior Result + 1%	N/A

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
8i: Number of individuals with developmental disabilities reached by the Councils who are independent, self-sufficient and integrated into the community. (Output)	FY 2014: 729,152	N/A	N/A	N/A
8ii: Number of all individuals trained by the Councils. (Output)	FY 2014: 369,182	N/A	N/A	N/A

Grant Awards Tables:

State Councils on Developmental Disabilities Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	56	56	56
Average Award	$1,275,750	$1,303,571	$1,290,536
Range of Awards	$246,128 - $6,459,004	$253,882 - $6,543,380	$251,429 - $6,480,163

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS 2/

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	1,267,110	1,294,230	1,281,726	(12,504)
Alaska	472,622	487,511	482,801	(4,710)
Arizona	1,377,490	1,415,169	1,401,497	(13,672)
Arkansas	752,586	772,804	765,338	(7,466)
California	6,459,004	6,543,380	6,480,163	(63,217)
Colorado	850,026	882,984	874,453	(8,531)
Connecticut	673,989	688,823	682,168	(6,655)
Delaware	472,622	487,511	482,801	(4,710)
District of Columbia	472,622	487,511	482,801	(4,710)
Florida	3,461,007	3,664,685	3,629,281	(35,404)
Georgia	2,019,042	2,070,716	2,050,711	(20,005)
Hawaii	472,622	487,511	482,801	(4,710)
Idaho	472,622	487,511	482,801	(4,710)
Illinois	2,590,984	2,624,831	2,599,472	(25,359)
Indiana	1,469,351	1,488,546	1,474,165	(14,381)
Iowa	764,194	774,177	766,697	(7,480)
Kansas	606,663	614,589	608,651	(5,938)
Kentucky	1,182,615	1,201,176	1,189,571	(11,605)
Louisiana	1,357,983	1,375,723	1,362,432	(13,291)
Maine	472,622	487,511	482,801	(4,710)
Maryland	995,159	1,008,160	998,420	(9,740)
Massachusetts	1,305,975	1,365,884	1,352,688	(13,196)
Michigan	2,437,488	2,543,752	2,519,177	(24,575)
Minnesota	1,012,073	1,025,295	1,015,389	(9,906)
Mississippi	902,449	914,238	905,405	(8,833)
Missouri	1,336,501	1,367,975	1,354,759	(13,216)
Montana	472,622	487,511	482,801	(4,710)
Nebraska	472,622	487,511	482,801	(4,710)
Nevada	472,622	541,498	536,290	(5,208)
New Hampshire	472,622	487,511	482,801	(4,710)

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	1,533,290	1,553,320	1,538,313	(15,007)
New Mexico	483,919	490,241	485,504	(4,737)
New York	4,062,646	4,101,074	4,061,454	(39,620)
North Carolina	1,976,156	2,020,952	2,001,427	(19,525)
North Dakota	472,622	487,511	482,801	(4,710)
Ohio	2,810,012	2,846,721	2,819,219	(27,502)
Oklahoma	885,680	897,250	888,581	(8,669)
Oregon	773,163	781,292	773,744	(7,548)
Pennsylvania	2,987,494	3,026,521	2,997,282	(29,239)
Rhode Island	472,622	487,511	482,801	(4,710)
South Carolina	1,082,855	1,097,001	1,086,403	(10,598)
South Dakota	472,622	487,511	482,801	(4,710)
Tennessee	1,442,550	1,461,395	1,447,276	(14,119)
Texas	4,742,116	4,813,917	4,767,410	(46,507)
Utah	630,623	635,274	629,136	(6,138)
Vermont	472,622	487,511	482,801	(4,710)
Virginia	1,482,561	1,501,929	1,487,419	(14,510)
Washington	1,170,066	1,170,579	1,159,270	(11,309)
West Virginia	732,246	739,342	732,199	(7,143)
Wisconsin	1,276,488	1,311,944	1,299,269	(12,675)
Wyoming	472,622	487,511	482,801	(4,710)
Subtotal, States	67,982,884	69,452,541	68,781,573	(670,968)
American Samoa	246,128	253,882	251,429	(2,453)
Guam	246,128	253,882	251,429	(2,453)
Northern Mariana Islands	246,128	253,882	251,429	(2,453)
Puerto Rico	2,474,604	2,506,931	2,482,711	(24,220)
Virgin Islands	246,128	253,882	251,429	(2,453)
Subtotal, States and Territories	71,442,000	72,975,000	72,270,000	(705,000)
Undistributed 1/	250,000	25,000	730,000	705,000
TOTAL	**71,692,000**	**73,000,000**	**73,000,000**	-

1/ The undistributed line reflects the amount reserved from the State DD Councils appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

2/ AoD/AIDD is in the final stages of developing a new formula for the State DD Councils and P&As. The estimates for non-minimum allotment States will likely change with the new formula. Those new estimates are estimated to be completed and released by April 1, 2016 to meet the statutory requirement as set forth in the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

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Developmental Disabilities – Protection and Advocacy

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
DD – Protection and Advocacy	$38,734,000	$38,734,000	$38,734,000	--
FTE	--	--	1.3	+01.3

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

FY 2017 Developmental Disabilities Assistance and Bill of Rights Act Authorization.....Expired

Allocation Method .....Formula Grant

Program Description and Accomplishments:

Established in 1975, Protection and Advocacy (P&As) provide a range of legal services to traditionally unserved or underserved individuals with developmental disabilities to ensure they are protected from abuse and neglect and 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 and to promote system change. There is a P&A system in each State, the Territories, and the District of Columbia. There is also a Native American Consortium for a total of 57 P&As.

P&As continue to play a key role in promoting community living, which is a strategic DHHS priority, and have been supported by a number of Federal and state policies and initiatives 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 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. Community living was also supported in the U.S. Supreme Court's 1999 decision in *Olmstead* v. *L.C.* requires states to eliminate unnecessary segregation of people with disabilities, and to ensure that they receive services in the most integrated setting possible.

Examples of P&A accomplishments that increase opportunities for individuals with developmental disabilities to make decisions for themselves about where and with whom they live 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. Thirty-one percent of P&A cases are in the area of education. As one example, a result of Michigan P&A (MPAS) advocacy, the Michigan Department of Education (MDE) ordered four school districts, including the largest urban district in the state, and nine charter schools to make systemic policy and practice improvements in their handling of finding and identification of students who might need special education services and supports. Furthermore, MDE ordered 12 school districts and two charter schools to make systemic policy and practice improvements in their handling of discipline and disability-related behavior issues.

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.

As more individuals with developmental disabilities, including those who require long-term services and supports, choose to live in the community and States and Territories move to new models of services and supports, the demand for P&A legal service will likely increase and

become more complex. These changes create new challenges for Protection and Advocacy programs as well as for the Long-Term Care Ombudsman program that is also supported by ACL. 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. 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 87 percent of the P&A clients living in the community.[104] 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 2012 .....$40,865,000
FY 2013 .....$38,559,000
FY 2014 .....$38,634,000
FY 2015 .....$38,734,000
FY 2016 .....$38,734,000

Budget Request:

The FY 2017 request for the Developmental Disabilities Protection and Advocacy program is $38,734,000, the same as the FY 2016 enacted level. This request will allow the P&A system to continue 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,

[104] U.S. Profile, FY 1977 – 2013, State of the State in Developmental Disabilities.

including children, are at increased risk of experiencing abuse and neglect.[105] 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.[106] 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 2014, the 57 P&As remedied 7,368 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 2014:

- 33 percent were resolved using short-term assistance strategies;
- 31 percent were addressed through technical assistance in self-advocacy;
- 12 percent involved investigation and monitoring; and
- 15 percent were addressed through negotiation.

[105] 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

[106] 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:

Developmental Disabilities Protection and Advocacy

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
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) (Outcome)	FY 2014: 86.24% Target: 87.54% (Target Not Met)	Prior Result + 0.5%	Prior Result + 0.5%	N/A

Indicator	Year and Most Recent Result /	FY 2016 Projection	FY 2017 Projection	FY 2017 Projection +/-FY 2016 Projection
8iii: Number of clients receiving professional individual legal advocacy for the Protection and Advocacy program. (Output)	FY 2014: 17,327	N/A	N/A	N/A
8iv: Number of people receiving information and referral from the Protection and Advocacy program. (Output)	FY 2014: 38,790	N/A	N/A	N/A

Grant Awards Tables:

Developmental Disabilities – Protection and Advocacy Formula Grant Awards[107]

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	57	57	57
Average Award	$674,378	$674,170	$667,253
Range of Awards	$194,139 - $3,312,386	$205,808 - $3,239,697	$205,808 - $3,197,054

[107] Excludes grants to tribal organizations.

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS 2/

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	622,622	612,842	604,775	(8,067)
Alaska	362,881	384,693	384,693	-
Arizona	680,282	679,160	670,220	(8,940)
Arkansas	383,218	396,365	394,524	(1,841)
California	3,312,386	3,239,697	3,197,054	(42,643)
Colorado	452,679	455,700	451,390	(4,310)
Connecticut	371,977	384,693	384,693	-
Delaware	362,881	384,693	384,693	-
District of Columbia	362,881	384,693	384,693	-
Florida	1,911,603	1,911,812	1,886,647	(25,165)
Georgia	1,061,580	1,051,072	1,037,236	(13,836)
Hawaii	362,881	384,693	384,693	-
Idaho	362,881	384,693	384,693	-
Illinois	1,262,305	1,234,045	1,217,802	(16,243)
Indiana	761,016	743,896	734,104	(9,792)
Iowa	371,009	384,693	384,693	-
Kansas	362,881	384,693	384,693	-
Kentucky	578,171	565,714	558,268	(7,446)
Louisiana	566,211	553,812	546,522	(7,290)
Maine	362,881	384,693	384,693	-
Maryland	472,475	468,162	462,000	(6,162)
Massachusetts	609,367	601,031	593,119	(7,912)
Michigan	1,237,009	1,200,501	1,184,699	(15,802)
Minnesota	516,882	507,870	501,184	(6,686)
Mississippi	424,129	417,111	414,997	(2,114)
Missouri	692,225	677,427	668,510	(8,917)
Montana	362,881	384,693	384,693	-
Nebraska	362,881	384,693	384,693	-
Nevada	362,881	384,693	384,693	-
New Hampshire	362,881	384,693	384,693	-

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	747,718	732,670	723,026	(9,644)
New Mexico	362,881	384,693	384,693	-
New York	1,815,506	1,779,591	1,756,166	(23,425)
North Carolina	1,101,546	1,088,462	1,074,135	(14,327)
North Dakota	362,881	384,693	384,693	-
Ohio	1,323,626	1,287,080	1,270,138	(16,942)
Oklahoma	414,125	400,908	395,630	(5,278)
Oregon	414,781	414,158	410,394	(3,764)
Pennsylvania	1,357,807	1,317,038	1,299,701	(17,337)
Rhode Island	362,881	384,693	384,693	-
South Carolina	580,002	573,200	565,656	(7,544)
South Dakota	362,881	384,693	384,693	-
Tennessee	748,529	735,507	725,825	(9,682)
Texas	2,438,361	2,394,955	2,363,430	(31,525)
Utah	362,881	384,693	384,693	-
Vermont	362,881	384,693	384,693	-
Virginia	737,204	725,629	716,078	(9,551)
Washington	630,441	620,334	612,168	(8,166)
West Virginia	362,881	384,693	384,693	-
Wisconsin	637,263	622,558	614,363	(8,195)
Wyoming	362,881	384,693	384,693	-
Subtotal, States	36,128,794	36,086,860	35,728,314	(358,546)
American Samoa	194,139	205,808	205,808	-
Guam	194,139	205,808	205,808	-
Northern Mariana Islands	194,139	205,808	205,808	-
Puerto Rico	859,831	825,493	814,626	(10,867)
Virgin Islands	194,139	205,808	205,808	-
Subtotal, States and Territories	37,765,181	37,735,585	37,366,172	(369,413)
Native American Organization	194,139	205,808	205,808	-
Undistributed 1/	774,680	792,607	1,162,020	369,413
TOTAL	**38,734,000**	**38,734,000**	**38,734,000**	**-**

1/ This line reflects the amount reserved from the P&A appropriation for statutory related activities, including training, technical assistance, grant systems, and review costs. Beginning in FY 2017, the undistributed line also includes an amount reserved from the Developmental Disabilities Protection and Advocacy appropriation for FTE and related overhead costs to conduct program monitoring and oversight and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

2/ AoD/AIDD is in the final stages of developing a new formula for the State DD Councils and P&As. The estimates for non-minimum allotment States will likely change with the new formula. Those new estimates are estimated to be completed and released by April 1, 2016 to meet the statutory requirement as set forth in the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

University Centers for Excellence in Developmental Disabilities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
University Centers of Excellence in Developmental Disabilities	$37,674,000	$38,619,000	$38,619,000	--
FTE	--	--	1.5	+1.5

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

FY 2017 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 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 and to be independent, productive, integrated and included in all facets of community life.

UCEDDs have played a key role in a significant number of advances in the disability field over the past four decades. Many issues, such as early intervention, health care, community-based services, inclusive and meaningful education, transition from school to work, employment, housing, assistive technology, and transportation have been directly improved by the services, research, and training provided by UCEDDs.

In FY 2015, the Administration on Intellectual and Developmental Disabilities (AIDD) awarded grants to continue funding for the 67 University Centers. Funding from AIDD establishes the UCEDD and provides the infrastructure support for the Centers to engage in interdisciplinary pre-service training, continuing education, community services, research, and information dissemination activities. UCEDDs leverage additional funds for carrying out these core activities from a variety of sources, including federal, state, and local agencies; private foundations;

donations; and fee-for-service earnings. In FY 2014, UCEDDs leveraged over $15 per AIDD dollar invested.

As liaisons to the community, including service delivery systems, UCEDDs serve to positively affect the lives of individuals with developmental disabilities and their families in a variety of ways. UCEDD accomplishments include:

- Directing exemplary interdisciplinary pre-service preparation with faculty and trainees that represent a variety of disciplines, such as pediatrics, education, psychology and nursing, thereby expanding opportunities for students to learn about the differing perspectives of various professionals who are providing services to, and working on behalf of, individuals with developmental disabilities and their families. 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.

- Providing community services that cut across Federal, State, and local systems to improve capacity and quality of services by incorporating evidence-based practices. UCEDD staff offer expertise and inform the field through training, technical assistance and demonstration, model activities for individuals with developmental disabilities and their families, and support for service organizations, professionals, paraprofessionals, students, systems, volunteers and others. Community services offer innovative designs and methods that addresses a local or universal need, can be replicated and promote the increased inclusion, integration, productivity, and human rights of individuals with developmental disabilities and their families (including people with developmental disabilities from racial and ethnic minority backgrounds) and improve access and use at community services and individualized supports in all aspects of community life.

- Contributing to the development of new knowledge through various research activities including basic or applied research, evaluation, and public policy analysis. UCEDD research engages people with developmental disabilities and their families in the development, design and implementation of research activities, as well as the dissemination of research information. 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.

- UCEDDs work to bridge the gap between research and practice by developing a variety of products and resources that promotes improvement in knowledge and practice.

UCEDDs also conduct national training and other initiatives to address unmet needs of people with developmental disabilities. Past training initiatives have supported post-secondary education opportunities for people with developmental disabilities, enhancing self-determination skills, and building partnerships with minority serving institutions.

Funding History:

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

FY 2012 .....$38,792,000
FY 2013 .....$36,602,000
FY 2014 .....$36,674,000
FY 2015 .....$37,674,000
FY 2016 ... .$38,619,000

Budget Request:

The FY 2017 request for UCEDDs is $38,619,000, the same as the FY 2016 enacted level. This request will provide operational and administrative support to maintain the existing 67 UCEDDs. This funding level will allow ACL to reserve up to 2% specified in law, totaling $772,380, to continue support for training and technical assistance (TA) to the UCEDDs to support improvements in the programs' performance and ability to meet performance targets. Without this dedicated TA funding, ACL may need to make future adjustments to the UCEDD formula to provide flexibility for funding of training and TA, and prioritizing such training over National Training Initiative(s) (NTI) and supplemental grants to existing Centers or grants to new Centers, in order to maintain the UCEDD core grants at their current level and pay for TA to Centers, the Cost Of Living Adjustments, NTI and supplemental grants. Training and TA is vital 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 COLA to Centers before funding NTIs and TA to Centers.

Funding of the UCEDDs will support the 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, 30 percent are in leadership positions with:

- 8 percent in academic leadership;
- 7 percent in clinical leadership;
- 7 percent in public health leadership; and
- 5 percent in public policy and advocacy leadership.

Over 40 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 2014, the federal investment of $36.6 million in UCEDD grant awards leveraged $559.6 million in other resources to help UCEDD's carry out their core activities.

Outcomes and Outputs Table:

University Centers for Excellence in Developmental Disabilities

Measure	Year and Most Recent Result / Target for Recent Result / (Summary of Result)	FY 2016 Target	FY 2017 Target	FY 2017 Target +/-FY 2016 Target
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 2014: 41.47% Target: 41.39% (Target Exceeded)	Prior Result + 1%	Prior Result + 1%	N/A

Indicator	**Year and Most Recent Result /**	**FY 2016 Projection**	**FY 2017 Projection**	**FY 2017 Projection** **+/-FY 2016 Projection**
8viii: Number of professionals trained by UCEDDs. (Output)	FY 2014: 5,550	N/A	N/A	N/A
8ix: Number of people reached through UCEDD community training and technical assistance activities. (Output)	FY 2014: 781,043	N/A	N/A	N/A
8x: Number of people receiving direct or model demonstration services from UCEDDs. (Output)	FY 2014: 90,021	N/A	N/A	N/A

Grant Awards Tables:

University Centers of Excellence in Developmental Disabilities Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	81	67	67
Average Award	$455,935	$550,937	$550,937
Range of Awards	$545,919	$545,919	$545,919

Resource and Program Data:

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--		
New Discretionary	17	1,992	2	1,358	42	23,238
Continuations	64	34,939	65	35,555	25	13,675
Contracts	1	717	1	1,630	1	1,630
Interagency Agreements	--	--	--	--		--
Program Support /1		27		77		77
Total Resources		37,674		38,619		38,619

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Developmental Disabilities – Projects of National Significance

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Developmental Disabilities—Projects of National Significance	$8,857,000	$10,000,000	$10,000,000	--

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

FY 2017 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 advancing the development of national and state policies, including federal interagency initiatives; funding 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 supporting longitudinal data collection projects. Examples of PNS activities include:

- In FY 2011 and FY 2012, PNS resources funded systems change grants to improve access to competitive, integrated supported employment for people with intellectual and developmental disabilities, with a particular focus on youth and young adults, as well as the evaluation of such efforts and technical assistance to the states funded.

- In FY 2012, PNS also funded two community practice projects that will work to build states' capacities to support competitive, integrated employment and family support activities for persons with intellectual and developmental disabilities, 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. Most recently, the grantees conducting longitudinal research have been tasked with expanding their reach to U.S. Territories.

- 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.

- PNS resources support a $1,000,000 grant related to inclusive transportation for those with disabilities.

- PNS resources also funded a grant to increase diversity among the current leaders within the DD Network and to enhance the cultural linguistic competence and leaderships skills of those leaders.

- Training and Technical Assistance for Developmental Disability State Councils.

In FY 2016, ACL/AIDD will continue to prioritize these efforts with the goal of bringing together entities such as state Developmental Disabilities agencies, 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."

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.

Funding History:

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

FY 2012 .....$8,317,000
FY 2013 .....$8,828,000
FY 2014 .....$8,821,000
FY 2015 .....$8,857,000
FY 2016... .....$10,000,000

Budget Request:

The FY 2017 request for the Projects of National Significance program is $10,000,000, the same as the FY 2016 enacted level. This funding level includes $643,000 for technical assistance for the State Councils on Developmental Disabilities. In addition, ACL will provide self-advocacy organizations with an opportunity to thrive and grow through a targeted technical assistance effort.

Funds will 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. For example, 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 also 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 2017, 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, as well as older adults, in the development and planning of the community transportation systems.

Grant Awards Tables:

Developmental Disabilities – Projects of National Significance Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	26	32	32
Average Award	$291,947	$264,508	$264,516
Range of Awards	$100,000 - $1,000,000	$175,000 - $1,000,000	$175,000 - $1,000,000

Resource and Program Data:

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

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	1	10	17	3,600	14	4,600
Continuations	25	7,581	14	4,600	17	3,600
Contracts	6	1,347	6	1,612	6	1,612
Interagency Agreements			--	--	--	--
Program Support /2		170		189		189
Total Resources	32	9,107	37	10,000	37	10,000

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

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National Institute on Disability, Independent Living, and Rehabilitation Research

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
National Institute on Disability, Independent Living and Rehabilitation Research	$103,970,000	$103,970,000	$103,970,000	--

Authorizing Legislation: Title II of the Rehabilitation Act of 1973, as amended

FY 2017 Rehabilitation Act Authorization.....$114,325,000

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 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. Research 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 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. NIDILRR's outcome domains are community living and participation, employment, and health and function.

- 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 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. RRTC funding supports coordinated and advanced programs of research, training, technical assistance, and information dissemination in problem areas that are specified by NIDILRR. 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.

- *Rehabilitation Engineering Research Centers (RERCs).* The RERCs conduct research on issues dealing with rehabilitation technology, including rehabilitation engineering and assistive technology devices and services. RERCs receive funding to conduct research or development activities to enhance independent living (including rehabilitation engineering and assistive technology) to enhance the opportunities of individuals with disabilities, and to diminish barriers that might limit their independence. Each RERC

must provide training opportunities to enable individuals, including individuals with disabilities, to become researchers and practitioners in the field of rehabilitation technology.

- *Model Systems*. NIDILRR funds model systems projects in three areas: spinal cord injury, traumatic brain injury, and burn injury. Model systems funding supports grants to conduct research on interventions to meet the wide range of needs of individuals in these areas. Grantees in each of the three areas contribute to information on long-term community integration and functional outcomes by collecting and submitting longitudinal data to their respective injury-specific national databases. 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/.) Currently, the NIDILRR SCI model systems database is the largest of its kind in the world. 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 are 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 rehabilitation care for burn injury survivors. Projects aim to improve outcomes for burn survivors by conducting research to improve rehabilitation treatments for burn injuries. 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.

- *Disability and Rehabilitation Research Projects (DRRPs).* Grantees under this program focus on addressing 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. These projects may be on topics identified by NIDILRR or may be identified by investigators.

- *ADA National Network Centers (ADA Network).* The ADA Network supports 10 regional centers that provide technical assistance, information, and training related to the requirements of the Americans with Disabilities Act (ADA). These efforts are designed to promote awareness and enforcement of the ADA.

- *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. This award is made to individuals.

- *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 2012 .....$108,817,000
FY 2013 .....$103,125,000
FY 2014 .....$103,970,000
FY 2015 .....$103,970,000
FY 2016… $103,970,000

Budget Request:

ACL requests $103,970,000 for the National Institute on Disability, Independent Living, and Rehabilitation Research in FY 2017, the same as the FY 2016 enacted level. Funding at this level will enable NIDILRR to fund multiple Disability and Rehabilitation Research Projects (DRRPs) targeting improved employment outcomes for individuals with disabilities, and support NIDILRR's Traumatic Brain Injury (TBI) and Burn Model Systems programs. About 79 percent of the funds requested would be used to cover the costs of grants that began in previous fiscal years ($85 million). In addition, an estimated $23 million would be used to fund new grant awards under a potential revised regulatory framework that NIDILRR proposes to publish for its research in FY 2017.

The FY 2017 budget request also includes general provision (Section 224) that would address an area of particular concern to NIDILRR, but one which has also affected other ACL programs. For NIDILRR to be able to accept funding from another agency for the purpose of making grants or cooperative agreements, specific authority is required. The lack of such authority precludes collaboration. The new proposed language would provide HHS agencies with statutory authority to transfer funds via reimbursable agreements from one agency to another for the purposes of making grants, allowing NIDILRR to collaborate on a wider scale (e.g., with the Department of Veteran's affairs on research projects to address the needs of disabled veterans). It would also improve the operational efficiency of NIDLIRR by allowing them to transfer funds via

reimbursable agreements to other OPDIVs for the purposes of making grants or cooperative agreements on their behalf.

Through priorities published in the Federal register in FY 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 clarify its major areas of research. In addition, NIDLIRR identified four broad disability categories—physical, psychiatric, developmental/intellectual, and sensory, to identify its principal populations of interest. NIDILRR has published broad priorities using the domains and, in some cases, the disability categories, that allow applicants to respond with proposed research of their own choice. These more field-initiated priorities would remain in place for up to five years. Applicants who are not successful in one competition are able to revise and improve their application and resubmit in subsequent years. Use of these recurring topical priorities also simplifies management of NIDILRR's competitions by reducing the need for annual rule-making. NIDILRR also reserves the right to publish agency-directed priorities as required to take advantage of new opportunities or respond to critical needs of individuals with disabilities and their families.

During FY 2017, NIDILRR plans to focus on the following broad priority topics in its domain areas:

Employment

- Technology to improve employment outcomes for individuals with disabilities.
- Individual and environmental factors associated with improved employment outcomes for individuals with 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 disabilities.
- Effects of government practices, policies, and programs on employment outcomes for individuals with disabilities.
- Practices and policies that contribute to improved employment outcomes for transition-aged youth with disabilities.
- Vocational rehabilitation (VR) practices that contribute to improved employment outcomes for individuals with disabilities.

Community Living and Participation

- Technology to improve community living and participation outcomes for individuals with disabilities.

- Individual and environmental factors associated with improved community living and participation outcomes for individuals with 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 disabilities.
- Effects of government practices, policies, and programs on community living and participation outcomes for individuals with disabilities.
- Practices and policies that contribute to improved community living and participation outcomes for transition-aged youth with disabilities.

Health and Function

- Technology to improve health and function outcomes for individuals with disabilities.
- Individual and environmental factors associated with improved access to rehabilitation and health care and improved health and function outcomes for individuals with disabilities.
- Interventions that contribute to improved health and function outcomes for individuals with 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 disabilities.
- Practices and policies that contribute to improved health and function outcomes for transition-aged youth with disabilities.

Outcomes and 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.

Grant Awards Tables:

National Institute on Disability, Independent Living, and Rehabilitation Research
(Dollars in Thousands)

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	225	227	222
Average Award	$449,619	$427,251	$436,185
Range of Awards	$70,000 – $1,246,000	$70,000 – $1,246,000	$70,000 – $1,246,000

Resource and Program Data:

National Institute on Disability, Independent Living, and Rehabilitation Research
(Dollars in Thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	54	15,096	80	34,115	60	20,308
Continuations	164	82,921	147	62,871	162	76,525
Contracts	7	4,718	8	5,587	7	5,745
Peer Review of new grant applications	1	824	1	954	1	950
Interagency Agreements	1	121	--	--	--	--
Program Support /1		290		443	--	442
Total Resources		103,970		103,970		103,970

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

Independent Living

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	2017 +/- FY 2016
Independent Living State Grants……..	$22,878,000	$22,878,000	$22,878,000	--
Centers for Independent Living.....	$78,305,000	$78,305,000	78,305,000	--
Total……	$101,183,000	$101,183,000	$101,183,000	--
FTE /1……	--	1.0	1.7	+0.7

Authorizing Legislation: Rehabilitation Act of 1973, Title VII, Parts B and C, and Chapter 1, as amended by the Workforce Innovation and Opportunities Act (Rehabilitation Act)

FY 2017 Rehabilitation Act Authorizations:
Independent Living State Grants $25,156,000
Centers for Independent Living $86,104,000

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 centers for independent living, Statewide Independent Living Councils, other Rehabilitation Act programs, 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 identify a Designated State Entity (DSE) to receive, disperse, and account for funds, and 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 SILC 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;
- 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 subtitle VII, Chapter 16 of the Rehabilitation Act, including minority groups and urban and rural populations.

Section 21(b)(1) of the Rehabilitation Act allows for 1 percent of funds appropriated under subtitle VII to be set aside for minority outreach activities as described in Section 21(b)(2). Activities may be carried out through a grant, contract, or cooperative agreement.

The 2014 reauthorization of the Rehabilitation Act by 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, and individual and systems advocacy. WIOA 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 that 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 grants to centers in each State. WIOA requires that grants be awarded to any eligible agency that had been awarded a grant for the preceding fiscal year. In most cases, funds are awarded directly to centers for independent living. In fiscal year 2015, 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 annually reserve between 1.8 and 2 percent of the funds appropriated for this program to provide (through grants, contracts, or cooperative agreements) 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 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.

Funding History:

Funding for Independent Living activities during the past five years is as follows:

Independent Living State Grants:

FY 2012 .....$23,359,000
FY 2013 .....$23,137,000
FY 2014 .....$22,878,000
FY 2015 .....$22,878,000
FY 2016 .....…....$22,878,000

Centers for Independent Living:

FY 2012 .....$79,953,000
FY 2013 .....$75,772,000
FY 2014 .....$78,305,000
FY 2015 .....$78,305,000
FY 2016 .....$78,305,000

Budget Request:

The FY 2017 request for Independent Living is $101,183,000, the same as the FY 2016 enacted level. Of this amount, $22,878,000 is provided to the Independent Living State Grants program (IL State Grants) and $83,305,000 is for the Centers for Independent Living program (CIL). CILs will continue to provide the core requirements for information and referral services, independent living skills training, peer counseling, and individual and systems advocacy, as well as continue to implement the new, fifth core service required by WIOA 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 2014, CILs served about 280,000 of the estimated 38 million individuals with a significant disability living in the United States.[108]

The request for the CIL program would continue support for existing centers, including any new center grants awarded in FY 2016. 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.

Outcome and 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.

[108] ACL, 704 Report, 2014. And U.S. Census Bureau, "Americans with Disabilities 2010" issued July 2012. Accessed 12/4/14. http://www.census.gov/prod/2012pubs/p70-131.pdf

Grant Awards Tables:

Independent Living Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards 1/	432	432	434
Average Award	$234,217	$233,997	$232,919
Range of Awards	$27,797 - $1,978,662	$27,770 - $1,980,977	$27,511 - $1,945,901

1/ Independent Living State Grants are awarded to 77 entities across 56 state and territory jurisdictions because some states have separate divisions for vocational rehabilitation and services for the blind.

Resource and Program Data:

Independent Living
(Dollars in Thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
Formula /2	77	22,878	77	22,216	77	22,216
New Discretionary	3	993	2	1,195	2	1,429
Continuations	352	77,311	353	77,676	355	77,442
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		1		97		97
Total Resources		101,183		101,183		101,183

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Independent Living State Grants (CFDA 84.169A)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	305,350	305,350	305,350	-
Alaska	305,350	305,350	305,350	-
Arizona	342,056	343,661	337,576	(6,085)
Arkansas	305,350	305,350	305,350	-
California	1,978,662	1,980,977	1,945,901	(35,076)
Colorado	305,350	305,350	305,350	-
Connecticut	305,350	305,350	305,350	-
Delaware	305,350	305,350	305,350	-
District of Columbia	305,350	305,350	305,350	-
Florida	1,009,287	1,015,609	997,626	(17,983)
Georgia	515,779	515,498	506,370	(9,128)
Hawaii	305,350	305,350	305,350	-
Idaho	305,350	305,350	305,350	-
Illinois	664,955	657,590	645,947	(11,643)
Indiana	339,179	336,788	330,825	(5,963)
Iowa	305,350	305,350	305,350	-
Kansas	305,350	305,350	305,350	-
Kentucky	305,350	305,350	305,350	-
Louisiana	305,350	305,350	305,350	-
Maine	305,350	305,350	305,350	-
Maryland	306,036	305,350	305,350	-
Massachusetts	345,473	344,372	338,275	(6,097)
Michigan	510,796	505,927	496,969	(8,958)
Minnesota	305,350	305,350	305,350	-
Mississippi	305,350	305,350	305,350	-
Missouri	311,990	309,563	305,350	(4,213)
Montana	305,350	305,350	305,350	-
Nebraska	305,350	305,350	305,350	-
Nevada	305,350	305,350	305,350	-
New Hampshire	305,350	305,350	305,350	-

PROGRAM/CFDA NUMBER: Independent Living State Grants (CFDA 84.169A)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	459,369	456,319	448,239	(8,080)
New Mexico	305,350	305,350	305,350	-
New York	1,014,359	1,008,100	990,251	(17,849)
North Carolina	508,341	507,667	498,679	(8,988)
North Dakota	305,350	305,350	305,350	-
Ohio	597,266	591,915	581,434	(10,481)
Oklahoma	305,350	305,350	305,350	-
Oregon	305,350	305,350	305,350	-
Pennsylvania	659,363	652,823	641,264	(11,559)
Rhode Island	305,350	305,350	305,350	-
South Carolina	305,350	305,350	305,350	-
South Dakota	305,350	305,350	305,350	-
Tennessee	335,312	334,363	328,443	(5,920)
Texas	1,365,213	1,376,228	1,351,861	(24,367)
Utah	305,350	305,350	305,350	-
Vermont	305,350	305,350	305,350	-
Virginia	426,389	425,080	417,554	(7,526)
Washington	359,853	360,511	354,128	(6,383)
West Virginia	305,350	305,350	305,350	-
Wisconsin	305,350	305,350	305,350	-
Wyoming	305,350	305,350	305,350	-
Subtotal, States	21,820,878	21,799,541	21,593,242	(206,299)
American Samoa	27,797	27,770	27,511	(259)
Guam	27,797	27,770	27,511	(259)
Northern Mariana Islands	27,797	27,770	27,511	(259)
Puerto Rico	305,350	305,350	305,350	-
Virgin Islands	27,797	27,770	27,511	(259)
Subtotal, States and Territories	22,237,416	22,215,971	22,008,636	(207,335)
Undistributed 1/	640,584	662,029	869,364	207,335
TOTAL	**22,878,000**	**22,878,000**	**22,878,000**	**-**

1/ The undistributed line reflects the amount reserved from the Independent Living State Grants appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

Limb Loss Resource Center

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Limb Loss Resource Center	$2,800,000	$2,810,000	$2,810,000	--

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,[109] and hospital costs associated with amputation total more than $8.3 billion annually.[110] 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.[111] 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.[112]

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

[109] 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

[110] HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality; 2009.

[111] 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

[112] HCUP Nationwide Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). In. Rockville, MD: Agency for Healthcare Research and Quality; 2009.

loss. Program accomplishments also include a nationwide awareness campaign, highlighted by 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 2012 .....$2,820,000
FY 2013 .....$2,788,000
FY 2014 .....$2,810,000
FY 2015 .....$2,800,000
FY 2016 .....$2,810,000

Note: This program was funded at CDC through FY 2014 and transferred to ACL during FY 2015.

Budget Request:

The FY 2017 request is $2,810,000, the same as the FY 2016 enacted level. In FY 2015, 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.

Limb Loss Resource Center

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	1	1	1
Average Award	$2,370,000	$2,736,987	$2,736,987
Range of Awards	NA	NA	NA

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

Limb Loss Resource Center

Resource and Program Data

(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	--	--	--	--	1	2,737
Continuations	1	2,730	1	2,737	--	--
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		70		73		73
Total Resources		2,800		2,810		2,810

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

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Paralysis Resource Center

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Paralysis Resource Center	$6,700,000	$7,700,000	$7,700,000	--

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 the 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.

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. Under ACL, the PRC will benefit from extensive ties to ACL's

disability networks including NIDILRR's Spinal Cord Injury Model Systems, 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 2012 .....$6,700,000
FY 2013 .....$6,352,000
FY 2014 .....$6,683,000
FY 2015 .....$6,700,000
FY 2016……..…….$7,700,000

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

Budget Request:

The FY 2017 request is $7,700,000, the same as the FY 2016 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.[113] 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.

[113]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 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--	--	--
New Discretionary	1	6,530	--	--	--	--
Continuations	--	--	1	7,506	1	7,506
Contracts	--	--	--	--	--	--
Interagency Agreements	--	--	--	--	--	--
Program Support /1		170		194		194
Total Resources		6,700		7,700		7,700

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

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Traumatic Brain Injury

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Traumatic Brain Injury	$9,321,000	$9,321,000	$9,321,000	
FTE	2	2	2	0

Note: TBI was funded at the Health Resources and Services Administration in FY 2015, and transferred to ACL at the beginning of FY 2016.

Authorizing Legislation: The Traumatic Brain Injury Reauthorization Act of 2014.

FY 2017 Authorization $8,600,000

Allocation Method .....Formula Grant / Competitive Grant / Contract

Program Description and Accomplishments:
Public-Law 113–196, signed November 26, 2014, gave the Secretary of Health and Human Services (HHS) Secretary the authority to determine the placement of the Traumatic Brain Injury Act within HHS. The Secretary took this opportunity to conduct a review of the program, including extensive engagement with TBI stakeholders, and decided to move the program from the Health Resources and Services Administration (HRSA) to ACL since it closely aligns with ACL's mission and goals to support the rights of older Americans and people of all ages with disabilities to live in their communities throughout their lifespan. ACL and HRSA will continue to collaborate to ensure continued linkages to HRSA's public health programs and networks.

The purpose of the federal Traumatic Brain Injury (TBI) Program is to develop comprehensive, coordinated family and person-centered service systems for individuals who sustain a TBI at the state and community level. TBIs occur when the head suddenly or violently hits an object, or an object enters brain issue causing disruption to typical activity. The majority of TBIs are considered mild although an estimated 80,000-90,000 of individuals who sustain a TBI annually will experience long-term, possibly life-long, challenges due to their injury. In the United States, it is estimated at least 3.2 million Americans require long-term or life-long assistance to perform activities of daily living as a result of TBI.[114] In addition, these national estimates do not include

[114] Traumatic Brain Injury in the United States: A Report to Congress. December 1999. http://www.cdc.gov/ncipc/pub-res/tbi_congress/TBI_in_the_US.PDF

individuals with TBI who are treated in military hospitals. TBI affects all age groups and can cause a range of symptoms, which may include memory loss, difficulty concentrating, confusion, irritability, personality changes, fatigue, and headaches. The CDC's March 2014 Morbidity and Mortality Weekly Report (MMWR) noted that reducing the incidence of TBI requires an integration of public health and health care delivery systems to ensure efficient, effective care and rehabilitation is delivered to those who need it. Public health interventions include primary prevention, early management, and comprehensive approaches to rehabilitation and community reintegration. However, individuals with TBI may also need a variety of services and supports, including rehabilitation, counseling, academic and vocational accommodations, independent living assistance, transportation assistance, and vocational training. These services and supports are often fragmented across different State systems of care, making access difficult for families. Through our various funding streams ACL works across the lifespan and focuses on multiple life domains outside of the health arena focusing on systems change in order to address fragmentation and ensure enhanced service delivery.

The TBI Program consists of two distinct grant efforts: 1) the State Implementation Partnership Grants (competitive grant), and 2) the State Protection and Advocacy (P&A) Systems Grants (formula grant).

State Implementation Partnership Grants

The goal of State Implementation Partnership Grants is to address barriers to needed services encountered by children, youth, and adults with TBI. States and Territories receive funds to assess the need for TBI services and the resources within their State or Territory. This is done through a needs and resource assessment designed to facilitate the development or expansion of a comprehensive, multidisciplinary, and easily accessible systems of care for individuals with TBI and their families. The system of services emphasizes early diagnosis, intervention and resource facilitation consistent with the model of medical home. A multi-year evaluation of state needs and resources indicated the need to focus on four areas for increasing access to rehabilitation and other services for individuals with TBI. The areas are as follows:

- screening to identify individuals with TBI,
- building a trained TBI workforce by providing professional training,
- providing information about TBI to families and referrals to appropriate service providers, and
- actively assisting families in navigating service systems to access resources for care, treatment, and support.

In line with the focus areas of the program, two developmental measures have been established to assess 1) whether individuals with TBI and their families are able to access needed services as a result of their interaction with grantees, and 2) whether professionals receiving training from

grantees report that they are better able to assess and meet the needs of individuals with TBI and their families.

State Protection and Advocacy Systems Grants

The P&A Program is the second component grant of the TBI Program. Section 1253 of the Public Health Service Act recognizes that State Protection and Advocacy (P&A) systems are critical to achieving the goals and objectives of the TBI Program. The P&A Program was authorized as a component of the Federal TBI Program in the Children's Health Act of 2000 to support and protect the rights of individuals with TBI. Since the inception of the program, grants have been awarded to P&A organizations in states, territories, the District of Columbia, and one Native American Consortium to provide advocacy support for individuals with TBI and their families. Formula grants continue to be awarded to 57 states, territories, and one Native American consortium to develop plans to ensure P&A services, including individual and family advocacy, self-advocacy training, self-advocacy assistance, information and referral services, and legal representation. P&A grants are formula based, with an average award of $50,000 for state grantees and $20,000 for territory grantees.

A vital part of P&A activities is providing training and education to consumers and providers. TBI training is tailored to meet the needs of specific audiences, and is intended to increase awareness about legal concerns and individual rights around TBI, provide information on identification and funding of services, and provide support to facilitate full participation in all aspects of life. In FY 2014, P&A grantees provided training to nearly 60,000 individuals. Topics addressed included:

- Signs and symptoms of TBI;
- Disability rights;
- Brain injury supports and services;
- Medicaid waivers;
- Transition planning; and
- Special education services.

These trainings were provided to support groups, independent living centers, service providers, caregivers, individuals with TBI, family members, state employees, hospital staff, university staff, and community representatives. They have resulted in greater awareness for training participants of the needs of persons with TBI and the availability of resources and support services.

Programs	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
State Grants for Demonstration Projects	$5,065,314	$5,065,314	$5,065,314
Protection and Advocacy Grants	$3,099,589	$3,099,589	$3,099,589

Funding History:

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

FY 2012 .....$9,760,000
FY 2013 .....$9,245,000
FY 2014 .....$9,321,000
FY 2015 .....$9,321,000
FY 2016 … $9,321,000
FY 2017 .....$9,321,000

Note: This program was funded at HRSA through FY 2015 and transferred to ACL at the beginning of FY 2016. Funding at HRSA included both grant and administrative funds.

Budget Request:

The FY 2017 request is $9,321,000, the same as the FY 2016 enacted level. TBI was funded at the Health Resources and Services Administration in FY 2015, and transferred to ACL at the start of FY 2016. This funding level currently supports 20 State Implementation Partnership grants which are anticipated to be awarded in FY 2016.

TBI Protection and Advocacy grants will receive approximately $3.1 million in FY 2017 awarded to 57 states and territories, the same as FY 2015 and FY 2016.

The TBI program also provides funding for a TBI technical assistance center (TBITAC) which is being renamed the Traumatic Brain Injury Coordinating Center (TBICC). The center was funded at approximately $442,000 for FY 2014, $500,000 for FY 2015, and is budgeted at $500,000 for FY 2016 and FY 2017 provided funds are available. The TBITAC has been responsible for providing technical assistance to grantees, maintaining a national listserv on issues that affect TBI service delivery with approximately 1,500 subscribers, maintaining an online collaboration space for grantees to share best practices for building and maintaining service-delivery infrastructure, and developing educational materials for the public about TBI.

This request supports the program's efforts to achieve its FY 2017 performance targets. Funding also includes costs associated with the grant review and award process, follow-up performance reviews, and information technology and other program support costs

Outcomes and Outputs Table

ACL will work with all relevant parties to review, develop, or refine performance measures and performance data collection for the Traumatic Brain Injury program.

Grant Awards Tables:

Traumatic Brain Injury: State Implementation Partnership / Protection and Advocacy

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	20 / 57	20/ 57	20*/ 57
Average Award	$250,000 / $54,379	$250,000 / $54,379	$250,000* / $54,379
Range of Awards	$224,344 - $250,000 / $20,000 - $145,854	$224,344 - $250,000 / $20,000 - $145,854	$224,344 - $250,000* / $20,000 - $145,854

*Note: Could potentially change in 2017 or after so that all states receive an award rather than 21.

Resource and Program Data:

Traumatic Brain Injury
(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	57	3,100	57	3,100	57	3,100
New Discretionary	--	--	20	4,981	--	--
Continuations	20	4,981	--	--	20	4,981
Contracts	3	726	3	726	3	726
Interagency Agreements	1	205	1	205	1	205
Program Support /1		310		310		310
Total Resources	81	9,321	81	9,321	81	9,321

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

technology support costs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: TBI Protection and Advocacy State Grants (CFDA 93.873)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	50,000	50,000	50,000	-
Alaska	50,000	50,000	50,000	-
Arizona	54,048	54,427	54,427	-
Arkansas	50,000	50,000	50,000	-
California	146,898	147,545	147,545	-
Colorado	50,000	50,433	50,433	-
Connecticut	50,000	50,000	50,000	-
Delaware	50,000	50,000	50,000	-
District of Columbia	50,000	50,000	50,000	-
Florida	91,382	92,643	92,643	-
Georgia	63,963	64,200	64,200	-
Hawaii	50,000	50,000	50,000	-
Idaho	50,000	50,000	50,000	-
Illinois	73,419	72,281	72,281	-
Indiana	54,324	54,036	54,036	-
Iowa	50,000	50,000	50,000	-
Kansas	50,000	50,000	50,000	-
Kentucky	50,000	50,000	50,000	-
Louisiana	50,000	50,000	50,000	-
Maine	50,000	50,000	50,000	-
Maryland	52,187	52,235	52,235	-
Massachusetts	54,516	54,467	54,467	-
Michigan	64,552	63,655	63,655	-
Minnesota	50,774	50,727	50,727	-
Mississippi	50,000	50,000	50,000	-
Missouri	52,835	52,488	52,488	-
Montana	50,000	50,000	50,000	-
Nebraska	50,000	50,000	50,000	-
Nevada	50,000	50,000	50,000	-
New Hampshire	50,000	50,000	50,000	-

PROGRAM/CFDA NUMBER: TBI Protection and Advocacy State Grants (CFDA 93.873)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	61,268	60,834	60,834	-
New Mexico	50,000	50,000	50,000	-
New York	93,117	92,216	92,216	-
North Carolina	63,505	63,755	63,755	-
North Dakota	50,000	50,000	50,000	-
Ohio	69,525	68,546	68,546	-
Oklahoma	50,000	50,000	50,000	-
Oregon	50,000	50,000	50,000	-
Pennsylvania	73,033	72,010	72,010	-
Rhode Island	50,000	50,000	50,000	-
South Carolina	50,000	50,000	50,000	-
South Dakota	50,000	50,000	50,000	-
Tennessee	53,910	53,898	53,898	-
Texas	110,469	113,152	113,152	-
Utah	50,000	50,000	50,000	-
Vermont	50,000	50,000	50,000	-
Virginia	58,889	59,057	59,057	-
Washington	55,048	55,385	55,385	-
West Virginia	50,000	50,000	50,000	-
Wisconsin	51,927	51,599	51,599	-
Wyoming	50,000	50,000	50,000	-
Subtotal, States	2,949,589	2,949,589	2,949,589	-
American Samoa	20,000	20,000	20,000	-
Guam	20,000	20,000	20,000	-
Northern Mariana Islands	20,000	20,000	20,000	-
Puerto Rico	50,000	50,000	50,000	-
Virgin Islands	20,000	20,000	20,000	-
Subtotal, States and Territories	3,079,589	3,079,589	3,079,589	-
Native American Organizations	20,000	20,000	20,000	-
Undistributed	-	-	-	-
TOTAL	**3,099,589**	**3,099,589**	**3,099,589**	**-**

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 State Health Insurance Assistance Programs (SHIPs) help to address these needs by providing information, outreach, and assistance to seniors and people with disabilities, so that they can effectively 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 objective and unbiased one-on-one counseling to help aging and disabled beneficiaries understand and make optimal use of their Medicare benefits.

Equally important are the programs that help 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 of all ages to obtain Assistive Technology devices and services. The Alzheimer's Disease Initiative Outreach Campaign, funded from the Prevention and Public Health Fund, also helps those struggling with Alzheimer's Disease to access services and plan for future needs.

The FY 2017 request for these programs is $101,397,000, the same as the FY 2016 enacted level. Not included in this figure is $37,500,000 in mandatory funding for the Medicare Improvements for Patients and Providers Act. This request would provide:

- $8,119,000 in discretionary funding for ADRCs, an increase of +$2 million over the FY 2016 enacted level. 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 2016 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), the same as the FY 2016 enacted level. SHIPs provide free, one-on-one counseling and assistance to help Medicare beneficiaries who are aging or have a disability 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 2016 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 their votes, and accessing polling places.

- $32,000,000 for Assistive Technology (AT), a reduction of -$2 million below the FY 2016 enacted level, the result of ACL not requesting funding for the AT Alternative Financing Program. Assistive Technology grants financially supports state programs that maximize the ability of individuals with disabilities of all ages 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.

Aging and Disability Resource Centers

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Aging and Disability Resource Centers	$6,119,000	$6,119,000	$8,119,000	+2,000,000

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

FY 2017 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"[115] (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 in 2008 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 thirteen ADRC/NWD-System states to build on, and promote the nationwide use of lessons learned and best practices from prior ADRC investments.

ADRC/NWD 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

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

from more costly forms of care, including institutional care and unnecessary hospital re-admissions. These systems are a key component in transforming states' long-term services and support programs, work which is not only vital, but ongoing. Services for all populations and all payers provided by ADRC/NWD 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, that are available to them;

- Streamlined access to publicly-supported long-term 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.

ACL, CMS and the Veteran's Health Administration have invested over $200 million in the Aging and Disability Resource Center/No Wrong Door System initiative since 2003. Recent accomplishments include:

- In 2010 the Affordable Care Act provided $50 million dollars over five years to support the further development of the Aging & Disability Resource Center (ADRC) Program. The Affordable Care Act also funded the CMS Balancing Incentive Program to incentivize states to rebalance their Medicaid LTSS spending and required participating states to develop statewide No Wrong Door Systems to make it easier for consumers to learn about and access LTSS. CMS used the ADRC model to provide guidance to the twenty-five states that received Balancing Incentive Program grants and committed to building a NWD System.

- In 2011, AARP in collaboration with The Commonwealth Fund, and The Scan Foundation published "Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers", the first state scorecard on LTSS. The Scorecard measures state's progress in developing high performing

LTSS systems. ADRC's were included as one of the key measures of access in the 2011 Report and the second edition published in 2014.

- In 2012, 8 states received 3-year grants to transform their state LTSS access functions into a high performing No Wrong Door system that would serve all populations. These states also committed to working with Federal partners to develop national guidelines for state ADRC/NWD System that all states could use. The major learnings from this investment included the critical leadership role the state must play in the design, implementation and ongoing administration of a ADRC/NWD System. This includes having the full support of the Governor and key Cabinet-level officials and the active involvement of the multiple state agencies that have a role in LTSS including the State Medicaid Agency. The learnings from this investment in these 8 states resulted in development of the guidelines in "Key Elements of a NWD System of Access to LTSS for All Populations and Payers" which is available at http://www.acl.gov/Programs/CIP/OCASD/ADRC/docs/NWD-National-Elements.pdf

- In 2014, using the lessons learned from the 2012 state grantees, 25 states received one year planning grants to develop plans to transform their multiple LTSS access programs and functions into a single statewide ADRC/NWD System for all populations and all payers. In 2015, 5 of the 25 state planning grantees received 3-year awards to implement their planning grants and the 8 states awarded 3-year grants in 2012 received a one-year grant to continue their work in developing their ADRC/NWD System.

- In 2015, CMS issued the "No Wrong Door System Reference Document for Medicaid Administrative Claiming Guidance" to support state efforts to develop statewide ADRC/NWD Systems. This guidance can be found at: No Wrong Door System and Medicaid Administrative Claiming Reimbursement Guidance page. It is estimated that if all states took advantage of this guidance, it would generate over $100 million available annually to support state's operations of their NWD/ADRC systems.

- The Veterans Health Administration is using the ADRC\NWD System to deliver Veteran Directed Home and Community Based Services (VD-HCBS) to help Veterans with disabilities to continue living in the community and to have control over the LTSS they receive. To date, the Veterans Health Administration has invested $100 million into the VD-HCBS program which has served over 3,500 Veterans nationally. The VD-HCBS program is available in 31 states, the District of Columbia and Puerto Rico.

Funding History:

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

FY 2012 .....$16,457,000
FY 2013 .....$15,585,000
FY 2014 .....$15,347,000
FY 2015 .....$6,119,000
FY 2016……....$6,119,000

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

Budget Request:

ACL's FY 2017 request for ADRCs is $8,119,000 a +$2,000,000 increase over the FY 2016 enacted level.

ACL plans to invest $8,119,000 to fund state grantees to continue their development and operation of sustainable ADRC/NWD systems based on the national guidelines established by ACL, the Centers for Medicare and Medicaid Services (CMS) and the Veterans Health Administration (VHA). Funded states will replicate the national guidelines 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 funded by this proposal to develop sustainable ADRC/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 states will show progress towards guidelines established by ACL, CMS, and VHA for ADRC/NWD Systems and be required to report on its progress and performance.

- Funded states will commit to using Medicaid administrative funding to support the ADRC/NWD system infrastructure on an on-going basis; and

- Funded states will ensure that local ADRC/NWD system sites:
    - Include a full range of organizations that play a formal reimbursable role in carrying out the ADRC/NWD system functions they have been designated by the state to perform to ensure the state's ADRC/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' ADRC/NWD systems, including local sites, will use the Federally-prescribed reporting data to continually evaluate performance and make improvements in ADRC/NWD systems at the state and local site level. Funded states will actively involve consumer stakeholders in this process.

Grant Awards Tables:

Aging and Disability Resource Centers
(Dollars in Thousands)

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	20	14	14
Average Award	$261,500	$363,786	$453,571
Range of Awards	$6,617 - $850,000	$6,617 - $850,000	$6,627 - $850,000

Aging and Disability Resource Centers
(Dollars in thousands)

Mechanism	FY 2015 Final #	FY 2015 Final $	FY 2016 Enacted #	FY 2016 Enacted $	FY 2017 President's Budget #	FY 2017 President's Budget $
Grants:						
Formula	--	- -	--	- -	--	- -
New Discretionary	7	4,150	9	1,180	--	--
Continuations	13	1,080	5	3,913	14	6,350
Contracts	1	864	1	950	1	1,669
Interagency Agreements	--	- -	--	- -	--	- -
Program Support /1		25		76		100
Total Resources		6,119		6,119		8,119

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

State Health Insurance Assistance Programs

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
State Health Insurance Assistance Programs (SHIP)	$52,115,000	$52,115,000	$52,115,000	--
FTE	8	7	7	--

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

FY 2017 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 14,000 (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 understand and make optimal use of their Medicare benefits and 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 2014, SHIPs had over 3.4 million one-on-one client contacts and more than 93,000 public and media events. SHIP activities align with the objective of developing a comprehensive, coordinated and cost-effective system of long-term services and

supports that helps elderly individuals and people with disabilities maintain their health and independence in their homes and communities.

Nearly two-thirds of the 54 state SHIP programs are already administered by State Units on Aging, with 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 other ACL programs, 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, people eligible for both Medicaid and Medicare, and people with cognitive and/or mental disabilities.

Funding History:

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

FY 2012 ..... $52,115,000
FY 2013 ..... $46,040,000
FY 2014 ..... $52,115,000
FY 2015 ..... $52,115,000
FY 2016 … $52,115,000

Budget Request:

The SHIP budget request for FY 2017 is $52,115,000, the same as the FY 2016 enacted level. This includes funding for 7 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 program administration. 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 55 million Americans who depend on Medicare for their health care are multifaceted and diverse. More than one-quarter of beneficiaries have cognitive impairments;[116] more than one-third have limitations in activities of daily living such as eating and dressing; one-fifth have not graduated from high school; and more than one in ten are over 85 years of age.[117] These beneficiaries can face any number of difficulties in trying to navigate the health care system. Recent changes in the system as a result of the Affordable Care Act (ACA) provide opportunities to beneficiaries for improved care, including increased Medicare preventive services and reduced out-of-pocket costs during the Medicare Part D coverage gap or "donut hole." These opportunities have increased the responsibilities of the SHIP counselors in terms of training, outreach and one-on-one counseling. The counselor knowledge base also now needs to include the inter-relationship of Medicare, expanded state Medicaid programs, and the new Health Insurance Marketplace 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 complement to the information provided more generally through www.Medicare.gov and 1-800-MEDICARE.

ACL will also seek legislation to fix a problem related to funding for the SHIP program that is provided for Medicare Improvements for Patients and Providers Act (MIPPA) activities. Currently this mandatory funding, which ACL awards as SHIP grantees, is appropriated to the Centers for Medicare and Medicaid and then transferred to ACL, a vestige of the period when the SHIP program was overseen by CMS. The proposed fix, in recognition that SHIP is now part of ACL as of 2014, would amend the authorization so that this funding is authorized directly to ACL.

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[116] Centers for Medicare & Medicaid Services, The characteristics and perceptions of the Medicare population. Data from the 2013 Medicare Current Beneficiary Survey. http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Data-Tables-Items/2013CNP.html. Accessed 10 January 2016

[117] Juliette Cubanski, Christina Swoope, Cristina Boccuti, Gretchen Jacobson, Giselle Casillas, Shannon Griffin, and Tricia Neuman. A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers. Kaiser Family Foundation. Mar 20, 2015. http://kff.org/report-section/a-primer-on-medicare-what-is-the-role-of-medicare-for-dual-eligible-beneficiaries/+

Outputs Table:

State Health Insurance Assistance Programs

Indicator	Year and Most Recent Result /	FY 2016 Projection	FY 2017 Projection	FY 2017 Projection +/-FY 2016 Projection
Output AH: Number of SHIP Public Media Events *(Output)*	FY 2015: 97,500	97,500	97,000	Maintain
Output AI: Number of SHIP Client Contacts *(Output)*	FY 2015: 3.5 M	3.6 M	3.6 M	Maintain

Grant Awards Table:

State Health Insurance Assistance Programs Grant Awards

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget
Number of Awards	59	55	55
Average Award	$835,781	$890,494	$890,494
Range of Awards	$40,870 - $5,028,121	$40,870 - $5,028,121	$40,870 - $5,028,121

Resource and Program Data:

State Health Insurance Assistance Program
(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	--	--	--	--		
New Discretionary	4	390	--	--	55	48,977
Continuations	55	48,921	55	48,977	--	--
Contracts	4	1,072	3	1,192	3	1,192
Interagency Agreements	1	124	1	147	1	147
Program Support /1		1,608		1,799		1,799
Total Resources		52,115		52,115		52,115

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

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Voting Access for Individuals with Disabilities

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017+/- FY 2016
Voting Access for People with Disabilities	$4,963,000	$4,963,999	$4,963,000	--
FTE	--	--	.3	+0.3

Authorizing Legislation: Section 291 of the Help America Vote Act

FY 2017 Authorization .....Such Sums

Allocation Method .....Formula Grant

Program Description and Accomplishments:

The Voting Access for Individuals with Disabilities program authorized by the Help America Vote Act (HAVA) provides formula grants to support Protection and Advocacy (P&A) 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. 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 two-year awards.

HAVA P&A grantees use these funds to promote systematic efforts to ensure that 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. As a result of the training and technical assistance, P&As 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 2012 .....$5,235,000
FY 2013 .....$4,961,000
FY 2014 .....$4,963,000
FY 2015 .....$4,963,000
FY 2016 .....$4,963,000

Budget Request:

The FY 2017 request for Voting Access for Individuals with Disabilities is $4,963,000, unchanged from the FY 2016 enacted level. Beginning in FY 2017, An example of the activities undertaken with HAVA 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 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	55	55	55
Average Award	$82,421	$82,421	$81,535
Range of Awards	$35,000 - $348,584	$35,000 - $347,489	$35,000 - $339,428

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

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

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

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
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	348,584	347,489	339,428	(8,061)
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	177,808	178,151	174,018	(4,133)
Georgia	90,866	90,425	88,327	(2,098)
Hawaii	70,000	70,000	70,000	-
Idaho	70,000	70,000	70,000	-
Illinois	117,146	115,350	112,674	(2,676)
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	89,988	88,746	86,687	(2,059)
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 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	80,928	80,044	78,187	(1,857)
New Mexico	70,000	70,000	70,000	-
New York	178,702	176,834	172,732	(4,102)
North Carolina	89,555	89,052	86,986	(2,066)
North Dakota	70,000	70,000	70,000	-
Ohio	105,222	103,830	101,421	(2,409)
Oklahoma	70,000	70,000	70,000	-
Oregon	70,000	70,000	70,000	-
Pennsylvania	116,161	114,514	111,857	(2,657)
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	240,512	241,409	235,808	(5,601)
Utah	70,000	70,000	70,000	-
Vermont	70,000	70,000	70,000	-
Virginia	75,118	74,565	72,835	(1,730)
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	4,430,409	4,390,960	(39,449)
American Samoa	35,000	35,000	35,000	-
Guam	35,000	35,000	35,000	-
Northern Mariana Islands	-	-	-	-
Puerto Rico	70,000	70,000	70,000	-
Virgin Islands	35,000	35,000	35,000	-
Subtotal, States and Territories	4,615,590	4,605,409	4,565,960	(39,449)
Undistributed 1/	347,410	357,591	397,040	39,449
TOTAL	**4,963,000**	**4,963,000**	**4,963,000**	**-**

1/ This line reflects the amount reserved from the HAVA appropriation for statutory related activities, including training, technical assistance, grant systems, and review costs. Beginning in FY 2017, the undistributed line also includes an amount reserved from the HAVA appropriation for FTE and related overhead costs to conduct program monitoring and oversight. Funds unused for these purposes at the end of the year are allocated to States.

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Assistive Technology

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	2017 +/- FY 2016
Assistive Technology……	$31,000,000	$32,000,000	$32,000,000	--
Alternative Financing Program.....	$2,000,000	$2,000,000	--	-$2,000,000
Total……..	$33,000,000	$34,000,000	$32,000,000	--
FTE ……	--	--	.9	+0.9

Authorizing Legislation: Assistive Technology Act of 1998 as amended

FY 2017 Authorization .....Expired[118]

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

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. Examples of such devices include 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, funding, access, provision, and training for 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;

[118] 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.

- 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;
- Coordination of AT-related activities among state and local agencies and other private entities;
- Awareness and facilitation of 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 territories 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 further 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 FY 2015 state distributions are based on the July 1, 2013 estimates published in December 2013. The FY 2016 state distributions will be based on the July 1, 2014 estimates published in December 2014. The FY 2017 state distributions will be based on the July 1, 2015 estimates published in December 2015.

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 to 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. Territories 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 FY 2015 state distributions are based on the July 1, 2013 estimates published in December 30, 2013. The FY 2016 state distributions will be based on the July 1, 2014 estimates published in December 2014. The FY 2017 state distributions will be based on the July 1, 2015 estimates published in December 2015.

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 is considered 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. 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 the Assistive Technology Act Programs during the past five years is as follows:

FY2012 .....$30,839,603
FY2013 .....$29,226,000
FY2014 .....$31,000,000
FY2015 .....$31,000,000
FY2016 .....$32,000,000

Funding for the Alternative Financing Program during the past five years is as follows:

FY2012 .....$1,996,220
FY2013 .....$1,892,000
FY2014 .....$2,000,000
FY2015 .....$2,000,000
FY2016 .....$2,000,000

Budget Request:

ACL's FY 2017 request for Assistive Technology Act programs is $32,000,000, the same as the FY 2016 enacted level. At this level, 10 States would be funded at a level below the $410,000 minimum. No funding is requested for the Alternative Financing Program, a reduction of -$2,000,000 below the FY 2016 enacted level.

The request includes $26,554,000 for the AT State Grant program, the same as the FY 2016 enacted level. These funds will be used to carry out the third 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.

The request also includes $4,450,000 for the Protection and Advocacy for Assistive Technology (PAAT) program, the same as the FY 2016 enacted level. At this level, 28 states would receive $50,000, the minimum amount allowed by statute to carry out this program. Territories would each receive $30,000. Funds would assist individuals with disabilities of all ages in the acquisition, utilization, or maintenance of AT services or devices.

The request would also provide $996,000 for National Activities, the same as the FY 2016 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, which are all supported by competitively awarded grants. In FY 2017, funds would be used to provide state training and technical assistance, build out the AT Act informational website, and continue support for the AT Act data collection activities.

Alternative Financing Program

No funding is requested for the Assistive Technology (AT) Alternative Financing Program (AFP), a one-year competitive-grant program no longer authorized under current law, which was

funded at $2 million through appropriations in FY 2016. In FY 2005, Congress amended the AT Act to eliminate the separate AFP authorization and instead authorized an AT State grant program that is inclusive of financing activities, including alternative financing loan programs. Since there is no separate AFP discretionary grant program authorization in the AT Act, ACL is not requesting such funding within the AT Act appropriations request for FY2017.

Outcomes and Outputs 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.

Grant Awards Tables:

Assistive Technology Total Grant Awards

	FY 2015 Final	**FY 2016 Enacted**	**FY 2017 President's Budget**
Number of Awards	119	116	113
Average Award	$277,261	$284,220	$274,137
Range of Awards	$100,000 - $1,032,987	$100,000 - $1,091,612	$100,000- $1,074,635

Assistive Technology
(Dollars in thousands)

Mechanism	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
	#	$	#	$	#	$
Grants:						
Formula	113	30,004	113	30,978	113	30,978
New Discretionary	3	2,000	3	1,992	--	--
Continuations	3	990	--	-	--	--
Contracts	--	-	2	962	2	962
Interagency Agreements	--	-	--	-	--	--
Program Support /1		6		68		60
Total Resources		33,000		34,000		32,000

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Assistive Technology State Grants (CFDA 84.224A)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	435,779	449,771	445,536	(4,235)
Alaska	422,568	431,469	428,809	(2,660)
Arizona	597,228	614,250	609,294	(4,956)
Arkansas	462,071	473,712	470,199	(3,513)
California	1,032,987	1,091,874	1,074,635	(17,239)
Colorado	456,167	471,379	466,951	(4,428)
Connecticut	395,956	408,305	404,550	(3,755)
Delaware	406,287	415,498	412,763	(2,735)
District of Columbia	364,080	372,978	370,349	(2,629)
Florida	666,456	701,384	691,386	(9,998)
Georgia	579,562	600,656	594,411	(6,245)
Hawaii	439,901	449,746	446,825	(2,921)
Idaho	413,426	423,587	420,584	(3,003)
Illinois	586,957	610,511	603,200	(7,311)
Indiana	461,618	477,809	472,905	(4,904)
Iowa	435,895	447,790	444,222	(3,568)
Kansas	397,029	408,621	405,132	(3,489)
Kentucky	458,031	471,516	467,449	(4,067)
Louisiana	485,442	499,264	495,106	(4,158)
Maine	452,886	462,506	459,619	(2,887)
Maryland	482,588	498,213	493,546	(4,667)
Massachusetts	502,007	518,603	513,643	(4,960)
Michigan	640,597	660,694	654,521	(6,173)
Minnesota	475,969	490,874	486,406	(4,468)
Mississippi	381,564	393,205	389,681	(3,524)
Missouri	540,829	556,320	551,621	(4,699)
Montana	435,334	444,639	441,870	(2,769)
Nebraska	445,890	456,271	453,173	(3,098)
Nevada	405,603	417,447	413,982	(3,465)
New Hampshire	420,649	430,278	427,393	(2,885)

PROGRAM/CFDA NUMBER: Assistive Technology State Grants (CFDA 84.224A)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	470,373	489,504	483,703	(5,801)
New Mexico	434,326	444,847	441,671	(3,176)
New York	675,651	708,323	698,383	(9,940)
North Carolina	532,464	553,294	547,108	(6,186)
North Dakota	362,497	371,524	368,864	(2,660)
Ohio	545,650	567,860	561,042	(6,818)
Oklahoma	420,047	432,964	429,102	(3,862)
Oregon	412,921	426,057	422,159	(3,898)
Pennsylvania	672,782	696,350	689,075	(7,275)
Rhode Island	360,958	370,261	367,480	(2,781)
South Carolina	505,737	520,063	515,835	(4,228)
South Dakota	411,024	420,122	417,419	(2,703)
Tennessee	432,336	448,702	443,816	(4,886)
Texas	847,552	892,445	879,742	(12,703)
Utah	445,375	457,285	453,781	(3,504)
Vermont	398,832	407,585	404,968	(2,617)
Virginia	484,306	502,926	497,360	(5,566)
Washington	468,676	485,973	480,891	(5,082)
West Virginia	413,556	423,756	420,670	(3,086)
Wisconsin	456,042	471,125	466,542	(4,583)
Wyoming	355,005	363,720	361,119	(2,601)
Subtotal, States	24,787,466	25,603,856	25,360,491	(243,365)
American Samoa	125,000	125,528	125,507	(21)
Guam	125,000	126,558	126,496	(62)
Northern Mariana Islands	125,000	125,498	125,478	(20)
Puerto Rico	416,534	428,256	424,520	(3,736)
Virgin Islands	125,000	126,008	125,968	(40)
Subtotal, States and Territories	25,704,000	26,535,704	26,288,460	(247,244)
Undistributed 1/	-	18,296	265,540	247,244
TOTAL	**25,704,000**	**26,554,000**	**26,554,000**	**-**

1/ The undistributed line reflects the amount reserved from the Assistive Technology State Grants appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ADMINISTRATION FOR COMMUNITY LIVING

FY 2017 DISCRETIONARY STATE FORMULA GRANTS

PROGRAM/CFDA NUMBER: Assistive Technology Protection and Advocacy (CFDA 84.343)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alabama	51,229	53,530	52,869	(661)
Alaska	50,000	50,000	50,000	-
Arizona	70,230	74,306	73,389	(917)
Arkansas	50,000	50,000	50,000	-
California	406,256	428,326	423,037	(5,289)
Colorado	55,835	59,121	58,391	(730)
Connecticut	50,000	50,000	50,000	-
Delaware	50,000	50,000	50,000	-
District of Columbia	50,000	50,000	50,000	-
Florida	207,225	219,594	216,883	(2,711)
Georgia	105,899	111,460	110,084	(1,376)
Hawaii	50,000	50,000	50,000	-
Idaho	50,000	50,000	50,000	-
Illinois	136,528	142,183	140,428	(1,755)
Indiana	69,640	72,820	71,921	(899)
Iowa	50,000	50,000	50,000	-
Kansas	50,000	50,000	50,000	-
Kentucky	50,000	50,000	50,000	-
Louisiana	50,000	51,326	50,692	(634)
Maine	50,000	50,000	50,000	-
Maryland	62,835	65,971	65,157	(814)
Massachusetts	70,932	74,460	73,540	(920)
Michigan	104,876	109,391	108,040	(1,351)
Minnesota	57,446	60,239	59,496	(743)
Mississippi	50,000	50,000	50,000	-
Missouri	64,057	66,933	66,107	(826)
Montana	50,000	50,000	50,000	-
Nebraska	50,000	50,000	50,000	-
Nevada	50,000	50,000	50,000	-
New Hampshire	50,000	50,000	50,000	-

PROGRAM/CFDA NUMBER: Assistive Technology Protection and Advocacy (CFDA 84.343)

State/Territory	FY 2015 Actual	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
New Jersey	94,317	98,665	97,447	(1,218)
New Mexico	50,000	50,000	50,000	-
New York	208,267	217,970	215,279	(2,691)
North Carolina	104,372	109,767	108,412	(1,355)
North Dakota	50,000	50,000	50,000	-
Ohio	122,630	127,983	126,403	(1,580)
Oklahoma	50,000	50,000	50,000	-
Oregon	50,000	50,000	50,000	-
Pennsylvania	135,379	141,153	139,410	(1,743)
Rhode Island	50,000	50,000	50,000	-
South Carolina	50,605	53,344	52,685	(659)
South Dakota	50,000	50,000	50,000	-
Tennessee	68,846	72,296	71,403	(893)
Texas	280,304	297,567	293,893	(3,674)
Utah	50,000	50,000	50,000	-
Vermont	50,000	50,000	50,000	-
Virginia	87,546	91,910	90,776	(1,134)
Washington	73,884	77,949	76,987	(962)
West Virginia	50,000	50,000	50,000	-
Wisconsin	60,862	63,555	62,771	(784)
Wyoming	50,000	50,000	50,000	-
Subtotal, States	4,100,000	4,241,819	4,205,500	(36,319)
American Samoa	30,000	30,000	30,000	-
Guam	30,000	30,000	30,000	-
Northern Mariana Islands	30,000	30,000	30,000	-
Puerto Rico	50,000	50,000	50,000	-
Virgin Islands	30,000	30,000	30,000	-
Subtotal, States and Territories	4,270,000	4,411,819	4,375,500	(36,319)
Native American Organizations 1/	30,000	30,000	30,000	-
Undistributed 2/	-	$8,181	445,000	436,819
TOTAL	**4,300,000**	**4,450,000**	**4,850,500**	**400,500**

1/ The Tribal Organizations line reflects the funds provided to Native Americans in New Mexico.

2/ The undistributed line reflects the amount reserved from the Assistive Technology Protection and Advocacy appropriation for: statutory related activities, including contingencies; FTE and related overhead costs to conduct program monitoring and oversight; and for program support costs including information and systems, technical assistance and evaluation. Funds unused for these purposes at the end of the year are allocated to States.

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Alzheimer's Disease Initiative - Outreach Campaign

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Alzheimer's Disease Initiative—Outreach (Prevention Fund)	$4,200,000	$4,200,000	$4,200,000	--

Note: Funding in FY 2015 and FY 2016 was provided from the Prevention and Public Health Fund, and FY 2016 and FY 2017 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 2017 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. An estimated 5.2 million individuals in the United States are living with Alzheimer's disease and related dementias (ADRD), and that number is expected to increase by 40 percent by 2025.[119] 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

[119] Alzheimer's Association. *2014 Alzheimer's Disease Facts and Figures.* Accessed April 14, 2014 at http://www.alz.org/alzheimers_disease_facts_and_figures.asp .

taken previously. Given the success of the television spot, including awards from a health care and an advertising organization, this approach may reach a new and broader audience.

The campaign's goal is to inform people caring for people with Alzheimer's disease that there are federal, state, local, and nonprofit resources available to help them. The campaign highlights the alzheimers.gov website and deploys television, radio and print advertisements as well as search engine optimization and advertisements on specific web sites. Traffic to the new web site will be studied to determine what information care givers appear to value most and to adjust outreach strategies accordingly.

Funding History:

FY 2012 .....$4,000,000
FY 2013 .....$150,000
FY 2014 .....$4,200,000
FY 2015 .....$4,200,000
FY 2016… $4,200,000

Budget Request:

For FY 2017, ACL requests $4,200,000 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 in FY 2016 levels as set in the PPHF.

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 2017 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.

Alzheimer's Disease Initiative--Outreach Campaign
Resource and Program Data
(Dollars in thousands)

	FY 2015 Final		FY 2016 Enacted		FY 2017 President's Budget	
Mechanism	**#**	**$**	**#**	**$**	**#**	**$**
Grants:						
		-		-		-
Formula	--	-	--	-	--	-
		-		-		-
New Discretionary	--	-	--	-	--	-
		-		-		-
Continuations	--	-	--	-	--	-
Contracts	1	4,058	1	4,139	1	4,139
Interagency		-		-		-
Agreements	--	-	--	-	--	-
Program Support /1		142		61		61
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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Program Administration

	FY 2015 Final	FY 2016 Enacted	FY 2017 President's Budget	FY 2017 +/- FY 2016
Program Administration	$37,709,000	$40,063,000	$41,063,000	+$1,000,000
FTE[120]……	178.6	177.6	185.6	+8

Note: Funding and FTE for FY 2015 reflects the annualized dollars and FTE transferred to ACL for program administration, based on a determination order between the Department of Education and ACL. Funding for the programs was directly appropriated to ACL in FY 2016.

Authorizing Legislation: Older Americans Act (OAA), the Developmental Disabilities Assistance and Bill of Rights Act (DD Act), the Help America Vote Act (HAVA), the Assistive Technology (AT) Act, the Rehabilitation Act, 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 2017 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 (ADD), 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). ACL was created with the mission of assisting seniors and people of all

[120] FTE numbers above for Program Administration only reflect those FTE funded from the Program Administration budget line. Other sources of funding for ACL FTE include staff charged to reimbursable and mandatory funding sources such as the Health Care Fraud and Abuse Control account (7 FTE in each of FY 2015-FY 2017), Medicare Improvements for Patients and Providers Act (MIPPA) activities (5 FTE in FY 2016 and 6 FTE in FY 2017), and funding received from the Centers for Medicare & Medicaid Services for activities performed on behalf of dual Medicare/Medicaid beneficiaries funds (3 FTE in FY 2015-FY 2017). ACL also supports a limited number of FTE from within its various program line items All FTE charged to program dollars are included in the appropriate narrative tables in other sections of this document.

ages with disabilities to live independently and to be able to fully participate in their communities. In the ensuing years, ACL has continued to grow, bringing together other programs from inside and outside of HHS that share its mission. The FY 2014 appropriation transferred the State Health Insurance Assistance Program (SHIP) and the Paralysis Resource Center program to ACL. Later in 2014, as part of the 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 was followed in FY 2015 by the Limb Loss Resource Center, transferred from the Centers for Disease Control and Prevention, and at the beginning of FY 2016, the Traumatic Brain Injury (TBI) program, transferred from the Health Resources and Services Administration (HRSA).

Program Administration funds the direction and support of ACL programs established under the Older Americans Act (OAA), Developmental Disabilities Assistance and Bill of Rights Act (DD Act), Rehabilitation Act, Help America Vote Act (HAVA), Assistive Technology (AT) Act, Public Health Services Act (PHSA), Elder Justice Act, Medicare Improvements for Patients and Providers Act (MIPPA), and Omnibus Budget and Reconciliation Act (OBRA) of 1990. The majority of these funds cover salaries and benefits, 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 2016, Program Administration funding will support 177.6 of ACL's 206 FTE in both central office and in ACL's regional offices. Other sources of funding for ACL FTE include staff charged to reimbursable and mandatory funding sources such as the Health Care Fraud and Abuse Control account, Medicare Improvements for Patients and Providers Act (MIPPA) activities, and funding received from the Centers for Medicare & Medicaid Services for activities performed on behalf of dual Medicare/Medicaid beneficiaries. ACL also supports a limited number of FTE from within its various program line items, as described in more detail below.

Funding History:

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

FY 2012[121]	$29,558,000	145	FTE
FY 2013	$28,064,000	135	FTE
FY 2014	$29,802,000	135	FTE
FY 2015[122]	$37,709,000	184	FTE
FY 2016	$40,063,000	178.6	FTE

Note that the above FTE numbers do not include FTE funding from reimbursable or program sources.

Budget Request:

ACL's request includes $41,063,000 and 185.6 FTE for Program Administration, a net increase of +$1,000,000 and +8 FTE over the FY 2016 enacted level. This funding increase is necessary to fund higher occupancy and external services costs projected as a result of ACL's growth as well its headquarters move to the Switzer building. In prior years additional administrative resources have been provided to fund the costs related to ACL's headquarters relocation and to meet the needs of programs transferred in from other agencies. Remaining costs will fund the FY 2016 1.6% pay raise.

Higher Occupancy Costs

In December 2015, ACL relocated to the Mary E. Switzer building as part of a long-standing plan to consolidate the HHS real estate footprint by moving from leased space into Federally owned and managed buildings. Headquarters space in the Switzer building was established prior to the transfer to ACL of programs and 40 staff positions from the Department of Education. Additional space for these staff was negotiated on part of the second floor of the Switzer building. The FY 2016 appropriation provided the requested increase of $850,000 to cover increased rent related to the 1st floor space. ACL experienced higher than expected rental costs covering a second floor build out in FY 2016 and requests an increase in funding to cover the higher rental costs in FY 2017. In addition to higher space-related costs, the actual move has highlighted other occupancy costs related to IT, further design and configuration work, and

[121] Funding for FY 2012 through FY 2014 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).

[122] Funding and FTEs for FY 2015 reflect annualized dollars and FTE actually transferred to ACL for program administration, based on a determination order between the Department of Education and ACL.

additional modifications that were not foreseen prior to the move. Together, $415,000 in additional funding is requested to cover these higher occupancy costs.

External Services/Investments in ACL staff development

The majority of ACL's Program Administration budget request covers resources needed for fixed costs including salaries and benefits, shared services/JFAs, and rent. Expenditures for these three activities require approximately 90% of ACL's administrative resources. This leaves ACL with extremely limited resources to invest either in its employees or in upgrades to its systems and infrastructure. Therefore, ACL requests that $260,000 of its request be used, first, to offset any additional increases in either its external services or JFAs, and second, for investment in management support and in its workforce. Simply put, hiring additional staff is not enough—ACL needs to make continued investments in their training and development if it wishes to remain a cutting edge agency. ACL also needs to invest to insure that its business processes and systems reflect the agency's expanding mission.

FY 2017 1.6% Pay Raise

In FY 2017, ACL estimates that approximately $325,000 in additional funding is needed to pay for the President's proposed 1.6% FY 2017 pay raise.

FTE

In Program Administration, FTE levels are expected to increase in FY 2017 by 9 to account for projected hiring in FY 2016 that is not expected to occur until late in the fiscal year resulting in the need to annualize these hires in FY 2017. FY 2016 hiring primarily reflects the need to staff and fully support the programs that were transferred from the Department of Education in FY 2015 by the Workforce Innovation and Opportunities Act.

While ACL has received increases in its Program Administration appropriation in recent years, as noted above these resources have been almost exclusively related to the costs of ACL's central office relocation, and the need to support the new programs that have been transferred to the agency since ACL's creation. As such, ACL has not been able to make many of the needed investments in people and systems that would help to ensure the integrity of its core programs. These programs comprise over 80% of ACL's budget awarded through 15 formula grant programs to states and tribes, making it critical that the agency provide its grantees with the support they need to effectively and efficiently serve older adults and people with disabilities, as well as their families and caregivers.

Therefore, beginning in FY 2017, ACL will add an additional 18 FTE to conduct program monitoring and oversight and to provide technical assistance to our formula grantees. These 18 additional FTE would be responsible for performing oversight, conducting program evaluations, and providing technical assistance to enhance program performance and systems development

for the core formula grant programs. With the addition of these 18 FTE, ACL will be able to increase the resources devoted to program monitoring and integrity activities from approximately 23 FTE to 41 FTE. When fully implemented in FY 2017, these added resources will allow ACL to adequately staff both its central and regional office teams to engage more effectively with staff at the tribal, state and local levels to ensure programs are operating effectively and meeting the needs of the populations ACL serves.

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Object Classification Table - Direct

Administration for Community Living

(Dollars in Thousands)

	FY 2016 Base	FY 2017 Request	FY 2017 +/- FY 2016
Personnel compensation:			
Full-time permanent (11.1).....	19,333	22,637	3,304
Other than full-time permanent (11.3).....	2,123	2,248	125
Other personnel compensation (11.5).....	564	564	0
Military personnel (11.7).....	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation.....	**22,020**	**25,448**	**3,429**
Civilian benefits (12.1).....	5,399	6,320	921
Military benefits (12.2).....	-	-	-
Benefits to former personnel (13.0).....	-	-	-
Subtotal Pay Costs, ...	**27,419**	**31,768**	**4,349**
Travel and transportation of persons (21.0).....	568	568	-
Transportation of things (22.0).....	2	2	-
Rental payments to GSA (23.1).....	2,811	3,092	281
Communication, utilities, and misc. charges (23.3)	374	374	-
Printing and reproduction (24.0).....	15	15	-
Other Contractual Services:			
Advisory and assistance services (25.1).....	25,539	25,504	-35
Other services (25.2).....	167	167	0
Purchase of goods and services from.....	9,732	11,038	1,307
government accounts (25.3).....	-	-	-
Operation and maintenance of facilities (25.4).....	-	-	-
Research and Development Contracts (25.5)....	-	-	-
Medical care (25.6).....	-	-	-
Operation and maintenance of equipment (25.7)...	-	-	-
Subsistence and support of persons (25.8).....	-	-	-
Subtotal Other Contractual Services.....	**35,438**	**36,709**	**1,271**
Supplies and materials (26.0).....	50	50	0
Equipment (31.0).....	35	35	0
Land and Structures (32.0)	-	-	-
Investments and Loans (33.0.....	-	-	-
Grants, subsidies, and contributions (41.0).....	1,846,025	1,868,568	22,543
Interest and dividends (43.0).....	-	-	-
Refunds (44.0).....	-	-	-
Subtotal Non-Pay Costs.....	**1,885,316**	**1,909,411**	**24,095**
Total Direct BA by Object Class.....	**1,912,735**	**1,941,179**	**28,444**
Average Cost per FTE			
(excluding reimbursables from other agencies)			
Civilian FTEs	184	211	27
Civilian Average Salary/Benefits	149,016	150,560	1,544
Percent change		1.04%	
Military FTEs	0	0	0
Military Average Salary	N/A	N/A	N/A
Percent change	N/A	N/A	N/A
Total OPDIV FTEs	184	211	27
Total OPDIV Average Salary/Benefits	149,016	150,560	1,544
Percent change		1.04%	

Salaries and Expenses

Administration for Community Living
(Dollars in Thousands)

	FY 2016 Base	FY 2017 Request	FY 2017 +/- FY 2016
Personnel compensation:			
Full-time permanent (11.1).....	19,333	22,637	3,304
Other than full-time permanent (11.3).....	2,123	2,248	125
Other personnel compensation (11.5).....	564	564	-
Military personnel (11.7).....	-	-	-
Special personnel services payments (11.8)	-	-	-
Subtotal personnel compensation.....	**22,020**	**25,448**	**3,429**
Civilian benefits (12.1).....	5,399	6,320	921
Military benefits (12.2).....	-	-	-
Benefits to former personnel (13.0).....	-	-	-
Total Pay Costs.....	**27,419**	**31,768**	**4,349**
Travel and transportation of persons (21.0).....	568	568	-
Transportation of things (22.0).....	2	2	-
Rental payments to GSA (23.1).....	2,811	3,092	281
Communication, utilities, and misc. charges (23.3)	374	374	-
Printing and reproduction (24.0).....	15	15	-
Other Contractual Services:.....			
Advisory and assistance services (25.1).....	25,539	25,504	(35)
Other services (25.2).....	167	167	-
Purchase of goods and services from.....	9,732	11,038	1,307
government accounts (25.3).....	-	-	-
Operation and maintenance of facilities (25.4).....	-	-	-
Research and Development Contracts (25.5)....	-	-	-
Medical care (25.6).....	-	-	-
Operation and maintenance of equipment (25.7)...	-	-	-
Subsistence and support of persons (25.8).....	-	-	-
Subtotal Other Contractual Services.....	**35,438**	**36,709**	**1,271**
Supplies and materials (26.0).....	**50**	**50**	**-**
Total Non-Pay Costs.....	**39,256**	**40,808**	**1,552**
Total Salary and Expenses.....	**66,675**	**72,576**	**5,901**
Direct FTE.....	184	211	27

Detail of Full-Time Equivalent Employment (FTE)

Administration for Community Living

	2015 Est. Civilian	2015 Est. Military	2015 Est. Total	2016 Est. Civilian	2016 Est. Military	2016 Est. Total	2017 Est. Civilian	2017 Est. Military	2017 Est. Total
Immediate Office of the ..... Administrator.....									
Direct:.....	18		18	20		20	20		20
Reimbursable:.....	1		1	0		0	0		0
Total:.....	19	0	19	20	0	20	20	0	20
Administration on Aging.....									
Direct:.....	25		25	25		25	36		36
Reimbursable:.....	1		1	1		1	1		1
Total:.....	26	0	26	26	0	26	37	0	37
Administration on Disabilities.....									
Direct:.....	29		29	31		31	37		37
Reimbursable:.....	0		0	0		0	0		0
Total:.....	29	0	29	31	0	31	37	0	37
Center for Policy and ..... Evaluation.....									
Direct:.....	14		14	10		10	10		10
Reimbursable:.....	0		0	0		0	0		0
Total:.....	14	0	14	10	0	10	10	0	10
Center for Management and Budget.....									
Direct:.....	32		32	32		32	40		40
Reimbursable:.....	1		1	1		1	1		1
Total:.....	33	0	33	33	0	33	41	0	41
Center for Integrated Programs.....									
Direct:.....	10		10	10					
						10	10		10
Reimbursable:.....	12		12	15		15	16		16
Total:.....	22	0	22	25	0	25	26	0	26
Office of Regional Operations.....									
Direct:.....	26		26	28		28	30		30
Reimbursable:.....	3		3	5		5	5		5
Total:.....	29	0	29	33	0	33	35	0	35
National Institute on Disability, ... Independent Living, and ..... Rehabilitation Research.....									
Direct:.....	28		28	28		28	28		28
Reimbursable:.....	0		0	0		0	0		0
Total:.....	28	0	28	28	0	28	28	0	28
FTE Total.....	**200**	**0**	**200**	**206**	**0**	**206**	**234**	**0**	**234**

Average GS Grade	
FY 2013.....	12.9
FY 2014.....	13.0
FY 2015.....	12.8
FY 2016.....	12.8
FY 2017.....	12.8

Detail of Positions

Administration for Community Living

	2015 Actual	2016 Enacted	2017 Budget
Executive level I			
Executive level II			
Executive level III			
Executive level IV	1	1	1
Executive level V			
Subtotal			
Total - Exec. Level Salaries	155500	157770	159348
ES-6			
ES-5	2	2	2
ES-4	2	2	2
ES-3	2	2	1
ES-2	1	1	1
ES-1	1	1	1
Subtotal	8	8	7
Total - ES Salary	$1,303,076	$1,317,345	$1,164,770
GS-15	33	31	31
GS-14	37	48	53
GS-13	63	66	72
GS-12	30	33	38
GS-11	13	14	16
GS-10	1	1	1
GS-9	7	11	12
GS-8	1	0	0
GS-7	4	3	3
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	191	209	228
Total - GS Salary			
Average ES level	3.4	3.4	3.3
Average ES salary	$162,885	$164,668	$166,396
Average GS grade	12.8	12.8	12.8
Average GS salary	$104,693	$112,412	$112,776
Average Special Pay categories			
Administratively Determined (AD)	$130,487	$132,409	$133,733

Programs Proposed for Elimination

Administration for Community Living

ACL has no programs proposed for elimination.

FTE Funded by the Affordable Care Act

Administration for Community Living

Program	Section	FY 2013			FY 2014			FY 2015		
		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	$ 86	0	0	$ -	0	0	$ -	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ 25,000	0	0	$ -	0	0	$ -	0	0
New programs authorized and funded by ACA (Mandatory)										
Aging and Disability Resource Centers	Section 2405	$ 9,490	4	0	$ 9,280	3	0	$ -	0	0
New programs funded from the PPHF under ACA (Discretionary)										
Adult Protective Services (Prevention & Public Health Fund)	Section 4002	$ 2,000	0	0	$ -	0	0	$ -	0	0
Chronic Disease Self-Management Education (PPHF)	Section 4002	$ 7,086	1	0	$ 8,000	0	0	$ 8,000	0	0
Alzheimer's Disease Initiative--Supportive Services (PPHF)	Section 4002	$ -	0	0	$ 10,500	0	0	$ 10,500	0	0
Alzheimer's Disease Initiative--Communications (PPHF)	Section 4002	$ 150	0	0	$ 4,200	0	0	$ 4,200	0	0
Falls Prevention--(PPHF)	Section 4002	$ -	0	0	$ 5,000	0	0	$ 5,000	0	0
Programs authorized by ACA but funded by other sources (Discretionary)										
Elder Justice Initiative/Adult Protective Services	Subtitle H, Sections 6701-6703	$ -	0	0	$ -	0	0	$ 4,000	2	0

Program	Section	FY 2016			FY 2017		
		Total	FTEs	CEs	Total	FTEs	CEs
Pre-existing programs funded by ACA (Mandatory)							
National Clearinghouse for Long-Term Care Information	Title VIII	$ 1,000	0	0	$ -	0	0
Medicare Improvements for Patients & Providers Act Programs	Section 3306	$ -	0	0	$ -	0	0
New programs authorized and funded by ACA (Mandatory)							
Aging and Disability Resource Centers	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	$ 8,000	3	0	$ 10,000	4	0

Physicians' Comparability Allowance Worksheet

Administration for Community Living

ACL does not have anything to submit for this section.

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Significant Items in Appropriations Committee Reports

Administration for Community Living

Home- and Community-Based Supportive Services: The Committee directs ACL to work with States to prioritize innovative service models, like naturally occurring retirement communities (NORCS), which help older Americans remain independent as they age.

Actions Taken or To Be Taken: ACL appreciates and supports the Committee's continued interest in innovative service models that help older adults remain independent as they age. The 2015 White House Conference on Aging provided an important platform to highlight the need to focus on innovative strategies in the areas of housing, transportation, health care, and long-term services and supports in order to support healthy aging and aging in place.

ACL continues to work with states and others in the aging network to encourage livable communities and aging in place. We are committed to expanding the availability and accessibility of housing and service options that keep older adults living in the community by working in partnership with sister HHS agencies such as Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Centers for Medicare and Medicaid Services (CMS), as well as HUD to bring together housing and human services agencies on the state and local levels. For example, ACL worked with ASPE and HUD to develop design options for a demonstration of publicly assisted rental housing coordinated with health and long-term care services and supports for low-income older adults. ACL continues to support HUD's efforts to foster the development of replicable housing plus supportive service models that offer the most effective and cost-efficient approaches to meeting the needs of vulnerable populations.

ACL has also provided national leadership to help community-based organizations build networks with the capability to respond to delivery systems reform happening around the country including efforts to improve integration between hospitals, insurers, health care providers, and the community-based organizations (CBOs) that often provide day-to-day support to older people and people with disabilities.

Healthier Foods: The Committee encourages ACL to partner with organizations to review, identify, and disseminate best practices to provide healthier foods and menu options for seniors. These practices could include better food produce procurement, preparation techniques, and improved menu planning and recipe documentation to facilitate changes that support healthier meals. Coalitions of manufacturers, food service providers, and food service distributors could also be developed to explore ways to promote best practices and provide a more appropriate selection of healthier ready-to-use ingredients.

Actions Taken or To Be Taken: ACL appreciates and supports the Committee's continued interest in and support of healthy eating for older adults. We fund a national resource center that disseminates best practices in the field that include how to incorporate changes to support healthier meals. We work together with our colleagues in the Office of the Assistant Secretary for Health as well as with USDA to collaborate on ways to improve menu planning and food service distribution. We have convened a "brain trust" consisting of thought leaders and food service innovators to discuss ways to combat senior hunger, encourage healthier ready-to-use ingredients, and incorporate innovations in both congregate and home-delivered meals. Our resource center supports a listserv for state nutritionists and we use this method to communicate changes that support healthier meals. The 2015-2020 Dietary Guidelines for Americans were recently announced, which encourage healthy eating patterns. ACL was an active member of the HHS/USDA committee that developed the Guidelines and we will continue to support them.

There is always room for improvement and the FY 2017 request incorporates a proposal that would allow the use of up to 1 percent of ACL's nutrition programs for development of innovative, evidence-based practices for senior nutrition aimed at enhancing the quality and effectiveness of nutrition programs' services.

Examples of 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), new service models (testing variations and hybrid strategies) and other innovations to better serve older adults. These 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.

Tribal Advisory Council: The Committee encourages ACL to continue with their plans to establish a Tribal Advisory Council focusing on issues that affect the aging Indian population.

Actions Taken or To Be Taken: ACL appreciates and supports the Committee's continued interest in and support of issues affecting older American Indians. We are currently developing a new ACL Tribal Consultation Policy; we have followed the HHS Policy to this point, adding a special focus on Tribal Elders. We actively participate in all HHS Tribal Consultations, including Budget Consultations. We actively participate in the Secretary's Tribal Advisory Council (STAC), bringing a focus on Tribal Elders issues and needs. We participate with the National Congress of American Indians (NCAI), the National Indian Health Board (NIHB) the National Council of Urban Indian Health (NCUIH), the National Indian Council on Aging. We hold an annual consultation with tribal elders' needs and issues each August in conjunction with our National Title VI Training. We have several advisory committees on various program initiatives. We are very interested in developing a Tribal Advisory Council if resources are made available and it is authorized by law.

Elder Falls Prevention: The Committee intends that these funds should be used in coordination with CDC for public education about the risk of these falls, as well as implementation and dissemination of community-based strategies that have been proven to reduce the incidence of falls among seniors.

Actions Taken or To Be Taken: ACL has worked with CDC injury prevention staff for many years, coordinating our public education about the risk of falls and how to reduce the incidence of falls among seniors. CDC was an active participant in our Falls Summit held last year in conjunction with the White House Conference on Aging. We hold bi-monthly meetings with CDC staff and are currently working on formalizing our successful informal collaborations through a memorandum of understanding to be signed by the administrators of both agencies. CDC's falls prevention grantees attend the annual meetings our national falls resource center holds, encouraging one-on-one collaborations between each of our agencies' grantees. We participate in joint Twitter chats to help educate the public about the risk of falls, and have taken and support CDCs online training for falls reduction in clinical settings. Our complementary missions (CDC on the clinical aspect and ACL on the community programs) work well together and we plan to continue this relationship.

Aging and Disability Resource Centers: The Committee urges ACL to improve coordination among ADRCs, area agencies on aging, and centers for independent living to ensure that there is "no wrong door" to access services.

Actions Taken or To Be Taken: Since 2003, ACL (then the Administration on Aging) and the Centers for Medicare & Medicaid Services (CMS), in collaboration with the Veterans Health Administration (VHA), have been supporting state efforts to implement consumer friendly systems of access that make it easier for consumers and their families to learn about and quickly access long-term services and supports (LTSS). In 2012, ACL, CMS and VHA fully adopted the No Wrong Door System model which was the primary recommendation from Centers for Independent Living (CILs) across the country. This model also recognizes the recommendations from CILs that no specific organization or network has the capacity, expertise, or authority to carry out all the functions in a NWD System and ADRCs, AAAs, and CILs must be included.

In 2012, ACL published a competitive Funding Opportunity Announcement that incorporated this vision. As a result, ACL, CMS and VHA awarded three-year grants to 8 states to transform state LTSS access functions into a single No Wrong Door system that would serve all populations. This investment has resulted in a number of lessons learned which are used by federal partners to create the "Key Elements of a NWD System of Access to LTSS for All

Populations and Payers"[123] and has contributed to improved coordination. The NWD System Key Elements specifically require States to use a formal process for ensuring the ongoing and meaningful involvement of key stakeholders such as CILs in the development and implementation of their NWD System. ACL also learned that states would benefit from a planning grant to enable the inclusion of key stakeholders in the development of the state's NWD System. In 2014, ACL used the NWD System Key Elements as the basis to fund 25 states to develop 3-year plans they could use to begin to transform their various LTSS access programs and functions into a high-performing NWD System which coordinates LTSS access activities across ADRCs, AAAs and CILs consistent with the NWD System Key Elements. In 2015, ACL awarded 5 of the 25 states that received planning grants a 3-year implementation grant to transform the LTSS access functions into a NWD System.

The 2012 NWD System grantees also worked closely with the VA Medical Centers that serve Veterans within their states to expand access to the Veteran-Directed Home and Community Based Services (VD-HCBS) program. The VD-HCBS program is provided to Veterans by ADRCs, AAAs, CILs and State Agencies through the state's NWD System. On December 1, 2015 the U.S. Department of Veterans Affairs published an interim final rule recognizing the ADRCs, AAAs, CILs and State Agencies as providers.

With the passage and signing of the Workforce Innovation and Opportunity Act (WIOA) in July of 2014, the Independent Living (IL) Programs were transferred from the Department of Education to ACL. This transfer of the IL programs and the creation of the Independent Living Administration (ILA) within ACL will foster greater collaboration and partnership with all of the programs within ACL including ADRCs and AAAs. This in turn should provide additional information, resources and trainings to ADRCs, AAAs and CILs to further expand the "no wrong door" access to LTSS at the state and community level.

Further efforts to improve coordination across ADRCs, AAAs and CILs are also occurring through the relationship ACL has developed with the National Council for Independent Living (NCIL). NCIL is providing technical assistance to states and identifying promising practices which actively involve CILs as part of the NWD System.

Muscular Dystrophy: The Committee directs ACL to provide an update on all programs relevant to the Duchenne population, particularly those focused on supporting transitions of persons with Duchenne into adulthood. The Committee encourages ACL to develop plans for conducting

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[123] http://www.acl.gov/Programs/CIP/OCASD/ADRC/docs/NWD-National-Elements.pdf

comprehensive studies focused on evaluating the cost-effectiveness of independent living programs and supports for persons living with various forms of muscular dystrophy.

Actions Taken or To Be Taken: ACL appreciates the opportunity to provide an update on all programs relevant to the Duchenne population, particularly those focused on supporting transitions of persons with Duchenne into adulthood. The Administration on Disabilities (AoD) administers a number of programs relevant to the Duchenne population and other people with disabilities including those authorized under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), as well as the Independent Living programs which are authorized in Title VII of the Rehabilitation Act of 1973 (as amended). ACL also includes, the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), which conducts research and promotes its effective use to improve the abilities of all people with disabilities to perform activities of their choice in the community.

The DD Act authorized the State Councils on Developmental Disabilities, the Protection and Advocacy Agencies (P&As) and the University Centers for Excellence in Developmental Disabilities (UCEDDs). Separately each program may conduct research or provide programming in the area of Duchenne's and support the transition of people with Duchenne's into adulthood. Funding provided through the Administration on Disabilities is to establish systems that provide services to people based on the definition of developmental disabilities in the DD Act which is inclusive of Duchenne's (pending severity and age of inset) and other developmental disabilities. The same is true of the Independent Living programs which, via statute, must provide cross-disability programming and cannot focus on a specific disability type. Nevertheless, later in the fiscal year ACL will query the DD and Independent Living networks to provide an update to the relevant committees of jurisdiction in congress on all programs relevant to the Duchenne's population, particularly those focused on supporting transitions of persons with Duchenne into adulthood.

In NIDILRR ACL funded a 5-year "Rehabilitation Research and Training Center Promoting Healthy Aging for Individuals with Long-Term Physical Disabilities" at the University of Washington. The project provides $875,000 per year (through 2017) to conduct research

to better understand the factors associated with healthy aging in persons with spinal cord injury (SCI), multiple sclerosis (MS), late effects of polio (PPS), and muscular dystrophy (MD). Research activities focus on the impact of secondary conditions and barriers to health care access; testing the feasibility of community-based health and wellness intervention to promote healthy aging in persons with SCI, MS, PPS, and MD; developing an intervention to promote positive psychological adjustment in persons with MS; enhancing understanding of the effect of federal programs such as Medicaid Managed Care on receipt of and satisfaction with health care services; and serving as a national resource center on aging with long-term physical disabilities.

Four interrelated scientific studies on healthy aging and disability make up this project and are conducted with the full involvement of consumers and key stakeholder groups. Project I continues a recently-completed, longitudinal survey of 1,600 individuals with long-term physical disabilities, creating the largest longitudinal database of secondary health conditions in the target population. Project II tests the efficacy of an existing, empirically-supported health and wellness intervention in promoting healthy aging for adults with SCI, MS, MD, or PPS in collaboration with a large, regional community senior services agency. Project III develops and pilot tests a novel intervention designed to promote positive psychological factors that are key to healthy aging in individuals with MS. Project IV builds on an existing study of Medicaid Managed Care to evaluate the impact of Medicaid Managed Care on health care utilization, function, and consumer satisfaction in a sample of more than 14,000 individuals with long-term physical disabilities.

Dissemination activities associated with this project will include a state-of-the-science conference on aging with disabilities, publication of findings from the studies in national and international journals and presentations of the findings at high profile scientific conferences in the field.

No funding was provided by Congress to develop plans for conducting comprehensive studies focused on evaluating the cost-effectiveness of independent living programs and supports for persons living with various forms of muscular dystrophy. At this time ACL has no plans for new agency-directed research priorities specifically focused on muscular dystrophy.

Prevention and Public Health Fund

Administration for Community Living

In FY 2017, ACL is proposing the following funding from the Prevention and Public Health fund:

	FY 2015 Enacted	FY 2016 Enacted	FY 2017 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 2017 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 2017 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 2015 and FY 2016. 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 2015 and FY 2016 enacted budgets from PPHF. This FY 2017 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 2017, the request is at the same level as the FY 2015 and FY 2016 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 2017, the request is at the same level as the FY 2015 and FY 2016 enacted budgets. This funding is proposed from the Prevention and Public Health Fund. The funding mechanism used is a contract.