



Max Richtman, Chair

March 1, 2016

United States Senate
Washington, DC 20510

Dear Senator:

On behalf of the members of the Leadership Council of Aging Organizations (LCAO), I am writing to provide you with our comments on the proposals and funding levels in President Obama's Fiscal Year (FY) 2017 budget for crucial programs that enable older Americans to live independent and dignified lives.

LCAO is a coalition of 72 national not-for-profit organizations concerned with the well-being of America's 87 million people over age 50.

Views reflected in the attached document should not be considered exhaustive of the interests of LCAO members, collectively or individually. Rather, while the individual interests of LCAO groups may vary, the effort herein represents the concerns of the majority of our national member organizations and the millions of mature and older Americans whose interests we represent.

Compared with the 46 million seniors today, by 2030, 70 million people – 1 in 5 Americans – will be 65 or older. Many older Americans face economic and health challenges. Currently, nearly 90 percent of seniors have at least one chronic condition, 4.2 million adults over the age of 65 live in poverty and nearly one in six seniors struggle with hunger. Decades of stagnant wages and the erosion of employer-sponsored retirement benefits and savings are grinding away at the economic security of millions of seniors.

Given these demographic and economic realities, we urge you to ensure that the FY 2017 congressional budget resolution strengthens the financial and health security of older adults and to reject proposals that would increase costs or reduce benefits and services for current and future generations of older Americans.

We look forward to the opportunity to work with you to achieve shared goals.

Sincerely,



Max Richtman, Chair

COMMUNITY SERVICES

Older Americans Act (Department of Health and Human Services/Administration for Community Living-Administration on Aging)

The Leadership Council of Aging Organizations (LCAO) appreciates the Administration's proposed increase of \$28.4 million reflected in the Administration for Community Living's (ACL) FY 2017 budget request to support programs that enable seniors to age with dignity and independence in their homes and communities for as long as possible. We support those increases that are focused on boosting funding for core Older Americans Act (OAA) programs, including \$10 million for Older Americans Act Title III B Supportive Services and \$14.4 million for Title III Nutrition programs. We also appreciate that the President included the increase reflected in final FY 2016 appropriations for Title VI Native American Aging Programs. However, not all of the OAA core programs that serve frail older adults received increases and this is unfortunate. We understand that overall, the Administration's budget request adheres to the Bipartisan Budget Agreement (BBA) signed into law last year, and as such, the total amount of funding available for FY 2017 program requests was flat.

All OAA-supported programs and services are of great importance and need continued investment in order to meet an escalating need and rapidly growing population. Overall, LCAO will continue to support an increase of at least 12 percent for all titles in annual appropriations. This is necessary to ensure that OAA programs can begin to make up for years of stagnant funding, and restore federal, state and local cuts that have occurred both during economic crisis and sequestration. Furthermore, substantial increases are needed to address the growing population and demand for services as the population of older adults grows at a historically unprecedented rate. The OAA funds critical programs and services to protect and keep older adults independent, and LCAO supports increased funding for all programs that serve older adults. We will continue to ask the Administration and Congress to increase funding for all core OAA titles:

Title III B: Supportive Services and Centers, which enables local agencies to use a flexible pool of funds for up to 25 different activities that support older adults aging in place—from transportation to in-home chore services to adult day care.

Title III C 1: Congregate Meals, which provides congregate meals served in community settings such as senior centers.

Title III C 2: Home-Delivered Meals, which is often known as Meals on Wheels, offers reliable nutrition to homebound older adults and critical supports to prevent isolation, as the staff and volunteers may be the only direct human contact homebound seniors have during a day.

Title III D: Disease Prevention, which provides grants to deliver evidence-based health promotion and disease prevention programs to reduce illnesses that lower quality of life, drive health care costs and reduce an older adult's ability to live independently.

Title III E: National Family Caregiver Support Program, which provides grants to help family members caring for their older loved ones who are ill or who have disabilities. Supports include respite care, support groups and assistance accessing other resources.

Title IV: Aging Research and Training, which provides funding for innovation, research and training. This title has had its funding slashed in recent years; and we appreciate the administration's effort to reverse this dangerous trend to ensure that the Aging Network can find new and innovative practices and policies for delivering cost-effective services that provide high-quality outcomes. The Business Acumen Learning Collaborative is an example of such innovation.

Title VI: Native American and Native Alaskan/Hawaiian Aging Programs, which provides primary authority for funding nutrition and family caregiver support services to Native American (Indian, Alaskan and Hawaiian) elders, who are among the most economically disadvantaged elderly minority in the nation. According to an AARP report, the number of 65 and older American Indians and Alaska Natives is projected to triple, and the oldest old (85 and over) is projected to increase more than sevenfold in the coming decades. They are the second fastest growing minority racial group in the country. It is critical that funding continue to be increased for these services.

Title VII: Long-Term Care Ombudsman/Elder Abuse Prevention, which advocates for residents of long-term care facilities in order to resolve quality of life and care problems, protect residents' rights, and improve the long-term supports and services system. This title, which also requires states to raise public awareness and coordinate agency activities to identify and prevent elder abuse, neglect and exploitation, is critical to ensuring the health and safety of older adults who require institutional support and are unable to remain in their homes and communities. Once again, the proposed budget does not increase this vital program which serves some of the most vulnerable persons in our society.

If federal funding for core OAA services is not increased, or at a minimum fully restored from recent cuts, millions of seniors across the country will be unable to access the critical supports needed to age with dignity and independence in their homes and communities. Further, those in nursing homes will not have the benefit of advocates. We appreciate that the Administration continues to recognize this harsh reality and that in a challenging fiscal environment with stagnant funding, that the President's budget request took important steps toward reversing the current trajectory of declining funding for key OAA programs. However, we must do more during this time of growing need and we will continue to encourage additional measures to restore and increase funding for core OAA programs as the FY 2017 budget process moves forward.

Older Americans Act (Department of Labor)

LCAO supports at least the \$434,371,000 requested in the FY 2017 budget request for Title V, the Senior Community Service Employment Program (SCSEP), administered by the Department of Labor. However, this funding level falls far short of the need, and a much larger investment is

needed. The unemployment rate of low-income workers ages 55+ (13.3% in 2014) has consistently been three times greater than the rate for all workers ages 55+ (4.4%). According to the GAO, SCSEP is the only federal workforce development program targeted to serve older Americans and does not overlap with any other federal program. Low-income jobseekers, 55 years old or older, are assigned to paid community service employment opportunities where they update their skills through on-the-job training. SCSEP serves nearly all 3,000 counties in the U.S. Last year, about 70,000 SCSEP participants provided nearly 36 million hours of staff support to 21,000 libraries, senior centers, schools and other community- and faith-based organizations. The value of this work exceeded \$800 million, or nearly twice its appropriations. The income taxes paid by older workers who return to the labor force through SCSEP further adds to SCSEP's total social return on investment. Finally, the wages paid to SCSEP participants also help boost many local economies.

Elder Justice Act (Health and Human Services, Administration for Community Living)

For FY 2017, the LCAO again supported the FY 2016 budget's \$25 million funding request for elder justice and Adult Protective Services (APS) programs (Elder Justice Initiative) and an additional \$5 million for the Long-Term Care Ombudsman Program. Unfortunately, the President's FY 2017 budget reduced the amount requested to \$10 million. Congress provided only \$8 million of the FY 2016 requested funds in the FY 2016 omnibus appropriations bill. It was only the second direct appropriation for the bipartisan Elder Justice Act, which was signed into law in 2010 and authorized at slightly less than \$200 million per year. The Act received only \$4 million in funding in FY 2015. This funding has a direct and immediate impact by providing urgently needed support for state and local governments for Adult Protective Services (APS) programs, the front line of fighting elder abuse.

Elder abuse is a significant public health issue that impacts approximately 10-15% of people 65 and older; a conservative estimate for community dwelling adults. Adults with cognitive impairments, like Alzheimer's disease, suffer from abuse rates three to four times higher. There are approximately 47 million adults 65 and older in the U.S., which means 4.7 million seniors are impacted by this epidemic. Elder abuse costs billions each year, yet according to a 2009 GAO report spending by federal agencies totaled just \$11.9 million. Funding for violence against women programs totaled \$649 million dollars in the same time frame.

For FY 2017, we remain committed to supporting at least the \$25 million requested in FY 2016 for the Elder Justice Initiative and the additional \$5 million for the Long-Term Care Ombudsman Program under the Elder Justice Act which was previously requested by the President. This is not a time to pull back from the fight against elder abuse. Given the growing problems of elder abuse, neglect and exploitation, including billions of dollars taken from seniors each year, this is a modest amount for the federal government to spend to address a national tragedy.

LCAO is also concerned about the proposed lowering of funding for the Crime Victims Fund, established by the Victims of Crime Act (VOCA), which falls under the jurisdiction of the Office of Victims of Crime in the Department of Justice. The President's budget proposes a cap of \$1.6 billion for use in FY 2017. This is a decrease of \$900 million from FY 2016, and Congress in

each of the past two years voted to increase the VOCA cap. This could set back efforts to direct more VOCA funding to help victims of elder abuse.

Aging and Disability Resource Centers (ADRCs) (Health and Human Services, Administration for Community Living)

LCAO appreciates that the Administration's FY 2017 request continues to reflect the importance of establishing a robust, nationwide Aging and Disability Resource Center (ADRC) / No Wrong Door (NWD) network, which plays a critical role in aligning consumer needs for long-term services and supports (LTSS) with long-term care options in nearly every state. The ADRC/NWD model has proven to be a valuable tool for consumers of all ages and disabilities, as ADRCs serve as a streamlined point of entry for consumers and caretakers seeking information and referral assistance about public and private options for LTSS. We appreciate the requested \$2 million increase in discretionary funding for ADRC/NWD activities. We also recognize and appreciate that, given the current challenges in securing additional discretionary funding for ADRC activities, the Administration supports continued investment in these networks through CMS and the Veterans Health Administration.

Prevention and Public Health Fund (PPHF) Healthy Aging Programs

Falls Prevention (Health and Human Services/Centers for Disease Control and Prevention and Administration for Community Living): Each year, one in three Americans aged 65 and over falls. The death rate from falls among older adults has risen sharply over the past decade. In 2013, 2.5 million nonfatal fall injuries among older adults were treated in emergency departments with more than 734,000 of these hospitalized. The nation is spending over \$34 billion annually on direct medical costs arising from elder falls. If we cannot stem the rate of falls, it is projected that the cost in 2020 would be \$67.7 billion, including Medicare costs estimated at about \$52 billion. LCAO supports a PPHF allocation of \$10 million to support falls prevention activities at ACL and the CDC National Center for Injury Prevention and Control.

Chronic Disease Self-Management Education (CDSME) (Health and Human Services/Administration for Community Living): Older Americans are disproportionately affected by chronic diseases, which account for more than three-quarters of all health expenditures and 95 percent of health care costs for older adults. Over 90 percent of older adults have at least one chronic disease and two-thirds have two or more. Data show that as an individual's number of chronic conditions increases, there is a corresponding escalation in unfavorable outcomes including poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice—all of which lead to higher health costs and increased Medicare and Medicaid spending. We support a PPHF allocation of \$16 million to restore CDSME to its annual level in FY 2010-FY 2011. This work is in line with the prominence that chronic care has been given by Congress and the aging network itself through partnerships with the health care sector.

Alzheimer's Disease Priorities (Health and Human Services)

Alzheimer's disease in the U.S. is at crisis proportions. As our population ages, the number of persons affected by this insidious brain disorder are expected triple to 13.8 million Americans by 2050. Costs associated with Alzheimer's disease are also growing at an unsustainable rate. A RAND study of adults age 70 and older found that the cost of dementia in 2010 was estimated to be \$109 billion for direct care—higher than the costs of heart disease and cancer. That figure jumps from \$109 billion to \$215 billion when the cost of informal care—such as the type provided by family members—is included.

The following programs provide vital supports and services to those living with dementia and their family caregivers:

Alzheimer's Disease Supportive Services Program (ADSSP) (Administration on Aging, Administration for Community Living): We support funding of at least \$7.3 million, or \$2.5 million more than enacted for FY 2016, for this program that provides competitive grants to states to expand dementia-capable home and community-based long-term services and supports.

Alzheimer's Disease Initiative (ADI): We support a budget request of \$16.5 million, \$6 million more than FY 16, for this grant program that funds projects that address gaps that exist in the delivery of services to those with dementia. Focus areas include improving dementia-related services to people who live alone, and those affected by developmental and intellectual disabilities as well as training family caregivers in behavioral symptom management. In addition, we are requesting an appropriation of \$6.7 million for the Alzheimer's Disease Initiative - Communications Campaign. Past ADI awards for both specialized supportive services and the communications campaign were funded through Prevention and Public Health Funds.

Alzheimer's Disease Priorities (Department of Justice)

Missing Alzheimer's Disease Patient Alert Program: We support an allocation of \$5 million for this small, but cost-effective, program that provides grants to nonprofit organizations to enable them to establish and operate initiatives to identify, locate and protect individuals with Alzheimer's who wander away from home. It also saves time and resources for law enforcement and allows them to focus on other security concerns. These programs save time and resources for law enforcement and allows them to focus on other security concerns.

LCAO supports designated funding opportunities within all Alzheimer's Disease programs for programs and services that serve racial and ethnic minority populations. Alzheimer's programs targeting racial and ethnic minority populations are consistently under-funded, and the unique manifestations of the disease in the context of these communities are poorly understood. Recent research finds that American Indians suffer from Alzheimer's prevalence rates significantly higher than white and Asian populations and African-Americans are two times more likely to develop late-onset Alzheimer's. Both populations are less likely to have their disease ever diagnosed. The tribal health system and tribal and urban Indian communities, in particular, require focused training, support and services to help reduce significant disparities.

Social Services Block Grant (Health and Human Services/Administration for Children and Families)

We strongly support, at a minimum, the President's budget request of \$1.7 billion for the Social Services Block Grant (SSBG) for FY 2017. SSBG is a major funder of state and local services for older adults including adult protective services, in-home supportive services, congregate, home-delivered meals, and adult day services as well as case management. The strength in the program lies in its flexibility to allow state and local governments to determine how to best use funds to meet local needs.

Adult Protective Services (APS) is often dependent on SSBG funding and its workers frequently serve as first responders in cases of abuse, neglect or exploitation, working closely with a wide variety of allied professionals such as physicians, nurses, paramedics, firefighters and law enforcement officers. The funded services are designed to enable an elderly individual or other vulnerable adult to continue living independently at home and to protect her or him from further abuse. APS conducts investigations, evaluates client risk, develops and implements case plans, provides counseling, and arranges for a large variety of services that are also supported by SSBG. In past Congresses, SSBG has had bipartisan support on both the House Ways and Means Committee and the Senate Finance Committee.

Community Services Block Grant (CSBG) (Health and Human Services/Administration for Children and Families)

Since 1981, states have utilized these CSBG flexible funds to improve community health and living conditions for low-income families and seniors. For those age 55 and older, these services include home-based household and personal care activities, congregate meals and recreational activities, nutritious home-delivered meals, Adult Protective Services, and transportation to and from medical appointments or adult day health centers, making this program a pre-Medicare/Medicaid partner in the long-term care continuum. Over 20 percent of those served in FY 2014 were older adults age 55+, and nearly 8 percent of those served were 70 years or older. Approximately \$53 million of CSBG resources specifically was used to serve seniors. Overall, nearly 2.4 million seniors were helped to live independently in their own homes and remain engaged in their communities. We support funding that restores CSBG and the community services related activities to their FY 2010 pre-sequester level totaling \$775 million.

Housing Programs (Department of Housing and Urban Development/Federal Housing Administration)

Senior Housing: Seniors rely disproportionately on federally subsidized housing programs. The Administration should continue fostering collaboration between HUD, HHS, and other federal agencies to increase successful program linkages for seniors to help them successfully age in place. The Supportive Housing for the Elderly Program (Section 202) helps expand the supply of affordable housing with supportive services for low-income older adults, allowing them to live independently but in an environment that provides support activities such as cleaning, cooking, and transportation. LCAO supports the Administration request of \$505 million for FY 2017.

Housing Counseling: In addition to supporting homeownership counseling, the Housing Counseling program also invests in Home Equity Conversion Mortgage counseling that is mandatory prior to application for a reverse mortgage. The need for increased funding is especially acute to protect against fraud given recent changes in the reverse mortgage products marketplace, as well as for training, testing, and other implementation issues related to HUD counselor certification. LCAO supports an investment of

\$60 million, equal to the Administration's FY 2016 budget request, for HUD's Housing Counseling Assistance Program.

Low Income Home Energy Assistance Program (LIHEAP) (Health and Human Services/Administration for Children and Families)

About a third of households receiving LIHEAP benefits include an older adult age 60+ for whom this assistance means avoiding difficult choices between paying for utilities, food, or medicine. The level funding provided in recent years is only sufficient to serve 20 percent of the eligible population. Those who do receive LIHEAP assistance have seen their average grant reduced by nearly \$100 since 2010. LCAO opposes the \$390 million cut requested for FY2017 and joins bipartisan groups of national and local policymakers in continuing to call for funding of at least \$4.7 billion.

Legal Services

LCAO supports the legal services funding provided under Titles IIIB and VII of the Older Americans Act and would like to see those programs grow. In addition, LCAO believes that the Legal Services Corporation (LSC) plays a critical role in providing civil legal aid across the nation, particularly to the most vulnerable Americans, including older adults, veterans, victims of elder abuse, and people with disabilities.

LSC has been cut many times over the years, but there have been recent attempts to address the large number of people who are turned away because of a lack of funding and staff. The LSC was funded at a level of \$375 million for FY 2015 and in the Omnibus Budget Act of last December was allocated \$385 million for FY 2016. The President's budget request for FY 2017 is \$475 million. In previous years, LCAO has supported a minimum level of \$516.5 million. For FY 2017, LCAO again supports our previous request, but acknowledges the movement upward by the Administration and Congress.

Senior Transportation Programs (Department of Transportation/Federal Transit Administration)

LCAO supports the budget request for senior transportation programs for FY 2017. The Federal Transit Administration's (FTA) Section 5310 formula grant for the elderly and persons with disabilities is recommended at \$268.2 million, a slight increase over FY 2016. This amount is consistent with the authorized funding level in the Fixing America's Surface Transportation (FAST) Act. The current level of funding is nowhere near enough to ensure needed transportation for the millions of older adults age 60 and over and the tens of millions of people with disabilities currently living in the United States, let alone the coming influx of aging boomers. We believe this proposed increase will help nonprofit transportation providers meet at least part of the estimated \$1 billion a year in unmet senior transportation needs that now exist.

LCAO also supports the President's inclusion of funding for the National Aging and Disability Transportation Center (NADTC) as part of the Federal Transit Administration's technical assistance program at \$5 million for FY 2017 to assist local communities and states in the expansion and provision of transportation services for older adults.

Finally, LCAO supports the proposed funding for the Section 5311 Rural Formula Grant Program at a level consistent with funding growth during the current reauthorization period.

Nutrition Programs (Department of Agriculture)

It is critical that proven and effective federal nutrition programs serving our most vulnerable seniors are further strengthened; particularly now as both the need and demand for nutritious meals are already substantial and will only continue to climb exponentially due to a rapidly aging population. In addition to increasing funding for the nutrition programs authorized under the OAA, we support the following for the programs administered by USDA.

Supplemental Nutrition Assistance Programs (SNAP): SNAP is our nation's largest federal nutrition program, targeting households at or below 130 percent of the federal poverty line, or an annual income of \$15,180 for a senior living alone. Currently, only about 40 percent of eligible seniors are enrolled in SNAP and on average access \$129 a month in benefits. We support the budget request for \$10 million to create a new state option to eliminate barriers and improve SNAP access for seniors struggling with hunger. Based on successful state demonstrations in increasing senior participation in SNAP, this would allow states to adopt a set of policies to streamline and simplify the SNAP application, reporting requirements, and re-certifications for seniors.

Commodity Supplemental Food Program (CSFP): We support the \$14 million increase requested to address current demand and fund new caseloads to a total of 639,000 participants. CSFP provides a nutritious monthly food package to more than 600,000 low-income individuals nationwide. On average, more than 570,000 seniors received monthly CSFP packages in 2015. With one in six older Americans struggling with hunger, this is another crucial service that helps provide the nutrition needed to combat the poor health conditions often found in food insecure seniors.

Senior Corps

LCAO is disappointed that the Administration did not propose to increase the Senior Corps (Foster Grandparents, Senior Companions, and RSVP) programs administered by the Corporation for National and Community Service. Together, these programs will provide the nation approximately 96 million hours of service, with a value of \$2.1 billion.

Some 10,000 Baby Boomers are retiring every day and will do so every day for the next 20 years. Senior Corps is the only national program able to place large numbers senior volunteers in high quality volunteer positions. Senior volunteer programs have two benefits: they improve the quality of life in their communities and they help volunteers continue live independent and productive lives. The LCAO will advocate for the following request in FY 2017: \$110.6 million for Foster Grandparents (FGP), \$49.9 million for Senior Companions (SCP), and \$63 million for RSVP. This represents a combined increase of \$3.9 million above the FY 2016 enacted level and would support an increase in the hourly stipend for FGP and SCP from \$2.65 per hour to \$2.85. Our proposal for RSVP is \$17.5 million above the President's request and would restore funding for RSVP to its FY 2011 level and increase the number of RSVP volunteers from 230,000 to approximately 320,000.

Finally, LCAO supports the principle of competition but believes that Congress should not authorize legislative changes on appropriations bills. Competition in Senior Corps programs should be left to reauthorization of the Serve America Act.

HEALTH CARE

State Health Insurance Assistance Programs (SHIPs) (Health and Human Services/Administration for Community Living)

A total of 54 SHIP grantees oversee a network of more than 3,300 local SHIPs and over 15,000 mostly volunteer counselors to provide one-on-one assistance and counseling to Medicare beneficiaries and their families. SHIPs play a critical role in ensuring that older adults and people with disabilities make informed decisions about their Medicare coverage, including selecting among supplemental Medigap plans, Medicare Advantage (MA) plans and Part D prescription drug plans. SHIPs are also essential in helping beneficiaries navigate an evolving Medicare benefit that includes innovative programs such as Accountable Care Organizations (ACOs) and managed care demonstrations designed for beneficiaries dually eligible for Medicare and Medicaid. SHIP grantees regularly receive referrals from 1-800-Medicare for complex cases and requests for targeted assistance for beneficiaries. SHIPs are able to provide local in-person, in-depth management of cases that cannot be handled during operated assisted phone call.

Each day, 10,000 baby boomers become Medicare eligible. One-on-one assistance provided by SHIPs has grown from 1.2 million client contacts in 2005 to 3.4 million contacts in 2014, a 270 percent increase. If the SHIP investment had simply kept pace with inflation and the increasing number of Medicare beneficiaries since FY 2011, FY 2017 funding would be \$66.6 million. LCAO would like to see an increase in current funding levels to reflect the additional work needed to match the greater demand for assistance and the changing landscape of Medicare benefits and care.

National Institutes of Health (NIH/Health and Human Services)

LCAO supports increased investment at the National Institutes of Health and the National Institute on Aging (NIA) in order to better prevent, treat, and cure chronic diseases of aging. This is one of the most cost-effective ways to reduce health care spending. It is estimated that we will spend more than \$225 billion this year on treating Alzheimer's disease (AD) and other dementias. As many as five million Americans aged 65 years and older may have AD with a predicted increase to 13.2 million by 2050. To address this looming crisis, the NIA is currently engaging in research spanning the spectrum of discovery - from basic neuroscience through translational research to clinical applications. The NIA is spearheading several exciting trials incorporating biomarkers of disease and continues to support treatment trials to slow the disease or alleviate its symptoms. Through the NIA-supported Alzheimer's disease Sequencing Project (ADSP), researchers are now able to access data on rare genetic variants that protect against or contribute to AD and how genes vary among different racial/ethnic groups. The ADSP allows researchers to examine how brain images and other biomarkers are associated with genome sequences.

LCAO supports designated new investments at the NIH through the NIA and all other relevant institutes (e.g., minority health, nursing) in both research and opportunities designed to enhance the research workforce dedicated to addressing elder abuse. As previously mentioned, elder abuse is a significant public health issue that costs billions each year and is particularly prevalent for those with dementia. During the 2015 White House Conference on Aging, conferees identified lack of research as a major barrier to creating and implementing successful solutions to elder abuse. Consequently, in the fall of 2015, NIH convened a meeting and identified gaps and priorities for research in the field of elder abuse. A similar effort was undertaken several years ago, yet a research agenda was never developed and funding was never allocated. In addition to a general allocation of funding, LCAO also supports targeted

funding opportunities for programs of study that examine elder abuse in racial and ethnic minority populations. Like with many other health issues, racial minorities, including American Indians and Alaska Natives, African Americans, Latinos, Asian and others face significant disparities and oftentimes higher rates of different types of abuse, exploitation and neglect than whites.

The President's FY 2017 budget proposal includes \$33.136 billion a proposed increase of \$825 million from FY 2016 levels. The LCAO was pleased to see a significant increase in NIH and NIA funding through the Omnibus Budget Act and support further increases, particularly in aging related research and efforts to explore slowing the aging process. These increases are necessary sustain research needed to make progress in attacking the chronic diseases that are mounting significant cost increases in healthcare.

Geriatric Health Care Provider Training and Education (Health and Humans Services/Health Resources and Services Administration)

The Geriatrics Workforce Enhancement Program (GWEP) is the only federal program working specifically designed to enhance the skills and training of health care teams serving older adults.

In FY 2015, the Health Resources and Services Administration (HRSA) combined the Title VII and Title VIII geriatrics programs into a single comprehensive program, the GWEPs. The GWEP's aim is to improve care quality and safety and reduce the cost of care by providing appropriate training for the entire team serving older adults—family caregivers, direct care workers, and health care professionals such as physicians, nurses, social workers, pharmacists, and psychologists. While we are encouraged by the GWEP's strong focus on interdisciplinary team-based care and care coordination, recent funding levels remain insufficient for meeting our nation's eldercare workforce needs. At the same time that our nation's population of seniors is growing, including those with complex medical conditions, we are facing a serious shortage of healthcare workers (both professionals and direct care workers) with the skills and training to deliver high quality, patient centered care to older adults. We also are concerned that insufficient resources are being dedicated to the training of faculty in clinical geriatrics and gerontology.

Last year's Omnibus Budget Act provided \$38.737 million for the combined geriatric programs (GWEPs) for FY 2016. With our nation's burgeoning population of older adults, we need a stronger and sustained federal commitment to our eldercare workforce. LCAO strongly supports including at least \$45.0 million for the GWEP in the appropriations bill for FY 2017.

MEDICARE

The FY 2017 Budget includes a number of Medicare legislative proposals that would reduce net Medicare spending by \$419.4 billion over 10 years. Unfortunately, approximately \$56.4 billion of the total would be saved by implementing "structural reforms" that would shift additional costs directly onto Medicare beneficiaries.ⁱ LCAO continues to oppose these proposals. It is significant to note that in 2014, half of all people with Medicare lived on incomes less than \$24,150 per year – just above 200% of the federal poverty level, and one quarter of Medicare beneficiaries had annual incomes at or below \$14,350.ⁱⁱ

Implementing a Co-Payment for Home-Health Care: Starting in 2020, this proposal would create a home health co-payment of \$100 per 60-day home health episode, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay.ⁱⁱⁱ We oppose this proposal. It will

create a barrier to home-and-community based services, encourage hospitalization and decrease home care for people with long-term and chronic conditions. Further, the cost-savings are minimal.

Increasing the Part B Deductible for New Beneficiaries: We oppose the President's proposal to increase the Part B deductible (\$166 in 2016) for new beneficiaries by \$25 dollars in 2020, 2022 and 2024 (for a total \$75 increase). This proposal continues efforts to increase out-of-pocket costs for Medicare while beneficiary incomes remain low. According to the Kaiser Family Foundation, 50% of Medicare beneficiaries' annual incomes are below \$24,500.^{iv}

Further expanding Means-Testing of Medicare Part B and D Premiums: We oppose this proposal, as certain Medicare beneficiaries already pay higher Part B and D premiums based upon their income. Starting in 2020, this proposal would increase the amount of premiums paid by higher income individuals and also freeze the income level for higher payments at \$85,000, not adjusting for inflation, cost of living, or any other such factors, until 25% of beneficiaries were paying the higher premiums.^v

Encouraging the Use of Generic Drugs by Low-Income Beneficiaries: Starting in 2018, this proposal would incentivize increased use of generic drugs by Part D Low-Income Subsidy (LIS) enrollees by doubling copayments for brand name drugs from their current low level, while lowering specified copayments for generic drugs. We generally support promoting the use of generic drugs as long as the mechanism for doing so does not create a barrier to obtaining brand name drugs in the rare instances where generic drugs are not therapeutically equivalent. However, CMS should promote generic drugs in a manner that is not punitive to beneficiaries. The same goal to encourage generic use could be achieved by keeping brand copay amounts at current levels and dropping copays entirely for generic drugs.

Prescription Drug Rebates: We support the President's drug rebate proposal, which would restore the law to what it was before Part D, by allowing Medicare to benefit from the same rebates that Medicaid receives for brand name and generic drugs provided to beneficiaries who receive the Part D Low-Income Subsidy (LIS). Drug manufacturers would pay the difference between rebate levels already provided to Medicare Part D programs. Manufacturers would also be required to provide an additional rebate for brand name and generic drugs when their prices rise faster than inflation. Implementing drug rebates would save the Medicare program \$121.3 billion over ten years.

Other Drug-Related Provisions: We support the President's common-sense provisions aimed at bringing greater transparency to drug pricing and obtaining fair drug prices including prohibiting "pay for delay" arrangements between brand and generic drug manufacturers, which slow the entry of more affordable generics into the marketplace, and shortening the length of exclusivity for biologics from 12 years to 7 years. A proposal first introduced in last year's budget would allow the Secretary of Health and Human Services to negotiate prices with drug manufacturers for biologics and high-cost prescription drugs covered under Part D. While we support broader negotiation authority, this would be an important first step.

Closing the Part D Donut Hole More Quickly: We support the President's proposal in the budget that would close the Donut Hole in 2018 – two years sooner than under current law – by accelerating manufacturer drug rebates and increasing brand-name drug discounts in the Donut Hole.

Eliminating 190 Day Cap on Inpatient Psychiatric Hospital Care: As noted in the President's budget, this limit on services "is one of the last obstacles to behavioral health parity in the Medicare benefit."^{vi} We support the provision in the President's budget that would remove this obstacle.

36 Month Rental for Oxygen Equipment: We support repeal of the 36 month rental for oxygen equipment^{vii} as a better alternative for beneficiaries who have been stranded for services and equipment between months 37 and 60 in the event they moved from a service area or had unmet maintenance needs.

Part D “Lock-in” Proposal: In an effort to prevent prescription drug abuse, the budget includes a proposal to allow the Secretary of HHS to establish a program in Part D that “would require that high-risk Medicare beneficiaries only utilize certain prescribers and/or pharmacies to obtain controlled substance prescriptions”.^{viii} While the proposal notes that the program would be “required to ensure that beneficiaries retain reasonable access to services of adequate quality” we are concerned that, among other things, such a program might be overly restrictive on beneficiaries without adequate focus on potential provider-side solutions.^{ix}

Various Payment Reforms: While we support paying providers accurately for high-quality services, we are concerned about how access to care might be negatively impacted by several proposals aimed at delivery system and payment reforms. For example, one proposal focuses on Budget-Neutral Value-Based Purchasing for Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, Hospital Outpatient Departments, and Community Mental Health Centers.^x Value-based purchasing (VBP) demonstrations in Medicare Advantage, hospitals, and skilled nursing facilities did not find improved quality of care for Medicare beneficiaries or reduced Medicare costs. Extending VBP in a budget-neutral manner also perpetuates racial disparities.^{xi} Another proposal seeks to reinstate the 75% Rule for Inpatient Rehabilitation Hospitals.^{xii} By increasing from 60% to 75% the percentage of inpatient rehabilitation hospital (IRH) patients who must meet one of 13 conditions, the proposal would restrict the availability of IRHs for Medicare beneficiaries who need the intensive rehabilitation that only IRHs can provide.^{xiii}

Provide Authority to Expand Competitive Bidding for Certain Durable Medical Equipment: The Budget proposes to expand the competitive bidding program (CBP) to additional categories^{xiv}, including (but apparently not limited to): inhalation drugs (which are already included in the CBP^{xv}); ostomy, tracheostomy, and urological supplies (which makes sense given their recurrent, standard, and general nature); and all prosthetics and orthotics. The category of “all” prosthetics and orthotics is cause for concern. Straying far from the standard and general nature of current CBP categories into customized prosthetics and orthotics, uniquely tailored items should not be included in a highly volume driven, non-customized competitively bid program. Access and availability for customization that is medically necessary will be reduced when suppliers are not compensated for the extra labor and unique equipment. Customized orthotics and prosthetics should not be included in the CBP.

Reforming the Medicare Appeals Process

Over the last few years, the success rate concerning beneficiary appeals at the lower levels of review has diminished, and there have been significant delays in obtaining administrative law judge (ALJ) hearings,^{xvi} where beneficiaries are usually given the fairest review of their claim. We are greatly alarmed at proposals first introduced in last year’s budget and reintroduced this year that would further restrict access to meaningful review of individuals’ claims. These proposals include: establishing a refundable filing fee for providers, suppliers, and state Medicaid agencies, including those acting as a representative of a beneficiary, at each level of Medicare appeal; increasing the amount in controversy (AIC) for ALJ hearings (the 3rd, and most meaningful, stage in the appeals process) to equal the amount required for judicial review in federal court (the 5th and final stage in the appeals process). The ALJ AIC would increase ten-fold (from \$150 in 2016 to \$1,500). Proposals would also allow attorney adjudicators

(presumably with less experience and training than ALJs) to hear appealed claims below the higher AIC threshold, and remand appeals to the redetermination level with the introduction of new evidence.

Beneficiaries, who often have problems obtaining timely documents and other support for their appeals, experience an almost non-existent success rate at these lower levels (a denial rate of about 98%). In December 2015, the Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act of 2015 (S. 2368) was introduced in the Senate.^{xvii} Working from these appeals proposals in last year's Budget, the Senate Finance Committee improved several issues of concern to beneficiaries, but left others in place when marking up the AFIRM Act in June 2015.^{xviii} We remain concerned that rather than addressing the underlying reasons for the appeals backlog, including the quality of review at the first two levels of appeal, these proposals would hinder beneficiaries' appeal rights.

MEDICAID

Protecting and Expanding Medicaid Coverage

Medicaid provides critical health coverage for many low-income Americans, including older adults who are not yet eligible for Medicare. LCAO fully supports the President's proposal to provide three years of full support to states that elect to expand Medicaid to low income adults with household income up to 133 percent of the federal poverty level, regardless of when a state chooses to expand. We also support the President's proposal to create a state plan option that provides 12 months of continuous Medicaid eligibility for adults to prevent "churning," increasing the odds of them becoming uninsured and forgoing needed care.

Improving Access to Home and Community Based Services under Medicaid

Virtually everyone that develops a disability or chronic illness wishes to receive services in the least restrictive setting possible. Unfortunately, when it comes to providing long-term services and supports (LTSS), Medicaid remains "institutionally biased." LCAO supports your continued commitment to expanding home and community based services, while ensuring high quality care, including:

- A Pilot Comprehensive Long-Term Care State Plan Option;
- Expanding Eligibility under the Community First Choice Option;
- Expand Eligibility for the 1915(I) Home and Community-Based Services (HCBS) State Plan Option;
- Allow full Medicaid benefits for individuals in a Home and Community-Based Services State Plan Option.

Continue to Support and Improve Expired or Expiring HCBS Rebalancing Provisions

While the above proposals would help more people that receive LTSS remain in their communities, several critical programs that have expired or will soon were not included in the President's proposal, including Money Follows the Person, the Balancing Incentive Program, or spousal protections for HCBS under Medicaid. Established under the Affordable Care Act, the Balancing Incentive Program assists states in making structural changes and rebalancing their long-term services and supports systems from institutional to more cost-effective home and community-based services. The program has assisted 21

states with the greatest needs to rebalance to make significant progress, *but expired on September 30, 2015*. We urge the President to work with aging and disability advocates as well as Congress to extend and improve this important program.

Money Follows the Person (MFP) Demonstration Will Expired in September: The MFP Demonstration was originally established under the Bush Administration and extended by the Affordable Care Act through September 30, 2016. This bi-partisan program has been adopted by nearly all states. It has assisted states with transitioning tens of thousands of seniors and persons with disabilities from nursing homes back to the community. We recommend extending the program and working with aging and disability advocates as well as Congress to make improvements, such as those outlined in the President's FY15 budget proposal.

Spousal Protection for HCBS Should Be Permanent: Spousal impoverishment protections are mandatory for spouses of institutionalized enrollees, but not for spouses of HCBS enrollees. The Affordable Care Act temporarily repaired this institutional bias by extending spousal protections for HCBS until 2019. We hope in the final year of your presidency you will support making these protections permanent.

Medicare and Medicaid Dual Eligible Enrollees

Aligning Medicare Savings Programs and Part D Low Income Subsidy: We support the President's proposal to improve alignment of Medicare Savings Program and Part D Low-Income Subsidy income and asset definitions. We agree that beneficiaries who qualify for both Medicare Savings Programs and Part D Low-Income Subsidies should not be required to go through "separate and partially duplicative income and asset tests before they can receive benefits."^{xix}

Retroactive Part D Coverage of Newly Eligible Low-Income Beneficiaries: We support the proposal to permanently authorize the Medicare Part D Demonstration for Retroactive and Point of Sale Coverage for Certain Low-Income Beneficiaries (LI NET Demonstration). This demonstration allows CMS to contract with a single plan to provide Part D coverage to low-income beneficiaries while their eligibility is processed, which creates less disruption for beneficiaries.

Federal/State Coordinated Review of Dual Eligible Special Need Plan Marketing Materials: This proposal provides CMS with the ability to coordinate review of marketing materials for Medicare and Medicaid beneficiaries in DSNPs. We support increased coordination and a unified set of standards for such materials.

Integrated Appeals Process for Medicare-Medicaid Enrollees: This proposal grants authority to the Secretary to implement a streamlined appeals process to more efficiently integrate Medicare and Medicaid program rules and requirements. We appreciate that the proposal recognizes the need to preserve the beneficiary protections included in both programs. We urge any actions taken ensure that beneficiary protections are paramount.

Supporting Family Caregivers

LCAO was extremely pleased that the White House Conference on Aging made family caregivers a major theme of the event. LCAO was pleased to see that the budget provides \$2 million increase for the Lifespan Respite Care program, which helps to ease the burdens of caregiving. Although LCAO is pleased that no

cuts to Family Caregiver Support Services were made, significantly more funding is still needed for this critical program.

LCAO also urges that the Administration align the requirement for a caregiver assessment in the 1915(i) HCBS State Plan Option across all HCBS authorities. We also urge the provision of information and referral services to family caregivers of Medicare beneficiaries at the point of admission or discharge from a hospital or post-acute care setting in an effort to assist them in locating available community support services. Care transitions are a time when family caregivers often need additional information and resources.

INCOME SECURITY

Social Security Administration FY 2017 Budget

We are pleased that the President increased Limitation on Administrative Expenses (LAE) funding this year. The increase of LAE funding to \$13.067 billion will allow the Social Security Administration to continue to provide benefits for more than 59 million Americans. Beneficiaries depend on the Social Security Administration (SSA) and its staff to answer their questions and provide access to the benefits to which they are entitled. Everyday 10,000 Americans are turning 65 every day, and the backlog of those awaiting a hearing on their applications for disability benefits is once again growing and putting pressure on the Social Security Administration. The added funds will allow the agency to increase staffing; improve key service delivery areas, such as processing initial retirement and disability claims and disability appeals; and maintain the essential Social Security services upon which millions of Americans have come to rely.

UI/DI Offset

We are pleased that the President no longer included the Unemployment Insurance and Social Security Disability Insurance (UI/DI) offset in his budget. This provision should have never been in there. Only 0.4 percent of DI beneficiaries receive both UI and DI benefits.

The criterion for DI eligibility is not the complete inability to work, but rather the inability to perform “substantial gainful activity” (SGA). DI beneficiaries are permitted to work and, in fact, are encouraged to do so up to an earnings amount of \$1,130 a month. We should be doing everything possible to help those DI beneficiaries who can work to do so, rather than penalizing them. While many claim they want to do this, supporting the UI/DI provision sends the opposite message.

Chained CPI

We are also pleased that the President’s budget for a second year in a row did not include the “chained CPI”. The chained CPI would reduce Social Security’s annual cost-of-living adjustment (COLA) by 0.3 percent a year. This benefit cut would be compounded over time and would equal roughly 3 percent after 10 years, about 6 percent after 20 years, and close to 9 percent after 30 years.

Funding to Modernize SSA’s Information Technology

We are also pleased that the President's budget included \$240 million in mandatory funding over fiscal year 2018, 2019 and 2020. This funding, which is dedicated to modernizing SSA's information technology (IT), specifically its core databases, programming languages and IT infrastructure, will also help ensure added privacy protections.

Exclude SSA Debts from Discharge in Bankruptcy

We are concerned that the President's budget includes a provision that will disallow debts due to an overpayment of OASDI and SSI benefits and certain Medicare-related debts from being discharged in bankruptcy. Many beneficiaries, without knowing, find themselves owing money to Social Security as a result of being overpaid. Oftentimes, these beneficiaries have no way of paying this back without being economically devastated. Typically these types of debts are generally dischargeable in bankruptcy. Social Security does have the ability to ask the court to disallow the discharge when they suspect the individual knowingly committed fraud. However, the President's budget will not allow beneficiaries who are saddled with debt to free themselves of such obligations without going through extra hurdles. LCAO is concerned that this provision may cause many retirees and disabled beneficiaries whose benefits are already modest to not have adequate income to live on.

Increase to 10 Percent the Minimum Amount SSA Can Withhold to Recover an Overpayment

We are concerned that the President's budget increases the amount that the Social Security Administration can withhold to recover an overpayment from a minimum of \$10 to 10 percent of their monthly benefits. SSA currently has the discretion of withholding less than the full amount depending on the beneficiary's financial circumstances, with a minimum of at least \$10 a month. Increasing the minimum amount of withholding to 10 percent of the beneficiaries monthly benefits could cause undue hardship on many retirees and disabled beneficiaries. Currently, retired beneficiaries receive a modest average monthly benefit \$1,341 and disabled beneficiaries receive \$1,166. They are already struggling to make ends meet and this new proposed minimum withholding amount will only make things worse.

Supplemental Security Income

We regret that the President's budget did not include an increase to the resource limit and income disregards in the Supplemental Security Income (SSI) program to reflect, at a minimum, the rise in the cost of living since they were first enacted over 40 years ago. The SSI program provides a safety net for millions of low-income elderly, blind and disabled individuals. Under SSI, enrollees who demonstrate severe economic need are eligible for financial assistance to help meet the basic costs of food and shelter. The program's general and earned income exclusions and its \$2,000 resource limit have not changed in decades – a serious situation that needs to be addressed.

We also believe that the SSI transfer of assets penalty is far harsher than that in Medicaid long-term care and serves no purpose. Furthermore, it greatly increases the administrative burden on SSA staff.

In order to ensure that the neediest seniors receive critical SSI benefits, we recommend that an effective outreach program be developed and funded. In addition, the application for SSI should be simplified to be more appropriate for the population SSI serves. Many SSI recipients do not speak English (approximately 40% of applicants over age 65 have limited English proficiency). Large numbers have low literacy rates,

limited cognitive abilities or emotional disabilities. A complicated applications process can be a barrier for those who most need SSI assistance.

Further complicating the process is the current processing time. After a person files an SSI application, the average amount of time to receive a decision is several months. While waiting for the decision, an SSI applicant is often forced to decide between paying for food and paying for other necessities. An even more serious problem for those who face suspensions or reductions in their SSI benefits is the length of time required to resolve non-disability issues. Because backlogs in local Social Security offices are so large, appeals are not processed in a timely manner. Many SSI beneficiaries wait for months for decisions on their appeals.

SSA must undertake a major effort to augment its services for the increasingly diverse and limited English proficient SSI applicants and recipients. All too often, they receive no assistance in filling out the complex forms. So that SSA can more adequately provide the necessary services, LCAO recommends a significant increase in SSI's allocation for administrative expenses, which should be used to support an overworked and under-trained staff.

ⁱ See, e.g., President's Budget FY2017, p. 112, for cost savings estimate; see HHS FY 2017 Budget in Brief, p. 75 for detailed descriptions.

ⁱⁱ Jacobson, G., Swoope, C., and T. Neuman, "Income and Assets of Medicare Beneficiaries, 2014 – 2030," (Kaiser Family Foundation, September 2015)

ⁱⁱⁱ For information about the potential harm of charging copays for home health, see Leadership Council of Aging Organizations (LCAO) issue brief (February 2015) at: <http://www.lcao.org/files/2015/02/LCAO-Copay-Issue-Brief-Feb-2015.pdf>.

^{iv} <http://kff.org/medicare/issue-brief/income-and-assets-of-medicare-beneficiaries-2014-2030/> (site visited February 18, 2016).

^v For more information about the impact of further income-relating Medicare premiums, see the Leadership Council of Aging Organizations (LCAO) issue brief (January 2013) at: <http://www.lcao.org/files/2013/02/LCAO-Income-Related-Premiums-Issue-Brief-Jan2013.pdf>.

^{vi} HHS Budget in Brief, p. 70.

^{vii} HHS Budget in Brief, p. 73.

^{viii} HHS FY 2017 Budget in Brief, p. 74, available at: <http://www.hhs.gov/sites/default/files/fy2017-budget-in-brief.pdf>.

^{ix} For more information about Part D "lock-in" proposals, see the Leadership Council of Aging Organizations (LCAO) issue brief (November 2014) at: <http://www.lcao.org/files/2014/11/FINAL-LCAO-LockIn-Part-D-Brief.pdf>.

^x HHS Budget in Brief, p. 69.

^{xi} Center for Medicare Advocacy, "Yet Again, Value-Based Purchasing Did Not Improve Quality" (CMA Weekly Alert, Dec. 16, 2015), <http://www.medicareadvocacy.org/yet-again-value-based-purchasing-did-not-improve-quality/>.

^{xii} HHS Budget in Brief, p. 72.

^{xiii} See the Center for Medicare Advocacy's 2007 Weekly Alert describing the phase-in of the "75% rule" that requires 75% of an IRF's patients to have one or more of 13 specified conditions and otherwise require intensive rehabilitation services: *Maintaining Quality Rehabilitation Options for Medicare Beneficiaries* (March 8, 2007)

http://www.medicareadvocacy.org/News/Archives/RehabHosp_RehabOptions.htm.

^{xiv} HHS Budget in Brief, p. 72.

^{xv} See <https://www.medicare.gov/coverage/nebulizers-and-nebulizer-meds.html>.

^{xvi} Note that the Center for Medicare Advocacy has brought litigation aimed at both of these issues; see, e.g., <http://www.medicareadvocacy.org/hull-v-sebelius/>, <http://www.medicareadvocacy.org/lessler-v-burwell/>, and <http://www.medicareadvocacy.org/center-for-medicare-advocacy-sues-to-fix-broken-medicare-appeals-system-2/>. For more information, also see the Center for Medicare Advocacy's Weekly Alert (April 30, 2015), at: <http://www.medicareadvocacy.org/senate-finance-committee-holds-hearing-on-medicare-appeals-backlog-proposed-solutions-are-of-great-concern/>.

^{xvii} See the Center for Medicare Advocacy's Weekly Alert (December 10, 2015), at: <http://www.medicareadvocacy.org/proposed-appeals-legislation-leaves-unanswered-questions/>.

^{xviii} See the Center for Medicare Advocacy's Weekly Alert (June 4, 2015), at: <http://www.medicareadvocacy.org/senate-finance-committee-approves-medicare-audit-and-appeal-reform-bill/>.

^{xix} HHS Budget in Brief, p. 99.