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Links

An ANCOR publication of private provider practice and federal policy issues.

Public Policy Update

ANCOR Board Approves Principles for Medicaid Reform

In light of impending Medicaid reform efforts, the ANCOR Public Policy Division developed the following "Statement and Principles on Medicaid Reform," which was approved by the ANCOR Board of Directors on February 07, 2002. The purpose of this document is to clearly articulate the overarching principles that ANCOR believes should guide any Medicaid reform efforts.

ANCOR Statement and Principles on Medicaid Reform

The Medicaid program plays a critical role in providing necessary supports and services to 47 million Americans in 2002, including 11 million individuals with disabilities—7 million of whom are under age 65. Medicaid is the primary financing mechanism for health and long-term services for people with disabilities. Through its Federal/State partnership in the financing and delivery of services, Medicaid is also the major funding source for reimbursing providers of long-term supports and services to people with mental retardation and other disabilities. It is ANCOR's top priority to advocate for protecting and strengthening Medicaid as the critical safety net for people with disabilities.

ANCOR believes that the following overarching principles should guide any Medicaid reform:

• The Federal government must maintain its historic role financing the safety net for people with mental retardation and other disabilities and must assure adequate reimbursement rates for long-term supports and services.

• Medicaid financing must not be cut nor should reforms be used as a means of balancing the Federal budget.

• Any Medicaid reforms should be driven by the goals of enhanced coverage, quality, and adequate reimbursements; increased efficiency; decreased waste and fraud; and the delivery of services that meets the individual needs of people with disabilities.

• Neither people with disabilities nor their providers should bear the burden of efforts to contain the costs of Medicaid, nor should savings be exacted from Medicaid that place individuals or providers at undue risk.

• Medicaid waivers should not be used to diminish Federal protections for individuals or providers.

In addition, ANCOR adheres to the following principles regarding Medicaid reform.

Sound Infrastructure with Adequate Provider and Workforce Capacities

• Federal Medicaid policy must be based upon sound service and support infrastructures that include: (a) coordination of natural, generic and specialized supports as needed and desired by individuals; (b) adequate provider capacity; and (c) a stable, quality, and competitively compensated workforce.

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Industry Consultants To Be Featured in May Issue of *Links*

The May 2003 issue of *Links* will feature a special resource section highlighting industry consultants. This important resource section will provide an opportunity for individual consultants to share their expertise and the scope of their services in the context of critical issues facing today's private providers. Consultants will be asked to include three reasons why ANCOR members contact them. If you are a consultant who wants the private provider industry to know more about your services and unique capabilities, then this special issue is for you. Full-page section: $750.00. Make your reservations now! Call or e-mail Marsha Patrick at 703-535-7850 or mpatrick@ancor.org.

Space Reservations and FINAL Material Deadline: 4/2/03

ANCOR

The American Network of Community Options and Resources (ANCOR) was founded in 1970 to provide national advocacy, resources, services and networking opportunities to providers of private supports and services. *Links* provides a nexus for the exchange of information, ideas and opinions among key stakeholders.

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CEO Perspective

Some Ask Why; I Respond, Why Not?

Renée Pietrangelo

About a third of ANCOR members have taken up the mantle of the National Advocacy Campaign (NAC) through financial support, direct leadership and active participation. Where are the other 400 providers? Some of you I know still question the need and/or viability of this initiative. You ask why? My response is, why not?

If the summary of NAC progress and achievement which begins on page one of this issue of *Links* fails to assuage your doubts, I'd like to offer a different rationale. The quantum world teaches that there are no pre-fixed, definitely describable destinations. There are, instead, *potentials* that will form into realities and ideas depending on who the discoverer is and what he/she is interested in discovering. Only by venturing into the unknown do we enable new ideas and new realities to take shape. I view the NAC as a potentiality for the creation of new strategies and realities.

I believe some of our past approaches are outmoded, and that the longer we remain entrenched in our old ways, the further we move from those wonderful breakthroughs in understanding needed to move the agenda forward. As Albert Einstein is often quoted as saying, "No problem can be solved from the same consciousness that created it." The NAC is a serious and focused attempt to shift our collective consciousness in order to open the way for dynamic approaches to the challenges facing us.

The operative word here is *collective*. In community and working together, speaking with one voice we can effect change. The power of a unified voice is inestimable, best articulated by Robert Kennedy:

"Each time a person stands up for an idea, or act to improve the lot of others, or strikes out against injustice, (s)he send forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring, the ripples build a current that can sweep down the mightiest walls of …resistance."

The ripples from thousands of private providers, their staffs, Board members, consumers and families collectively will form a current that can change the course of the lives of hundreds of thousands of people with disabilities and those that support them. We know this to be true; ergo, why not? Join us! ■

Remember, you can advertise your employment opening or post your job qualifications at no cost on the ANCOR website: www.ancor.org in the "Careers" section. If you have any questions regarding our website, contact Catherine Dunkelberger at cdunkelberger@ancor.org.

Building the Future Today

Fred Romkema, President

Building the Future Today, the exciting theme of the ANCOR Winter Conference, suggests we are laying the cornerstone and placing upon it building blocks for future generations. Those of you who are attending the conference in San Antonio no doubt will hear national leaders expound on national trends and recommendations for change. Topics will include budgetary shortfalls, technology changes to enhance services, and the perennial challenge of finding and keeping employees. The conference will act as a change agent as we plan to enhance the delivery of services. In light of events that have and will occur, I relate to a Monday I recently experienced and the realities of day-to-day services.

As I came to work on the Monday morning after having absorbed the Columbia Space Shuttle tragedy, I was briefed by key management staff as to how the weekend went. Once again, I heard concerns over staffing shortages and how key management staff had gone in over the weekend to fill shifts and deal with aggressive behaviors that had sent one staff member to the emergency room.

These same staff had spent the previous week completing ICAP reports (Inventory for Client and Agency Planning), and had gone to the state capitol to testify before the Appropriations Committee. They, along with parents and myself, testified in favor of the governor's budget, which allocated a 2.2 percent increase in reimbursement to the community-based system. (They did an excellent job!)

I was struck with pride and awe...pride that key management staff exhibit such versatility of skills...and awe that I was NOT surprised! Staff had just gone from the completion of ICAP reports on all people served in our agency, to testimony before an intimidating group of legislators, to performance of day-to-day tasks in a residential setting in which aggressive behaviors occur. My surprise was that this was not an unusual Monday morning event. This is almost routine and expected that management staff fill in on the weekends and come to work on time on Monday morning to perform their "regular" duties. However, I also thought that this is not a good way to "run a railroad."

You see, our agency is faced with staff shortages. Inexperienced staff perform complex and difficult duties in sometimes difficult situations. We do the best with what we have, which is not enough, and I think about the Columbia Shuttle tragedy. Will it take a tragedy to alert people in decision-making roles to realize the crisis we are experiencing?

By the time you read this, ANCOR will have accomplished a proactive effort to recognize governors who supports what ANCOR believes in—supporting people in environments of their choice and inclusion in the community. As nearly all of us are dealing with the aftereffects of state budget deficits, we felt it appropriate to honor those governors who are sympathetic to our cause. Congratulations to staff for spearheading the effort and congratulations to the governors chosen!

An on-going effort that affects all of us is the National Advocacy Campaign. As part of this effort, Carol Mitchell and Rod Braun have has spearheaded campaigns to encourage their direct support staff to donate $5 to the effort. We need help in this endeavor. If you haven't encouraged your staff to donate, please do so now. The publicity portion of the campaign needs your assistance!!

Remember...*we are building the future today*...one donation and innovative practice at a time! ■

ANCOR Announces Furniture Vendor Partnership

ANCOR is proud to announce a new benefit for members. A partnership has been established with Furniture Concepts and Furniture Associates, a well-respected wholesaler that supplies furnishing to all types of residential care facilities nationwide, and now offers special discounts to ANCOR members.

Discounts on merchandise range from 1 to 5% based on the size of the order. ANCOR members need only identify themselves. Details are available by calling 1-800-969-4100.

Located outside of Cleveland, Ohio, Furniture Concepts and Furniture Associates is a third generation, family owned and operated wholesale distributor and manufacturer's representative for a broad variety of companies that supply furnishings for hard use environments. They have existing customers in every state including Hawaii and Alaska as well as Mexico, the Caribbean and Canada. Services include design, layout, procurement, and complete delivery and installation when requested.

Their dedication to old-fashioned service both before and after the sale have resulted in a long list of satisfied customers throughout North America. They operate under a philosophy of "corporate responsibility" and donate a portion of quarterly profits to selected charities that reflect the population served.

You'll be able to see and learn more about Furniture Concepts and Furniture Associates at their exhibit during ANCOR's Winter Conference in San Antonio.

Medicaid Reform

continued from page 1

Ensure Federal Entitlement with Comprehensive Benefits, Adequate Financing and Quality

• The Federal entitlement to Medicaid must be maintained, guaranteeing a Federal definition of disability and Federal requirements for eligibility, timely access to supports and services, quality standards, individual and provider protections, and a private right to action.

• Any revisions in current Federal law must maintain the vital Federal role that Medicaid now plays in financing supports and services for individuals with mental retardation and other disabilities.

• The delivery of long-term supports and services must be closely coordinated with the provision of primary and preventive health care services to individuals with mental retardation and other disabilities.

• Financing long-term supports and services for individuals with mental retardation and other disabilities must remain a distinct, identifiable role of the Federal-State Medicaid program in every state.

• Federal Medicaid policy must ensure the safety and health of individuals with mental retardation and other disabilities, including adequate reimbursements based on actual costs to ensure that sufficient funding for wages are available; cover the costs of quality enhancement, recruitment, retention and training of a quality workforce; and Federal oversight.

• Individuals with disabilities must not be burdened with inequitable and disproportionate costs that limit their access to supports and services and any cost sharing must preserve the individual's ability to meet the expenses of their other life necessities.

Individual Supports with Active Individual and Provider Involvement

• Long-term supports and services for individuals with mental retardation and other disabilities must be tailored to each individual's unique needs.

• Individuals with disabilities and their families are essential voices in determining the supports and services an individual receives.

• Providers (and other stakeholders) must be guaranteed meaningful, active participation in the design, negotiation, implementation, monitoring and evaluation of Medicaid long-term supports and services.

Community Inclusion, Investment and Maximizing of Resources

• Medicaid must promote full implementation of the Olmstead decision, self-sufficiency, broad opportunities for community inclusion, and the exercise of full citizenship rights by individuals with mental retardation and other disabilities.

• The institutional bias in Federal Medicaid policy and financing must be eliminated with home and community-based services authorized as a mandatory part of each state's plan and adequate financing to support this policy emphasis.

• Medicaid must be utilized to address the growing backlog of unmet service needs and eliminate waiting lists.

• Any reforms that produce Medicaid savings in long-term supports and services must be reinvested to meet the unmet needs of individuals with mental retardation and other disabilities.

• States must maximize their state resources and increase the proportion of total Medicaid expenditures devoted to community options. ■

ANCOR National Advocacy Campaign Continues Momentum

Throughout the implementation of the ANCOR National Advocacy Campaign (NAC), we have brought to ANCOR members and other key stakeholders periodic updates on campaign activities. This is the latest in that series.

Building a strong foundation is the prelude to any kind of activity, including public awareness. Before taking our cause to the American people, NAC leaders and volunteers worked to inform ANCOR members about the scope and objectives of the campaign and to encourage each member to get involved in a substantive way.

That effort included a series of focus groups to garner input from ANCOR members and important affiliates regarding a campaign theme. Working with that data and taking into account the many nuances and connotations, a theme emerged, *"America's Quiet Heroes—By empowering Americans with disabilities, direct support professionals strengthen all of America."*

With this in place, attention was turned to creating a poignant campaign video and brochure package. First unveiled at the March 2002 ANCOR Winter Conference in Myrtle Beach, the video and brochures have been presented at 27 state provider associations and numerous individual provider agencies. The touching visuals and stirring message has resonated with audiences and, very significantly, campaign membership is rising. There are currently 150 ANCOR members and affiliates supporting the campaign through financial and in-kind contributions totaling nearly $700,000.

A package of materials delineating the National Advocacy Campaign's key messages is currently in use by ANCOR members, leaders and state affiliates. Additionally, a grassroots development kit has been distributed to ANCOR member agencies and local civic groups that includes tools for informing and garnering NAC support by community leaders and private provider agency board members, direct support staff, consumers and family members. These materials plus much more are downloadable from the campaign website www.supportnac.org or via CD by request.

The National Advocacy Campaign has received the endorsement of major national disability organizations, including AAMR, The Arc of the U.S., The Council on Quality and Leadership, CARF, and the National Alliance of Direct Support Professionals.

Congress and the Administration Take Notice

To date, NAC contributors and members have been personally addressed by Secretary of Labor Elaine L. Chao, Deputy Secretary of HHS Claude Allen, and Congressman Pete Sessions (R-TX). Each has demonstrated an acute knowledge of the issues and challenges faced by the private provider community, a testament to the NAC's impact at raising federal awareness.

In what can only be cast as a genuine communication to our members in attendance at the September Governmental Activities Seminar, Department of Labor Secretary Elaine L. Chao acknowledged the critical value of private providers and pledged the Administration's full support in addressing the direct support workforce crisis through efforts to both increase the workforce pool and partner to address training and development issues.

Congressman Sessions and Congresswoman Lois Capps (D-CA) also voiced their support of the NAC during a September 2002 press conference at which time they announced the introduction of a Congressional Resolution calling for recognition of the critical role direct support professionals play in advancing community inclusion and enhancing the lives of hundreds of thousands of people with mental retardation and other developmental disabilities.

In poignant messages by these congress members, a parent and a dedicated direct support professional—Tonya Simmons—the fact the nation's objective of community inclusion for all Americans is at grave risk because of the crisis in recruiting and retaining a stable, quality direct support professional workforce resounded clearly. The Resolution will be reintroduced into the House and introduced into the Senate in March 2003 to coincide with the national observance of "Disabilities Awareness Month." In addition to the NAC campaign supporters noted earlier, the Congressional Resolution has also garnered the support of UCPA and the National Association State Directors of Developmental Disability Services.

ANCOR leaders have had fruitful meetings with Department of Labor and Centers for Medicare and Medicaid leaders throughout the past 18 months. A special briefing to campaign contributors by Lanny Griffith, a principal with Barbour Griffith and Rogers, the consulting firm directing ANCOR's advocacy initiative, is scheduled for the ANCOR Winter Conference in mid-March.

Crucial Summit Meetings

Two private provider CEO summit meetings were held in March 2001 and May 2002. A third summit meeting is planned for May or June 2003, the focus of which will be the Medicaid funding crisis threatening the stability of the private provider network, and impending Medicaid reform.

Research

The first of the NAC's research efforts culminated in the publication and dissemination of a report substantiating the grave decline in labor purchasing power private providers have experienced over the past nine years.

The research data released by BDO Seidman, a respected consulting firm highly regarded on Capitol Hill, substantiates the plight of private providers in assuring a stable, qualified workforce. Widely distributed among private providers, the research was also distributed with a compelling letter to state MRDD and human services directors. ANCOR encourages its state association members to use the report to support state legislative efforts. ANCOR also plans to use the research to drive Congressional hearings on the dimensions and severity of the direct support workforce crisis.

Of note is that wages have increased only $0.82 over a nine-year period versus $3.16 and $2.11 increases for "public" direct support workers and fast food workers, respectively. The percentage increases over that same period for public direct support and fast food workers were 200 to 300 percent, respectively.

"Private agencies serving the developmentally disabled cannot attain and retain qualified employees when wages in competitive

markets are increasing at a much faster rate," stated Joe Lubarsky, a principal partner with BDO Seidman. "The wage increases for direct support workers over an eight-year period are roughly one-third of the percentage increase in spendable income nationally over the same time period."

Public Awareness

Of major import is the current development of a series of public service announcements, the first to be unveiled and run nationwide in March 2003. These PSAs have been made possible by the generous contributions of Kathleen Chalfant of CBS TV's *The Guardian* series; Nancy Chalfant, one of the founding members of Verland, an ANCOR member agency in Sewickley, PA and the mother of a deceased child with severe developmental disabilities; Midge Soderbergh, mother of Academy Award-winning director Steven Soderbergh and Peter Soderbergh, an adult with developmental disabilities; David Smith, president of Sinclair Broadcast Group; and ANCOR member agencies and campaign supporters ResCare, Verland and YAI. Sinclair Broadcast, which operates in nearly 50 television markets nationwide has committed to airing NAC PSAs on each of their stations. Additionally, the expertise and creative talents of Triscari Productions and Ramirez Communications have been instrumental to the development of the campaign videos, web site and PSAs.

Keeping You Informed

The NAC website is updated monthly with progress reports and useable materials to help contributors implement their own grassroots initiative in support of the National Advocacy Campaign. Use of available technology has been maximized with the development of a CD that includes the newest campaign video, which highlights NAC strategies and success to date; a Power Point presentation for use at agency or local civic meetings; the complete text of the BDO Seidman research report; and other campaign information. All these tools are now available on-line via CD or the NAC web site.

The Work Remaining

No campaign of this scope and magnitude can achieve the sum of its goals in two years. It's anticipated that to reach its goals, the NAC will be a three- to five-year effort.

As noted earlier, the campaign has raised nearly $700,000, not including in-kind supports from many of our consultants and members. To support and sustain the level of effort needed for a three- to five-year campaign, we will need to raise am additional $2 million. That means we need the support and participation of every ANCOR member, their board and family members, and direct support staff.

In addition, ANCOR is actively seeking supplemental support from corporate and other grant awards. We encourage ANCOR members to do likewise.

In Shakespeare's play *Henry V*, King Henry, poised on the eve of battle and vastly outnumbered by the French, is asked about his army's readiness. *"All things are ready if the mind be so*," is his reply.

ANCOR's collective mind is certainly ready, and it has manifested that resolve in its aggressive National Advocacy Campaign. With every program of supports and services in the country at risk everyday, we must be resolved in order to tackle the workforce and funding challenges we face.

As Secretary Chao stated so eloquently, "I believe that when government, associations, business and individuals work together, we can make miracles happen."

Join us today! ■

ANCOR's Winter Conference

BUILDING THE FUTURE TODAY

MARCH 16-18, 2003

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A sampling of topics include:

- **Navigating in a Stormy Policy Environment**
- **Quality Assurance**
- **National Advocacy Campaign**
- **Cultural Shifting**
- **Leadership Survival Skills**
- **Fiscal Intermediaries**
- **Transforming Your Agency With Innovative Software**
- **Legal Liability/ Self Determination**
- **Workforce Recruitment/ Retention Strategies**
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Administration Proposes Medicaid Overhaul

With the states continuing to struggle with the worst budget crisis in half a century, and the Federal budget's return to deficits through the remainder of the decade, the Administration is proposing a *new optional program* for states. President Bush's proposed fiscal year 2004 budget request includes a plan to modernize the Medicaid and State Children's Health Insurance Programs (SCHIP) by offering a new option with increased flexibility to the states—the *State Health Care Partnership Allotment*. Most significantly, for the first time, the Federal government would stop paying for a share of care provided each individual who is enrolled. State Medicaid programs would rely on *fixed* Federal subsidies—designed and run by individual states. The proposed Medicaid changes require approval from Congress.

The proposal would import to the 38-year old Medicaid program, the central idea behind the overhaul of the welfare system and the creation of SCHIP in the 1990s. The plan seeks to consolidate Medicaid and SCHIP funding to states—converting the funding into two state grants—and would alter the notion of federally promised health care guarantees by restricting the federal responsibility for how the state programs are run and who receives help them with programs. The proposal would also provide states with an incentive to take the option because it is tied to additional upfront funding. The Administration estimates that the new program option would be *budget neutral* over ten years.

> We need to bring the same clear-eyed spirit of innovation to Medicaid that we brought to welfare. We need to leave behind the old definitions and look at how we can better serve today's beneficiaries.
>
> HHS Secretary Tommy G. Thompson

In a press briefing on January 31st prior to the release of its budget proposal on February 3rd, Department of Health and Human Services (HHS) Secretary Tommy G. Thompson announced the Administration's proposal to create this new state option in response to governors' pleas for increased federal financial assistance and increased flexibility. Thompson compared the need for improving Medicaid with the mid-1990s movement to reform welfare. (Note: Congress and the previous administration ended the individual entitlement to welfare and provided a fixed amount of Federal funding for welfare with its overhaul of the law in 1996.)

The FY 2004 budget proposal includes a set of underlying principles of the Administration's Medicaid and SCHIP plan. Included among the principles are to: curb the growth of federal and state program costs; provide states with increased flexibility to design benefit packages without waivers, including increased use of consumer-directed services and home-and community-based care; simplify payment policies and rules for the programs; increase federal partnerships to reduce the number of uninsured Americans; and enhance coordination and utilization of private insurance.

The new state option is based on the SCHIP model that Congress adopted in 1997 and the new Health Insurance Flexibility and Accountability (HIFA) Section 1115 Medicaid demonstration waiver created by the Administration in August 2001. The HIFA waiver enables states to used Medicaid and SCHIP funds with increased programmatic flexibility, waiver simplicity, and in concert with private insurance options to expand coverage to non-Medicaid eligible, low-income, uninsured individuals, with a focus on those individuals with incomes at or below 200 percent of the Federal Poverty Level. Seven HIFA demonstrations have been approved to date: four states (New Mexico, Maine, Illinois, and Oregon) to use Medicaid and SCHIP funds to support employer sponsored health insurance coverage and five Pharmacy Plus demonstrations (Illinois, Wisconsin, Maryland, South Carolina, and Florida) to extend Medicaid drug-only coverage to certain low income individuals who are elderly or have disabilities.

Limit Federal Funds and Provide Two State Allotments

The proposed new State Health Care Partnership Allotment would, if enacted, provide states with an option that, if selected, includes the following:

- States could elect to accept their combined Federal Medicaid and SCHIP funding in *two lump-sum allotments:* (1) one for all acute care/disproportionate share hospitals and (2) one for all long-term care.
- Provide an *estimated $3.25 billion in extra Federal Medicaid funding in FY 2004* for states, with $12.7 billion in extra funding over seven years.
- Provide states with the ability to transfer funding between each allotment (e.g., up to 10 percent).
- *Limit each state's allotment to FY 2002 expenditure levels*, increasing the allotment annually using a yet undetermined *specified trend rate* (adjusting federal funding to a *predictable* level).
- Require states to *contribute maintenance of effort* (MOE) funds based on FY 2002 state expenditures—inflated annually by a trend rate—*but a rate lower than that for Federal allotments* (reducing state MOE requirements over the long term).
- Provide states with *significant flexibility* (eligibility, benefit packages, co-payments) within each allotment to design health insurance options for their uninsured populations, encouraging states to seek private sector solutions including premium assistance and Federally enacted health tax credits.
- Provide states the flexibility to *design programs without waivers*, including increased use of consumer-directed services and home and community-based services.

Although it offers inducements to states to elect this new option with a short-term increase in funding, states would be confronted with a choice between two alternatives:

- States could select the current Medicaid program and try to operate it without any financial relief from the Federal government to help them get through their current fiscal crises—a path likely to lead to deeper Medicaid cuts; or

• Receive some modest additional funding for the next few years, but only if they agreed to convert much of their Medicaid program into a combined and capped grant, under which federal funding no longer would rise to meet increases in need due to recession, epidemics, or other factors. States electing this second option would have to pay back the additional funding by the end of the decade.

The proposal would provide additional funding to states initially. Secretary Thompson said states would see *reduction in the Medicaid expenditures* and additional federal Medicaid assistance over seven years. However, states would receive less money than under current law.

The table below lays out the costs and savings associated with the new allotment option, as well as the budgetary impact of other Medicaid and SCHIP proposals (e.g., Money Follows the Individual, other New Freedom Initiatives, Extension of 2000 SCHIP allotments, and other reform proposals). The *scoring* for both the new combined allotments and other Medicaid/SCHIP proposals depends on the number of states that take up the option. The other proposals apply only to states that do not chose the new allotment option. Generally, the costs and savings associated with the other proposals decrease as more states take up the allotment options.

Reshaping of Optional Medicaid Recipient and Service Categories

According to HHS Secretary Thompson, the Administration's proposal does not amount to a block grant nor end the basic entitlement to certain populations. Thompson said the proposal *preserves comprehensive benefits for mandatory groups* (those individuals automatically eligible for Medicaid under current law, including individuals with disabilities dependent on Supplemental Security Income (SSI), poor children and welfare recipients). At the same time, the proposal would *give states expanded flexibility to tailor coverage for non-mandatory recipients* (e.g., medically needy categories, individuals receiving Social Security Disability (SSDI) payments above the SSI level, some individuals under the home- and community-based waiver services and some individuals eligible for Medicaid under the Ticket to Work state program option) *and non-mandatory services which comprise three-fourths of Medicaid spending* (e.g., intermediate care services for persons with mental retardation and related conditions (ICFs/MR, home- and community-based waiver services (HCBS), personal care services, prescription drugs, physical therapy and related services, home health care services, clinic services.) [Note: Under current law, the *only mandatory long-term service is nursing home services. ICFs/MR, HCBS waiver services, personal care and other home- and community-based services are non-mandatory services—are at the option of each state. Also, approximately one-fourth of all Medicaid beneficiaries with disabilities are optional coverage for states.]*

> We can't get this legislation passed unless governors are enthusiastically behind it and push it. If they do, then we have a good chance of passing it.
>
> HHS Secretary Tommy G. Thompson

The Administration states that the new option is not a *block grant*. While it may not be as sweeping as Republican proposals in the mid-1990s to end the automatic guarantee of health and long-term benefits to low-income elderly and people with disabilities, it does have some of the same elements. A primary goal of the new proposal appears to be to reduce federal Medicaid expenditures over time. It would fundamentally alter current law and end the current entitlement nature of Medicaid; consolidate and convert both Medicaid and SCHIP funding, as well as other Medicaid grants and demonstrations into combined allotments; eliminate the current automatic federally funded-formula that fluctuates based on each state's per capita, disability, and other factors; reduce the current formula with fixed funding to states; and provides states with far more flexibility and discretion in designing their programs.

Response to Administration's Plan

Medicaid has been a politically sensitive issue since its creation in 1965. President Reagan proposed to convert the Medicaid program into a system of block grants in 1981. That idea was revived when some in the mid-1990s some in Congress focused on block grant reform and Medicaid cuts and included in the 1995 reconciliation bill that was ultimately vetoed by President Clinton. Congress then provided Medicare and Medicaid cuts and increased latitude to place Medicaid enrollees in managed care plans without a waiver in the 1997 Balanced Budget Act.

Some individual governors have expressed interest in the new proposal that appeared to include many of the recommendations in a January 16th letter to President Bush and HHS Secretary Thompson from Governors Jeb Bush (R-FL), John G. Rowland (R-CT), and Bill Owens (R-CO). [The text of that letter was sent to ANCOR members in the January 31st electronic transmission of ANCOR's Washington Insiders Club Update.] However, the National Governors Association (NGA) issued a short, non-committal response on January 31st and stated that they need more time to study the plan.

House Energy and Commerce Committee Chairman Billy Tauzin (R-LA) supports the Administration's efforts to modernize Medicaid and hopes to move legislation to bring major revisions to the program through his committee this year. A February 6th hearing scheduled to begin a series of hearings on Medicaid reform—and including Governors Bush and Bill Richardson (D-NM)—was postponed due to a memorial service for NASA astronauts.

However, Senate Majority Leader Bill Frist (R-TN) has stated that writing such bold changes into federal law are unlikely this year and that the most important Medicaid changes will come through enactment of a proposed Medicare prescription drug benefit that shifts to the federal government the costs of providing drugs to individuals eligible for both programs. Senate Finance Chairman Charles Grassley (R-IA) issued a short statement indicating that he would not comment on

Medicaid/SCHIP Federal Funding Levels
(In millions of dollars)

Year	2003	2004	2005	2007	2011	2012	2013	2004-2013
Allotments	0	3,258	1,053	1,213	-153	-4,410	-8,285	-66
All other proposals	225*	154	331	117	-636	-723	-781	-2,396

*Current Grants to States for Medicaid

the President's Medicaid proposal at this time, but would await further study of the proposal; while Senate Finance Committee's Ranking Member Max Baucus (D-MT) issued a statement that called for immediate fiscal relief for the states instead of the fundamental changes proposed by the Administration and declined to support the President's proposal.

> What Medicaid needs is to be strengthened, and the federal government needs to assume its fair share. It's federal neglect, not federal regulations that are damaging the program.
>
> Senator John D. Rockefeller IV (D-WVA), sponsor of the State Budget Fiscal Relief Act (S. 138)

Democrats responded unfavorably to the Administration's plan with Senator Ted Kennedy calling it a *never-ending assault on health programs for the poor*. He stated that he would fight any attempts to give states flexibility from federal rules which would lead to limits on eligibility and benefits.

Low-income health care, disability, and other national organizations also responded with statements raising concern about the Administration's Medicaid proposal. ANCOR joined with more than 50 national organizations and the Consortium for Citizens with Disabilities in issuing a statement detailing these concerns.

ANCOR recognizes the challenges facing the nation regarding long term care, supports the need for long term care financing reform, and is committed to working with the Administration and Congress to address these issues.

However, long-term reform must include the involvement of all stakeholders—consumers, families, providers, federal, state and local governments—to ensure adequate infrastructures, quality supports and services, and adequate provider capacity. It must be done in the context of overall reforms to Medicare, Medicaid, and Social Security to provide individuals with disabilities the financial, health, and long-term care security that they deserve. In the short-term, ANCOR believes that an immediate, temporary infusion of Federal Medicaid assistance to states is necessary to avert the current Medicaid crisis and life-threatening eligibility and benefit cuts to individuals. This will enable the nation to take the necessary time and necessary measures to provide responsible overall long-term care reform tailored to individual needs that enhance consumer choice and cost-effective quality supports, addresses the burgeoning waiting lists, the direct support professional crisis, inadequate provider reimbursements, and the impending retirement of the baby boom generation.

ANCOR provided members with an Alert on the Administration's plan in early February and has additional information on its website at www.ancor.org. ■

Reports Confirm State Budget Crises, Medicaid Cuts in Two-Thirds of States, and Reductions in Jobs Wages and Business Activity

States continue to confront the most daunting fiscal situations they have faced in decades, according to the Kaiser Commission report.

Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003.

While states planned for tough fiscal times during their budget deliberations for fiscal year 2003, halfway through the year nearly two-thirds of states have had to implement or are planning a second round of Medicaid cuts. With many calling the state fiscal condition the worst since World War II, Congress is being pressed to provide a temporary infusion of Medicaid funding to states to avert Medicaid cuts that place at risk the health and long-term care coverage of children and adults with disabilities and the elderly.

The Kaiser Commission on Medicaid and the Uninsured (KCMU) released three new reports about the states' fiscal crisis and it's effect on health coverage at a Washington, D.C. briefing in January. According to its updated survey of 50 states and the District of Columbia, KCMU found that 49 states have planned or implemented Medicaid cuts in FY 2003—with 32 of them having taken action twice.

Within a few days of the KCMU briefing, Families USA released a new report showing that proposed state Medicaid cuts would significantly reduce jobs, wages and business activity. The report indicates that states stand to lose an average of 37 jobs for every million dollars cut in their Medicaid program in 2003 and to lose on average $3.4 million in business activity for each million-dollar reduction in Medicaid spending.

The reports showed that the fiscal pressures states faced last year have increased in recent months—leading to deterioration in services and supports to individuals and gravely undermining provider stability. These national reports, confirming what many ANCOR members continue to report to national headquarters, underscored ANCOR's steadfast commitment to work with Congress and the Administration to provide immediate fiscal relief to the states. Resolute in its belief that the current situation is unprecedented and will adversely affect the nation's long-term supports and health services' infrastructure that assists individuals with disabilities, ANCOR has also stepped up activities seeking an immediate, temporary infusion of funding to states.

In collaboration with Citizens for Long Term Care and other national organizations, ANCOR held a press conference February 21s with governors on the eve of the National Governors' Association meeting in Washington, D.C., and called on Congress for immediate relief. ANCOR has also stepped up work with other coalitions formed last year that led to a bipartisan Senate-passed fiscal relief bill. ANCOR sent letters to every Senator in January and began Capitol Hill visits in February on the Rockefeller-Collins-Nelson-Smith bipartisan State Budget Relief Act of 2003 (S.138). In early February, ANCOR began work again in support of the King-Brown bill scheduled for reintroduction in mid-February. Both bills are designed to provide a quick, one-time infusion of Medicaid and Title XX Social Services Block Grant funds to states. Other relief bills have begun emerging and ANCOR will continue to work for state relief and inclusion of temporary funding in an economic stimulus package to be voted on this spring.

Deepening Fiscal Crisis Threatens Medicaid Coverage

The KCMU report on *Medicaid Spending Growth* was conducted in December 2002 and updates the survey of state budgets conducted in June 2002. Virtually every state and the District of Columbia have already taken Medicaid cost-containment actions for FY 2003.

The survey also revealed that 32 states found it necessary to take further action to reduce spending for the year and 5 states, which had not taken action prior to July, now feel cuts are necessary. KCMU reports that these actions come in the face of a worsening fiscal situation and widening budget gaps. State cost containment efforts include the following:

• 27 states report that their Medicaid budget shortfall is even greater than they had

projected at the beginning of the fiscal year;

• 37 states have made provider payment reductions, including freezing provider rates or reducing rates or increases;

• 16 states implemented provider taxes;

• 45 states have established prescription drug cost controls, including prior authorization, preferred drug lists, monthly prescription limits, new or higher beneficiary copayments, and mandating generics;

• 25 states have reduced benefits, including restricting or eliminating dental coverage, occupational or physical therapy, and inpatient hospital days;

• 27 states have instituted eligibility cuts and restrictions;

• 17 states have increased beneficiary copayments; and

• 19 states have planned to or have taken action to reduce spending on long-term care, both in nursing homes and community-based settings. (NOTE: Four states have raised the minimum criteria for acceptance into their HCBS Medicaid waivers and one state froze the number of HCBS slots available.)

With the state fiscal crisis entering its third year and the crisis expected to continue, budgetary pressures are building. Unlike previous times of fiscal crisis, depleted rainy day funds and tobacco settlements and Federal curtailment of options to maximize Federal dollars have left states with limited options. KCMU projects that deeper cuts are likely.

Observations of Medicaid Officials Regarding the Outlook for FY 2004

It doesn't matter what I tell you about how our program looks right now, because it won't be the same in July.

For a copy of KCMU's *Medicaid Spending Growth: A 50 State Update for Fiscal Year 2203, The State Fiscal Crisis and Medicaid: Will Health Programs Be Major Budget Targets*, case study reports, and to view the KCMU Washington, D.C. webcast, visit ANCOR's website at www.ancor.org or www.kff.org/content/2003/20030113.

Medicaid Cuts Will Harm State Economies

As states face fiscal crises and consider big cuts to their Medicaid program, the Families USA report—*Medicaid: Good Medicine for State Economies*—documents that cuts would significantly harm each state's ailing economy. The report indicates that a significant factor in states' improved economic activity due to Medicaid spending arises because the Federal government provides matching funds for each state's Medicaid program. The matching rate varies from state to state—ranging from $1.00 to $3.27 in Federal funds for each state dollar.

When states slash their Medicaid programs, they hurt everyone through losses in jobs, wages, and economic activity. This harm is in addition to the many difficulties faced by low-income families when their Medicaid lifeline is cut. Cuts to the Medicaid program are short-sighted. Medicaid is a powerful stimulus to state economies, and Medicaid cutbacks will exacerbate states' economic problems.

Ron Pollack, Executive Director, Families USA

The report provides state-by-state numbers that show how proposed state Medicaid cuts significantly reduce jobs, wages, and business activity. Their website also provides a *Medicaid cuts Calculator* that enables viewers to compute how Medicaid cut proposals will affect each state's business activities, jobs, and wages. ANCOR encourages providers to use the calculator to identify the effects of proposed or implemented cuts in their state when they communicate with state legislators or their Congressional delegation.

Highlights of the Families USA report include the following:

• State Medicaid spending in 2001 generated over 2.9 million jobs—approximately 58,785 jobs on average per state.

• Employee wage increases attributable to state Medicaid spending in 2001.

• States spent nearly $98 billion on Medicaid in 2001, but this investment generated an almost three-fold return ($279 billion) in new business activity.

• States stand to lose an average of 37 jobs for every million dollars cut in the Medicaid program in 2003.

• States could lose on average $3.4 million in business activity for each million-dollar reduction in Medicaid spending.

• The ten states with the largest wage from new jobs attributable to state Medicaid spending in 2001 are New York ($11.7 billion), California ($11.4 billion), Texas ($645.9 million), Pennsylvania ($487.4 million), Florida ($426.8 million), Illinois ($355.4 million), Michigan ($333.1 million), North Carolina ($320.6 million), and New Jersey ($289.9 million).

• The ten states with the largest number of jobs generated by state Medicaid spending in 2001 were New York (300,352), California (291,439), Texas (187,901), Pennsylvania (143,110), Florida (132,215), Ohio (132,028), North Carolina (100,353), Michigan (98,754), Illinois (98,435), and Tennessee (81,675).

• The 10 states that would experience the greatest job loss per million dollars in Medicaid cuts in 2003 are Mississippi (72 jobs), New Mexico (67), Arkansas (65), Montana (64), Oklahoma (62), Utah (60), West Virginia (57), Idaho (56), Louisiana (55), and Alabama (55).

• The 10 states that would lose the most state business activity per million dollars in Medicaid cuts in 2003 are Mississippi ($6.25 million), New Mexico ($5.72 million), Arkansas ($5.41 million), Utah ($5.27 million), West Virginia ($5.16 million), Oklahoma ($4.98 million), Alabama ($4.93 million), Montana ($4.90 million), Louisiana ($4.87 million), and South Carolina ($4.78 million).

For a copy of the Families USA *Medicaid: Good Medicine for State Economies* and to compute the affects of Medicaid cuts on wages, jobs and business activities on their Medicaid cuts calculator, visit ANCOR's home page at www.ancor.org or www.familiesusa.org. ■

ANCOR Calendar

2003

March 16-18 — **ANNUAL WINTER CONFERENCE**
Building the Future, Today
Adam's Mark Riverwalk Hotel
San Antonio, TX
(Board meetings 3/15-16)

Sept. 7-9 — **ANCOR's 2003 Governmental Activities Seminar**
Washington Court Hotel
Washington, DC

President Proposes $1.75 Billion Five-Year Option for Community Transition

Prior to release of the President's budget on February 3rd, Department of Health and Human Services (HHS) Secretary Thompson announced a new $1.75 billion, five-year program to help individuals with disabilities transition from nursing homes and other institutions to living in the community as part of President Bush's FY 2004 budget request.* The new proposal is one of several new efforts to be included in the Administration's FY 2004 budget for the President's New Freedom Initiative. (See ANCOR's electronic transmission of Washington Insiders Club Update of January 23rd for HHS press release.)

> Improving our programs for people with disabilities, including the need to tackle the institutional bias in some programs, is a daunting task. It will require sustained effort over many years. We've made a start with the most comprehensive survey ever taken of problems and opportunities in federal programs, as well as new structures to support our efforts. The President's budget proposals will take us to the next level, with substantial demonstration activities and more help for Americans with disabilities to enter and stay in the workforce.
>
> HHS Secretary
> Tommy G. Thompson

ANCOR readers will recall that the New Freedom Initiative is the President's nationwide effort to integrate people with disabilities more fully in the community and to implement the U.S. Supreme Court's 1999 *Olmstead* decision. The new FY 2004 proposals are based on recommendations to the President last year in *Delivering on the Promise*—the government-wide review and recommendation regarding federal policies and rules impeding community living for individuals with disabilities.

Last year, HHS Secretary Thompson created a new Office of Disability within the department to coordinate activities across HHS and serve as a focused contact point for disability issues—including the New Freedom Initiative. Dr. Margaret Giannini is the Director of the Office of Disability.

A Few Highlights

Altogether the President requests $2.1 billion over five years in planned new spending for New Freedom Initiative proposals, with $417 million in new spending for FY 2004. However, the FY 2004 budget proposal estimates assume program operation in the absence of Medicaid and State Children's Health Care Insurance Program (SCHIP) proposed overhaul, with the Medicaid/SCHIP proposals dependent on state participation in the new legislation proposal—the State Health Care Partnership Allotment option.*

Although details were limited at press time, highlights of some of the proposals in the FY 2004 budget request for people with disabilities include the following legislative proposals:

• **Money Follows the "Individual" Rebalancing Demonstration:** The budget proposes to create a new five-year demon-

stration that finances Medicaid services for individuals with disabilities who transition from institutions to the community. The $350 million proposal for FY 2004 ($1.75 billion over 5 years) is designed to assist states in developing and implementing a strategy to *rebalance their long term care systems so that there are more cost-effective choices between institutional and community options.* Federal Medicaid grant funds would pay the full cost of home and community-based waiver services (HCBS) for one year, after which the participating states would continue services at the regular Medicaid matching rate. The demonstration would also test whether increased use of home and community-based services reduces spending on institutional services.

• **New Freedom Initiative Demonstrations:** The budget *reproposes* four demonstrations contained in the President's FY 2003 budget request that were not included in the final Congressional FY 2003 appropriations. One demonstration will test the extent to which methods to alleviate direct care workforce shortages and instabilities might be addressed through better coordination with the Temporary Assistance for Needy Families (TANF) program and includes making vouchers for worker health insurance or for tuition or day care credits available to qualifying individuals. Participating states would be expected to develop options for workers to purchase affordable group health coverage through the state health insurance system or similar organized insurance group. *This $3 million project would be funded out of the Center for Medicare and Medicaid (CMS) Research, Demonstration and Evaluation budget.*

HHS is proposing three other demonstrations at a cost of $8 million in FY 2004 and $778 million over ten years to promote at-home supports as an alternative to institutionalization. These demonstrations would be funded out of mandatory Medicaid funds.

1. respite services for caregivers of adults with disabilities;

2. respite services for caregivers of children with severe disabilities; and

3. home and community-based services for children currently residing in psychiatric residential treatment facilities.

• **Systems Change Grants:** The budget proposes $40 million to continue funding for Real Choice System Change Grants designed to allow states to improve community support systems to enable children and adults with disabilities and long-term illnesses to: (1) live in the most integrated community setting possible; (2) exercise choices about their living environment; and (3) obtain quality services in a manner as consistent as possible with community living preferences and priorities. In FY 2002, 25 new and 5 supplemental Real Choice System Change grants were awarded to states. The continuation of system change grants would be funded out of the Center for Medicare and Medicaid (CMS) Research, Demonstration and Evaluation budget.

• **Presumptive Eligibility for Community-Based Services:** The budget proposes a new state Medicaid option allowing presumptive eligibility for institutionally qualified individuals who are discharged from hospitals into the community, rather than alternative institutional settings or to ensure that the institutional placement is of short duration. The proposal will have no effect on the Medicaid budget.

• **Ticket to Work Spousal Exemption:** This proposal extends eligibility for Medicaid benefits to spouses of individuals with disabilities who enter the workforce. This proposal requests $16 million in FY 2004 ($95 million over five years).

Additional highlights of President Bush's FY 2004 budget affecting Medicaid are located elsewhere in this issue of *Links*. ANCOR will continue to analyze and monitor the Administration's budget requests and legislative proposals, providing ANCOR members further information as details unfold.

*NOTE: According to the Administration's FY 2004 Budget book, these new proposals *that create new Medicaid demonstrations or fund new or extended coverage apply only to states that do not choose the allotment*"—the Administration's proposal for combined Medicaid and State Children's Health Insurance Program overhaul (State Health Care artnership Allotments) that provide states the option of selecting two individual allotments: one for acute care and the other for long-term care. The proposal would provide increased flexibility to states and allow some beneficiaries to enroll in private health insurance, but would eliminate much of Medicaid's entitlement for some populations and benefits, and cap funding based on a yet unspecified *trend rate* that makes the Medicaid program *predictable in terms of cost*. For more information on the Medicaid and SCHIP proposal, see related article located in this issue of *Links*. ■

HIPAA Privacy Rule—Determining If Your Agency Must Comply

Recent member inquiries indicate that some ANCOR members are still unsure whether or not they must comply with the Health Insurance Portability and Accountability Act's (HIPAA) *Standards for Privacy of Individually Identifiable Health Information* (the *Privacy Rule*). There is no easy answer when it comes to determining whether you must comply with the Rule. Simply being a private provider does not mean your agency is a covered entity or is required to comply. However, ANCOR members providing supports and services are not automatically exempt from compliance, either. *You will need to determine if your agency is a Covered Entity and whether you must comply.*

If you are not a covered entity because you do not currently transmit health information *electronically*, keep in mind that your agency may become one in the future. HIPAA's Standards for Electronic Transactions and Code Sets requires providers

doing business electronically, health plans—including Medicaid, and clearinghouses to use certain health care transactions and code sets in order to facilitate electronic transactions. As a result, many state Medicaid agencies are moving toward electronic billing and other electronic transactions. If and when your state requires electronic billing for Medicaid, you may also be required to comply with the Privacy Rule.

Determining If Your Agency Is a Covered Entity Under HIPAA's Privacy Rule

Whether or not your agency is a health care provider for purposes of the Privacy Rule hinges on two important factors:

• If your agency conducts certain administrative and financial transactions electronically; and

• Whether the supports and services your agency provides are health care.

1. Does your agency transmit any health information electronically?

Does your agency electronically exchange (send/receive via Internet, Extranet, dial-up lines, private networks, or magnetic tape, disks or compact disks) with another covered entity (such as the state Medicaid agency) individual health information in connection with one (or more) of eight named administrative and financial transactions? (See www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf on pages 8-10 for listing of transactions.)

For Example:

• Do you utilize e-mail or a web site to submit for reimbursement from your state Medicaid agency—and include individual health information—a person's name, address, birth date, Social Security Number, etc.—in the submission?

• Do you inquire with the state Medicaid agency as to whether an individual you support is enrolled in/eligible for Medicaid? Do you submit that inquiry electronically—via e-mail or a web site?

• Do you electronically inquire with the state Medicaid agency about the status of your reimbursement? Do you receive a response to your inquiry electronically?

If your agency DOES NOT exchange health information electronically in connection with one (or more) standard transaction, your agency IS NOT A COVERED ENTITY and IS NOT REQUIRED TO COMPLY with the Privacy Rule.

If your agency DOES exchange health information electronically, YOUR AGENCY MAY BE A COVERED ENTITY and MAY NEED TO COMPLY

continued on page 20

Private providers must comply with the *Privacy Rule* if they are one (or more) of the following HIPAA *Covered Entities:*

1. Any provider (including those providers of health and long-term care services) who transmits any individual health information *in electronic form* in connection with a standard transaction;
2. A health plan (such as Medicaid, Medicare, private health insurance companies, HMOs, and employers who self-insure to provide health insurance for their employees); or
3. A health care clearinghouse.

ANCOR Foundation Leadership Brief

Leave a Legacy of Leadership

When you give a gift to the ANCOR Foundation, you leave a legacy to the field of private providers. By designating the ANCOR Foundation as a beneficiary in your will or insurance policy, you directly support the continuation of the critical work needed to assure the success of the next generation of leaders in the field.

For more information on the ANCOR Foundation, contact Renée Pietrangelo at (703) 535-7850 rpietrangelo@ancor.org

ANCOR Foundation Enters Active Phase

The ANCOR Foundation corporate structure was formed in mid-2000 and, to date, components of the research and public awareness objectives of the National Advocacy Campaign have been conducted under the auspices of the ANCOR Foundation.

With a commitment to move ANCOR Foundation activities to a much more active phase, the Foundation's Board of Directors met in January 2003 to map out a vision and objectives. The result was a commitment to moving the agenda forward with regard to person-centered outcomes in the community of choice.

As it evolves, the Foundation's program of work will be focused within two main venues: The Center for Leadership and the Center for Innovation and Information.

The Center for Leadership

The Center for Leadership will offer an extensive array of learning and development opportunities for the community, focusing on building the capacity of forward thinking leaders. These leaders include service providers, direct support professionals, people with disabilities and family members, business and community leaders, and public officials, and may include others who impact the lives of people with disabilities.

The Center for Innovation and Information

The Center for Innovation and Information will gather, assess and disseminate strategies, techniques, innovative practices, information and resources relevant and applicable to building community capacity. These activities might include case studies, surveys, research, evaluations, demonstrations and various forms of applied research.

ANCOR members interested in getting involved with ANCOR Foundation as a volunteer leader or who wish to support the Foundation with either financial or in-kind support should contact Renee Pietrangelo at ANCOR—rpietrangelo@ancor.org; 703-535-7850. ■

Vision: People with disabilities living meaningful, productive and well-supported lives in the communities of their choice.

Mission: To build the capacity of communities to improve the quality of life for people with disabilities.

Career Opportunity

Vice President Programs and Services

Ability Beyond Disability, formerly Datahr Rehabilitation Institute, a leading health and human services provider with a 50 year history, is seeking an experienced individual to oversee the residential, supported living, employment, and vocational programs for 800 persons served in NY and CT. Reporting to the President as a vital member of the senior management team, the V.P. is responsible for budget, quality, management development, staff competency and satisfaction, and community outreach. Qualified candidates will have a bachelor's degree with strong preference given to advanced degree I human services, healthcare or management. Must have at least 10 years of progressive supervisory experience, preferably in related field and/or not-for-profit environment with a record of constructive relationships with third party payers. Must have strong leadership, team building, communication, interpersonal and negotiation skills with demonstrated success in creating innovative consumer services that lead to independence and dignity.

Please visit our website at AbilityBeyondDisability.org for more information. Fax resume with salary requirements to (203) 740-7129 or e-mail: jobs@abilitybeyonddisability.org.

Human Resources
135 Old State Road
Brookfield, CT 06804
EOE/AA

ANCOR National Advocacy Campaign Contributors

We wish to extend our sincere appreciation to the following members, who have made a contribution in support of the ANCOR National Advocacy Campaign launched in September 2001. Their contributions to date total $589,715.78.

Agency Contribution $ 0-999

ADDP
Adelante Development Center
Aditus Inc.
ARC of the Bluegrass, Inc.
ARCA
ASKAN Corporation
Avenues to Independence
Bost Human Development Services, Inc.
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Agency Contribution $ 1,000-4,999

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Agency Contribution $ 5,000-14,999

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OHI
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South Dakota Association Of Community Based Services
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Agency Contribution $ 15,000-39,999

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The Council on Quality and Leadership
The National Alliance of Direct Support Professionals

No Good News for Employment, Training and Rehab Programs in FY 2004 Budget Proposal

Charlie Harles and Kara Freeburg

Administration Announces Plan to Consolidate DOL Programs

Pledging to continue its mission to make a difference in the lives of America's working families, Secretary of Labor Elaine Chao announced February 3rdthe details of the President's Fiscal Year (FY) 2004 budget proposal for the Department of Labor (DOL). For FY 2004, the President's request for the Department is $56.2 billion, a $15 billion cut from last year's budget proposal.

Assistant Secretary for Labor Cameron D. Findlay stated that the budget proposal was developed with a focus on performance and reflects the Department's goals for 2004:

- Get Americans Back to Work;
- Protect Employees' Benefits;
- Ensure Workers' Rights and Safety; and
- Modernize DOL for the 21st Century.

DOL Employment and Training Administration's (ETA) budget proposal also provides the first glimpse of the Administration's plans for reauthorization of the Workforce Investment Act (WIA) this year. ETA administers WIA programs and funding. The President's budget proposes *to make significant improvement in Federal job training and employment programs*, which the Department plans to achieve through consolidating programs, strengthening resource allocation, improving accountability; enhancing the role of employers in the national workforce system; and increasing state flexibility. At the same time, the FY 2004 budget proposal reduces funding for almost every job-training program.

The budget provides $101 million to the states for *new methods of providing employment and related information through One Stop Career Centers*. This would be a $12 million decrease from current funding levels. Interestingly, the budget material distributed by the Department of Labor highlighted text stating, *the One Stop Career Centers deliver a full array of effective employment and training services to people with disabilities.* This statement would certainly be challenged by most organizations representing persons with disabilities or organizations providing employment and training services to persons with disabilities. Funding for the services provided in the One Stop Centers comes from the 19 mandatory partners in the program.

The Department's Employment Standards Administration (ESA) will also see its budget reduced under the President's proposal. ESA administers and enforces a variety of laws, including the Fair Labor Standards Act. ESA budget proposal calls for improving customer satisfaction by decreasing the number of days for the Wage and Hour Division to conclude a complaint.

Highlights from the DOL budget are available at: www.ancor.org/dev/links/nogoodnews.htm.

Budget Proposal Continues to Eliminate Separate Funding for Supported Employment, Other Rehab Act Programs

The Department of Education received the largest budgetary increase of any domestic agency in the Administration's FY 2004 proposal. However, the proposal again provides no funding for Supported Employment (SE) State Grants, Projects with Industry (PWI), and other rehabilitation and training programs. The Administration first proposed consolidating SE State Grants, PWI, and other funding as part of the Vocational Rehabilitation (VR) State Grant in FY 2003. The VR State Grant program would receive only the statutorily required cost-of-living increase. Other programs authorized under the Rehabilitation Act would receive level funding or slight increases, with the exception of Assistive Technology state grants. Funding for AT grants was eliminated.

Budget documents noted that the state vocational rehabilitation program would be subject to *close examination*

ANCOR Welcomes New Members

North Central Region
Rod Braun, Regional Director

Spectrum Industries
Kris Timp
Decorah, IA
Tom Daniels, Representative

T.A.S.C., Inc.
Mary Ament
Waukon, IA
Tom Daniels, Representative

Mid-Atlantic Region
Bill Loyd, Regional Director

Maxim Habilitation Services
Brian Wynne
Columbia, MD
Marty Lampner, Representative

Great Lakes/West Region
Tom Lewins, Regional Director

Goodwill Industries of Greater Grand Rapids,Inc.
Susan Cloutier
Grandville, MI
Vacant, Representative

Great Lakes/East Region
Carol Mitchell, Regional Director

The Arc of Schuyler County
James Wilson
Watkins Glen, NY
Dan Berkowicz, Representative

Northeast Region
Emily Ennis, Regional Director

Community Support Services, Inc.
Nina Watkins
Salem, OR
Shelia Barker, Representative

when it comes up for reauthorization in 2005. (Note: The Rehabilitation Act is authorized through 2004 but there is a provision to automatically extend the program one year).

In addition, the Individuals with Disabilities Education Act (IDEA) would receive a $1 billion funding increase for FY 2004. Congress must reauthorize IDEA this year.

Highlights from the Department of Education's budget are available at: www.ancor.org/dev/links/nogoodnews.htm.

RESOURCE LINK **Harles & Associates provides consulting services to ANCOR on employment and training-related issues.**

ANCOR's Fax-On-Demand is available 24 hours a day, 7 days a week at 1-888-715-5501 INFORMATION IS JUST A PHONE CALL AWAY!

ANCOR Honor Roll

The following agencies have submitted the names of homes that have succeeded in having deficiency-free surveys, which qualifies them for appearance on the ANCOR Honor Roll.

ANCOR congratulates all of the staff who make these honors possible. Send your submission for the Honor Roll to: Attn: Barry Noel, ANCOR, 1101 King St., Suite 380, Alexandria, VA 22314.

Please send supporting documentation of the surveys.

Arizona

A.I.R.E.S
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17 Stewart Street
44 Evelyn Avenue
12 Queen Anne Road
102 Sanford Avenue
258 Market Street
Main Street (Fultonville)
Highland Gardens
Holland Gardens

Oregon

Spruce Villa Inc.
1880 Fisher Road (8 Years)

Texas

American Habilitation Services, Inc.
Longview HCS
Offer House
Amarillo HCS-O

INDEPENDENT SKILLS ASSESSMENTS

Independent Skills Assessment Scale 2003

Designed for persons receiving or being considered for fewer than 24 hours of staffing time. Key indicator areas are:

- Meal Planning and Preparation
- Personal Appearance and Hygiene
- Apartment/Home Maintenance and Upkeep
- Personal Safety/Use of Emergency Resources
- Civil Rights and Responsibilities
- Social/Recreation/Transportation
- Shopping,
- Personal Medications
- Money Management
- First Aid and Health,
- Telephone and Other Utilities
- Coping Skills and Behavior

Independent Skills Assessment Scale	10 for $20.00 25 for $40.00 50 for $75.00

Clinical Nursing Care Needs

The scale assists in determining the level of Clinical Nursing Services and suggests a number of Clinical Nursing hours (RN or LPN) necessary for individual consumers as well as entire group facilities.

Personal Strengths and Needs

A quick, 100 item, two-page assessment designed to show skills and abilities, as well as programming and health needs, for persons of all ability levels and ages.

Nutritional Needs

Aids in determining nutritional needs for the individual, developing individualized skill training goals for food shopping and preparation, supplying health related information to the physician, planning pertinent staff training, arranging staffing patterns during meal times, and in screening referrals to the agency or program

Clinical Nursing Care Needs Personal Strengths and Needs Nutritional Needs	20 for $10.00 50 for $20.00

Sexuality Assessment

Helps determine an individual's social/sexual vulnerabilities and supervision needs. Identifies individual program objectives in the area of sexuality, prioritizes sexuality goals and objectives, and establishes homogeneous social skills groups.

Sexuality Assessment/Curriculum Guide:
The guide is to be used in conjunction with the Sexuality Assessment Worksheet. Describes how each assessment item should be answered and provides information that can serve as a basis for training and program development. Included with the guide are 18 line drawings in a three ring binder, helpful in both assessment and training.

Sexuality Assessment Worksheet:
100 questions designed to address knowledge and performance in such areas as privacy and ownership, basic anatomy, relationships, positive touch, sexual expression, birth control, victimization and sexually transmitted diseases. It can be used with individuals of varying levels of knowledge and abilities.

Sexuality Kit:
Includes 20 Sexuality Assessment Worksheets, a Sexuality Assessment / Curriculum Guide, 18 line drawings, anatomically correct male and female dolls, sanitary pads, condoms, an artificial penis and a soft carry bag.

Sexuality Kit – includes guide and 20 worksheets:	$200.00
Sexuality Guide – Includes 20 worksheets:	$20.00
Sexuality Assessment Worksheet:	20 for $10.00 50 for $20.00

Add 8% to the above prices for shipping & handling, MN residents should include sales tax or a tax exempt number.

For an order form, or to order, write or call

Bald Eagle Assessments
111 11th Ave. N. E., Austin, MN 55912
507-437-2074
wbaldus@yahoo.com fax 507-433-4597

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with the Privacy Rule.

You must now determine if your agency provides health care services. Read on.

2. Does Your Agency Provide Health Care Services as Defined By the Privacy Rule?

Does your agency provide health services and is your agency paid (that is, reimbursed by Medicaid or another health plan or provider) for doing so?

Health care services are not specifically listed in the Privacy Rule, but rather are defined by broad categories or types of service (e.g., preventive, maintenance, rehabilitative, and therapeutic care, service or procedure related to an individual's physical/mental condition or functional status). Private providers must look at the individual supports and services provided (nursing services, physical therapy)—not the funding streams that pay for them.

If your agency DOES provide health care services and DOES transmit information electronically in connection with an electronic transaction, your agency MUST COMPLY WITH THE PRIVACY RULE by April 14, 2003. There are no exceptions to this date.

If your agency DOES NOT provide health care services, YOU ARE NOT REQUIRED TO COMPLY with the Privacy Rule.

Note: If you determine your agency is not required to comply with the Privacy Rule, it is recommended that you obtain a statement from your legal counsel attesting to the fact that your agency has determined it is not required to comply.

This alert is for information only and does not constitute legal advice. Questions regarding your agency's status as a covered entity should be addressed to your legal counsel. ■

Examples of Private Providers as Covered Entities

Example 1: Agency A offers ICFs/MR services to several individuals. By definition, ICFs/MR services must include round-the-clock nursing services. Agency A bills the state Medicaid agency via a secure web site, which is accessed using a dial-up modem. When submitting for reimbursement, names and Social Security numbers of individuals receiving services are included.

Agency A is a covered entity for HIPAA purposes because:

1.) It transmits health information electronically via a web site.

2.) It provides health care in the form of nursing services.

Example 2: Agency B provides a variety of services—including physical therapy—to individuals served under their state's home and community-based waiver. Agency B bills the state Medicaid agency for reimbursement using a diskette. Additionally, each month Agency B verifies the eligibility of the individuals it serves under the waiver for Medicaid using a secure web site. When submitting for reimbursements, Agency B includes individuals' names and their Social Security number. When verifying an individual's eligibility, Agency B receives the individual's name, address, date of birth, and Social Security number.

Agency B is a covered entity for HIPAA purposes because:

1.) They send and receive health information electronically.

2.) They provide health care in the form of physical therapy.

ANCOR Mission:

To promote and assist private providers who offer services and supports to people with disabilities and their families.

ANCOR Vision:

To be the premier association providing advocacy, services and resources to private providers.

ANCOR
American Network of Community Options and Resources

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