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WALK 2013

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On Sunday, September 22, the 10th Annual Arc/Morris Foundation Walk to support the programs and services of The Arc/Morris was held under sunny skies! Over 350 walkers, supporters, and volunteers helped to make the day a success and raise over \$25,000!

is a publication of The Arc/Morris, an association that serves people with intellectual and related disabilities and their families. If you would like to learn more about

The Arc/Morris, please write us at: P.O. Box 123, Morris Plains, NJ 07950, call us at (973) 970-9326, Ext. 326, or find us on the web at www.arcmorris.org



MEDICAID

and the new eligibility rules for services

A MESSAGE FROM THE EXECUTIVE DIRECTOR

The lives of people with intellectual and other developmental disabilities (I/DD) have long been governed by the decisions of others. Those decisions generally revolved around two issues: where care should be provided; and, how that care would be paid for. For the longest time, the matter was considered a private one; families were expected to manage on their own, with their own resources. When that was not possible, the public offered institutional care, at the expense of local governments. Later, the cost of much institutional care was assumed by the federal government through the Medicaid program. By the late 1970s, however, a consensus was developing that institutional care was not the optimal living situation for the majority of people affected by I/DD, and that it was very expensive.

In response to both progressive concerns about least restrictive environments in caring for people with I/DD and conservative concerns about the cost of institutional care, New Jersey began to promote the development of community-based care settings in the early 1980s. The New Jersey Division of Developmental Disabilities (DDD) initially promoted the development of community-



based residential settings and day programs, and later supported employment options, and in-home respite services for individuals and families affected by I/DD. It created opportunities for people with I/DD to live, and receive services, in the community, provided simply that they were determined to be categorically eligible for them by DDD, based on generally accepted definitions and metrics of developmental disability. Funding for these services was provided by the state.

At the federal level, legislation was enacted that resulted in the creation of the Home and Community Based Services Waiver, now commonly referred to as the Community Care Waiver (CCW). It helped to facilitate the transformation of a service system dominated by institutional care, by offering states the option to use Medicaid funds for non-institutional service options based in local communities. With costs now shared equally by the state and federal governments, the waiver accelerated the creation of the service system as we know it today.

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To be eligible for services going forward, one must be(come) eligible for Medicaid.

Today, however, we find ourselves undergoing what I believe is the single greatest challenge to that system in decades. Earlier this year, the state of New Jersey announced that eligibility for services would no longer be based solely on determination of developmental disability, but on the ability to pay for services, through eligibility for Medicaid. Put simply, to be eligible for services going forward, one must be(come) eligible for Medicaid. So, while you can become eligible for services through the Division of Developmental Disabilities, you really aren't going to get any services unless and until you become eligible for Medicaid, and then become eligible for a waiver.

There are now two different waivers in New Jersey that will determine who gets what services—the Community Care Waiver and the new Supports



Program Waiver. Each provides for an array of services. An individual's particular needs will determine which of the two

waivers they are placed in. Depending on which of the two waivers you are in, you will be able to choose from a list of services they contain. The state's plan is to have all future services provided under the umbrella of one or the other of the two waivers.

On the surface, this appears pretty good, or at least not too bad. After all, the vast majority of people with I/DD are Medicaid eligible. And channeling all services through waivers that are federally funded has the potential to maximize revenues received from Washington, DC. Clearly, tighter state budgets have made the federal funding much more attractive. So, over the past five to ten years, the trend has been to maximize the federal government's share of the costs of state I/DD systems. One might also assume that with additional funding will come additional services.

But let's consider all of this a bit more closely.

There are a couple of things about the Medicaid program that must be understood if we are to see clearly where the changes the state has planned may lead us. Remember, the Medicaid program has service **mandates** and service **options**. The mandate—the entitlement portion of Medicaid—is to provide acute health care services for poor people. The services provided under both of New Jersey's Medicaid waivers, including long-term care services like group homes and other residential settings, are optional services. All of which might not matter so much, except for one thing—the Affordable Care Act (ACA).

As the ACA becomes fully implemented over the next few months, there will be a significant growth in the number of people on the Medicaid rolls, since New Jersey is one of the states that opted to accept new federal Medicaid dollars in exchange for expanded, and expansive, eligibility criteria for Medicaid. By some projections, there will be a 33% increase in the number of people eligible for the Medicaid program in New Jersey, approximately 100,000 new enrollees. And these people will be eligible for the mandated health care services. Granted, the federal government has committed dollars to each state that opts into the new Medicaid eligibility scheme, at least for the first three years. But, will it be enough money to fund all mandated health care services for the expanded eligible pool of Medicaid enrollees, and to continue to fully fund the optional services (e.g. residential care and day programs) for people with I/DD that are largely underwritten with that same federal Medicaid money?

I have several concerns here. Given our experience so far, it seems improbable, at best, that either local or state government offices will be able to absorb the drastic increase in activity that the

state's changes will require. Already, there has been a flurry of activity that has absorbed huge amounts of time on the part of DDD and its contractors (like us!) Governmental agencies that handle Medicaid (local Boards of Social Services and regional Social Security Offices) have been swamped with inquiries and applications.

There is no expectation that either the state workforce or bureaucracy will be reduced, even as the responsibility for directly billing Medicaid for services rendered—a task that has been the state's for the past three decades—is shifted to the 150+ agencies that contract with DDD to provide services for people with I/DD.

As concerning as the planned growth of state bureaucracy being put in place to "administer" the new system are the soft costs (i.e. costs completely unrelated to actual provision of direct services) associated with that. For example, each new consumer entering the Supports Program Waiver will be assigned not only a Case Manager (re-titled as a Waiver Assurance Coordinator) but also a Supports Broker, whose job will be to secure services for consumers, which is what Case Managers are now supposed to do. If my math is correct, this doubles the non-direct service costs associated with people who are already in the system!

Above all else, however, I am concerned by the change in values that seems to underscore this direction. It appears to me that the Medicaid mandate is creating a disincentive to independence and self-sufficiency. It forces consumers to divest themselves of any resources they may have. It requires them to only work in jobs that don't pay too much. It limits access to services that have been historically available and important to both individuals affected by I/DD and their families. At base, it requires that people with I/DD be reduced to poverty in order to be eligible for services that we have fought long and hard for over these past 60 years of advocacy. That isn't right! ■

MEDICAID FAQ

What is Medicaid?

Medicaid is a national health insurance program for individuals or families with low incomes and minimal resources. It is jointly funded by the federal and state governments, is means-tested, and available to citizens and legal permanent residents who meet certain income and assets standards, including people with certain disabilities. It is the largest source of funding for medical and health related services for people with limited income in our country.

Is there more than one type of Medicaid?

Yes.

What kind of Medicaid do people with I/DD need?

People with I/DD need the kind of Medicaid that will pay for the services/supports they need, usually long-term care (residential or health-related) or other services provided through a Waiver Program.

Income and assets limits apply for all Medicaid recipients. In most cases, countable assets must not exceed \$2,000, and gross monthly income will be between approximately \$730 - \$2,094. When Medicaid pays for long-term/residential care, the individual recipient's income must be applied to offset the cost of the long-term care.

Medicaid benefits are automatically provided to people who are eligible for the Social Security program known as *Supplemental Security Income (SSI)*. It tends to be the most common route to Medicaid for people with I/DD.

Is Medicaid different from the Medicaid Waiver?

Yes, Medicaid Waivers are funding vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid. There are two primary waivers that will be relevant to most people with I/DD seeking services in New Jersey: the *Home and Community-Based Services Waiver*, which has primarily funded residential and day program services since 1982; and the *Supports Program Waiver*, which funds primarily day programs and other non-residential services. There are separate applications for these waivers aside from the Medicaid application. You must be on Medicaid in order to apply for either of these waivers and can only be on one or the other.

Why is it now critical for people with I/DD to be Medicaid eligible?

In January of this year, the state Division of Developmental Disabilities amended the eligibility requirements for its services. In doing so, it essentially linked the majority of available services to two Medicaid Waiver programs. In essence, an individual must be Medicaid eligible to secure these waiver services.

Where do I go to apply for Medicaid?

In Morris County: Office of Temporary Assistance, 340 West Hanover Avenue, Morris Township. Telephone: (973) 326-7800

For additional information, visit the following websites:

www.morrishumanservices.org/ota/

www.state.nj.us/humanservices/dfd/programs/njsnap/cwa/

www.medicaid.gov/

www.state.nj.us/humanservices/ddd/services/medicaideligibility.html