

# Medicaid Home Care and Tribal Health Services for Maine

A Tool Kit for Developing New Programs

By Steven P. Wallace, PhD, Delight E. Satter, MPH, Andrea Zubiante



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Bruce Finke, M.D., Project Officer*

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**UCLA Center for Health Policy Research**  
**American Indian, Alaska Native Research Program**  
10911 Weyburn Avenue, Suite 300  
Los Angeles, CA 90024

(310) 794-0909

(310) 794-2686

<http://www.healthpolicy.ucla.edu>

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## **Introduction**

In 2000, at the conference of the National Indian Council on Aging in Duluth, Minnesota, more than 1,200 Elders from 105 Tribes across America attended and contributed to the “Spiritual Message from our Elders.”<sup>1</sup> Part of the Elder’s message said:

*“...We pray that children will honor and respect their elders -- that is where the wisdom comes from. This respect will not allow forgotten elders. We are all equal, with each having our own special gift to contribute...Let us unite together so that we may have the strength to protect our future. Strength comes from working through trials and tribulations.”*

We, along with the Indian Health Service and our Advisory Board members, recognize elders as an invaluable resource in our communities, deserving of honor and respect and the best care that we can give. We assembled a team of individuals with unique skills and knowledge to contribute to this project. Now, we share this guide with tribal and urban communities to assist them as they work on providing care to elders and disabled people. We will remember the “Spiritual Message from our Elders” as we look toward our future projects.

## **Overview**

The number of American Indian and Alaska Native (AIAN) elders is growing rapidly. This places new pressures on AIAN health care systems to provide long-term care for AIAN elders. Providing long-term care is a challenge since those systems were designed mainly to handle acute care needs.

Planning and financing long-term care services for AIAN elders is a challenge. Institutional care (i.e. nursing homes) is not desired by most elders and has high costs for both the elders and tribal governments. In contrast, less expensive home care can provide enough assistance to keep most disabled elders in their own or their relatives’ homes, where they prefer to be. State Medicaid programs are one source of funding for home and community based long-term care services on reservations.

This tool kit provides a road map for tribal health programs that are considering community-based long-term care services, with a focus on personal care services for the elderly and disabled people that can be funded by Medicaid.

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<sup>1</sup> <http://www.nicoa.org/message.html>

## **Why Provide Medicaid Personal Care Services?**

- \* To help AIAN elders and disabled people who need assistance with daily activities like bathing and dressing.

According to the 2000 U.S. Census, about 14% of American Indian and Alaska Native elders (age 65 and over) have difficulty dressing, bathing, or getting around inside the home because of health problems. These “functional limitations” often make it difficult to live independently. Limited assistance in the home is frequently all that is needed for these elders to be able to remain in their own or their relatives’ homes.

- \* To create new sources of employment for tribal members while offering culturally competent care.

Tribal elders are likely to receive assistance in ways with which they are most comfortable when other tribal members provide it. Hiring local care providers also offers new employment opportunities.

- \* To generate new revenue for tribal health programs.

The existing administrative infrastructure of many Tribal health and/or aging programs can be used to establish Medicaid-reimbursed home care programs. These programs can contribute to the overhead expenses of the overall health and welfare departments.

## **What Are Personal Care and Other Non-Medical In-Home Services?**

In rural areas, people who need assistance with their daily activities are often widely spread out. Programs that already offer outreach services to those people, such as Community Health Representatives (CHRs), may be in a position to provide non-medical in-home care efficiently.

In-home services can cover a range of human assistance provided to persons of all ages who have disabilities and chronic illnesses. The assistance enables the person to do tasks that they would normally do for themselves if they did not have a disability. The assistance can be in the form of hands-on assistance (like bathing the person). It can also be in the form of directing or reminding a person how to do the task by him/herself (like coaching a person with Alzheimers how to prepare a meal or even get dressed). In-home long-term care assistance that involves activities of daily living (ADLs) is most often provided by “personal care.” Instrumental activities of daily living (IADLs) are the activities most often provided by “homemaker” services.

ADLs are daily activities that immediately affect the person such as bathing, dressing, toileting, transferring (i.e. getting in and out of a bed or a chair), and eating or feeding. Walking independently in the home can also be considered an ADL. IADLs are activities that typically involve the household and require a level of stamina and clear thinking, such as cleaning, cooking, shopping, using the telephone, and paying bills. Managing medications, walking outside the home, and doing laundry are also sometimes listed as IADLs. These in-home services can be provided on a continuing basis (such as every morning) or on an as-needed basis (such as only during arthritis flare-ups). Skilled services that can be performed only by a health care professional, such as wound care, are outside the boundaries of personal care. There are a variety of different services described in Medicaid regulations that can be provided in the home, which are described below.

- ❖ ***Personal care services*** (also known by other names such as personal attendant services, personal assistance services, or attendant care services): Assistance with eating, bathing, dressing, personal hygiene, and/or activities of daily living. This service may include help with making meals, but it does not include the cost of the meals. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, but they have to be necessary as part of the bathing, dressing, and other personal care activities. Personal care providers must meet State standards for this service.
- ❖ ***Homemaker services***: Services consisting of general household activities (meal preparation and routine household care). These are done when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him/herself or others in the home. Homemakers meet standards of education and training that are established by each State.
- ❖ ***Chore services***: Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors,

windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access. These services are provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/ volunteer agency, or third party payer is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, as written in the lease, is examined prior to any authorization of services.

- ❖ **Respite care:** Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.
- ❖ **Home Health Care:** Skilled intermittent health care which is provided under the orders of a physician. Individuals eligible for home health nursing or home health aide services must need medical care in their home and have their care, which is specific to the patient's diagnosis, ordered by a physician. Because this service relies on a medical model and requires specialized licensing, this type of care is *not* covered in this guide.

The descriptions above are based on those used by the Medicaid program (available at <http://cms.hhs.gov/medicaid/1915c/cwaiverapp.pdf>).

### **Medicaid Programs that Provide In-Home Services**

There are at least two ways that states can provide in-home services to help an older person. The first is through a Medicaid service called "Personal Care." Most, but not all states have personal care services (PCS) as part of their regular Medicaid program, called "state plan" services. They can also offer personal care and related services through a special program called a "1915c waiver." This is a special program that allows states to provide services in the home and community to help Medicaid recipients stay out of nursing homes. Most, but not all, states have waiver programs that cover elderly and disabled people.

- ❖ **Personal care services (PCS)** must be ordered by a physician as part of a treatment plan in most states (although *federal* law no longer requires a physician's order), be provided by a "qualified" individual who is not a family member, and be provided in the elder's own or their family's home (that is, not in a nursing home). Since these services are part of the regular Medicaid **state plan**, there can be no waiting list or cap on the number of persons served under this program, and it must be available statewide. The requirements for obtaining services, and the types of services provided, are usually more restrictive than those provided under "waiver services" (see following). PCS also usually has hours of service or other limitations on the total amount of service per person.



- ❖ **Waiver services** can only be provided to people who are nursing home eligible under Medicaid. These may also be called “home and community based care” services, or “1915c” services. A social worker or nurse usually conducts the assessment of nursing home eligibility. The need for nursing home level care is typically based on the person’s level of disability (physical and mental) and how available family and friends are to help the person. Waiver services cannot be the same as those provided under the regular Medicaid plan’s personal care benefit (see above), so they usually complement those services by providing care to persons who do not qualify for PCS because their medical needs (in contrast to their personal care needs) are not severe enough, the type of assistance they need is not covered by the state’s PCS program, or the elder or disabled person needs more hours of care than available through PCS.

### **How Personal Care and Other In-Home Services are Provided**

Two different models of service provision exist for personal care. The traditional model, called an **agency model**, is where an agency hires, supervises, and bills Medicaid for services. It is common for states to require agencies to hire a nurse to supervise the home care workers. Agency workers are also often required to have some training, which is often provided by the agency, on working with the elderly.

A newer model is the **consumer directed** or “independent contractor” model. The service *recipient* controls the hiring and supervision of the care provider in this model that is available in most, but not all, states. An agency is typically not involved at all in the process, and the payment goes directly to the home care worker. There are usually fewer worker training requirements under this model, and family members (but not the spouse) can usually be hired to provide the care. The consumer directed model has been particularly popular with younger disabled persons who want to maximize their autonomy, but also has appeal to older persons. This model costs states less since they pay no agency overhead.

To learn more about consumer directed care, see:

<http://aspe.hhs.gov/daltcp/reports/primer.htm#Chap7>

Understanding Medicaid Home and Community Services: A Primer. Chapter 7: Consumer-Directed Home and Community Services. George Washington University, Center for Health Policy Research. October 2000.

## **Different Levels of Involvement for Tribal Programs in Home Care**

1. Referral Only – The least level of involvement is for Tribal Health and Tribal Aging programs to serve as information and referral sources only. This takes a minimal financial investment on the part of the tribe, but if there are sufficient home care resources in the region, providing information and referral services can assist tribal members who need assistance to obtain needed services. In at least one state, several nurses who used to work for the state government in assessing Medicaid nursing home eligibility had gone to work for the IHS. It was reported that these HIS nurses now often accompany state Medicaid eligibility nurses when on the reservation to help assure that the elder is accurately assessed. Medicaid does not pay for this type of information/referral/assessment brokering
2. Fiscal Agent Only – Many states contract with organizations to act as their fiscal agents for paying home care providers who work under a consumer directed model. The fiscal agent has limited or no oversight role of the home care provider. This role generates modest revenues for the fiscal agent. Most, but not all, states use a single fiscal agent for the whole state.
3. Agency Provider – In states with agency based providers, the agency must hire, supervise, and provide the infrastructure for personal care services. This vehicle provides more tribal control over the types of persons hired as home care workers, and the Medicaid reimbursement includes funds for the management and training of workers. This model also involves substantially more responsibility and management oversight. In some states, agencies that act as direct providers can also act as fiscal agents so that they are involved in a wider range of cases in their service area.

## **When Developing a Plan for Delivering Medicaid Home Care Services**

Identifying community needs and your institutional capacities are important first steps in developing a home care service program. The following issues need to be considered when developing a plan for Medicaid home care:

*Who needs this type of service?*

Persons with difficulties in “activities of daily living” (ADLs: dressing, bathing, getting in and out of a chair or bed, eating, toileting, and walking) are most likely to need assistance, and to qualify for Medicaid programs. Persons with difficulties in “instrumental activities of daily living” (IADLs: cooking, shopping, light housework) may also need assistance. Difficulty with these activities is more common among older people, but younger people with disabilities also have these needs. Even when they live with family members, persons with ADL or IADL difficulties can receive additional help to provide a break for family caregivers or to provide help that family caregivers are unable to provide.

### *How many people are likely to need the service?*

A needs assessment survey of the potential service area provides the best information (contact the National Resource Center on Native American Aging for more information; see key contacts at end of this toolkit). A general idea of needs can be obtained from the 2000 Census (see Assessment Tools, page 11).

An even simpler approach is to take the disability rate of AIAN elders from Tribes across the country and apply that to the population age 65 and over in the proposed service area. The National Resource Center on Native American Aging, using data primarily from reservation areas, found about 40% of AIAN elders had one or more ADL difficulties (22% with two or more difficulties out of a list of six). Among all AIAN elders nationally, the 2000 Census found 14% had ADL difficulties. This can be considered the likely range (14-40%) of *potential* home care users. Not all elders with ADL difficulties will need assistance because they may receive all the care they need from family and friends, or they may not want others helping them. On the other hand, there are usually a number of persons under age 65 who are disabled and need similar assistance.

The number of potential users is important because there are fixed costs that have to be paid whether the agency serve three or 30 clients. In addition to standard business costs (phone, electricity, accounting, marketing, etc.), a Medicaid home care agency must also have someone on staff who is able to accurately complete the Medicaid billing forms, and someone who can supervise the caregivers. If an agency has to rely entirely on Medicaid revenues, some states recommended having a minimum of 30-40 clients to generate enough funding to cover fixed costs. Smaller numbers of clients would be feasible if the home care agency was part of a Tribal clinic or aging program that shared some of the administrative and supervision costs.

### *Where will the funding come from?*

The largest public source of funding for non-medical in-home services is Medicaid (which is limited to low-income people age 65 and over), disabled people, pregnant women, children, and families with dependent children). All states have Medicaid programs (except Arizona, which has a similar program), so this is the most likely source of funding for in-home long-term care programs.

The federal Administration on Aging also funds a variety of aging programs, and has a special funding stream for AIAN programs (Title VI of the Older Americans Act). This agency has very limited funds for in-home care for elders age 60 and over. Some states have special programs funded entirely by state dollars which typically cover in-home services or populations not covered by Medicaid. Medicare – the program that pays for hospital and doctor services for most people after age 65 – only pays for relatively short-term recovery or treatment-oriented services in

the home. Some Tribes contribute general funds to help support in-home services as well.

*What organizational issues should be considered?*

Most states have a number of requirements for agencies that provide Medicaid reimbursable services. You do not need to be a clinic or home health agency to provide personal care services, but you may need to show coverage for liability, some states require an operating reserve, and some states require that supervisors and/or home care workers have specified training (e.g. RN or MSW for the supervisor, 10-40 hours of training for home care workers). The requirements in each state differ. You should check with your state's provider enrollment department to learn about their current requirements.

States also report that in their experiences some providers face problems in billing Medicaid. Some states allow paper billing, but all states prefer electronic billing. The billing information must be accurately completed, meaning that the billing staff in the provider organization must be well trained and consistent. Since Medicaid is a federal program, it is also important to keep good records in case of an audit. Finally, many parts of the country have labor shortages and providers can have trouble hiring and keeping reliable home care workers.

Placing a home care program in an existing aging program or medical program can provide a useful synergy. Many Tribal medical programs are already Medicaid providers and have established billing systems. Existing CHRs might be able to serve as initial home care workers. Existing Tribal aging programs should be able to identify at-risk elders and make referrals that would quickly build program participants. Medicaid home care waiver programs in many states are located in the State Aging Departments.

Some potential Tribal Medicaid providers have been deterred by the nondiscrimination clause in Medicaid that requires providers to offer services to all persons, regardless of race, who request it. In many states, however, it is possible to define your service area in terms of reservation boundaries. When that is not possible, if you market services under the banner of a tribal agency and focus your program on AIAN culturally-competent care, you are unlikely to attract many non-Indians. They would turn to programs that may emphasize cultural competency for other groups (white or Latino, for example).

*Potential concerns to prepare for*

- ❖ ***Deciding how many hours of service a client needs.*** Each state uses their own standard form to determine if they are disabled enough to qualify for home and community based care under Medicaid Waiver programs (the other Medicaid program, PCS, usually requires a doctor's care plan that includes the service). In most states, county health or aging department's social workers have the

responsibility of completing this assessment. Conflict can occur when there are different views of the level of need between a Tribal provider who makes a referral and a nonTribal county worker who performs the Medicaid assessment. Some Tribes report that they try to send out a CHR or nurse to help the elder when the county's Medicaid worker visits to make an initial assessment. This can ease cultural and bureaucratic barriers, but it is not a reimbursable service. States can allow tribes to conduct these "level of care needs assessments," but it is not common.

- ❖ ***Estate recovery*** is a complex and controversial issue. The value of the elder's home is not counted as an asset when financial need is determined for Medicaid. The federal government, however, requires that after the Medicaid recipient dies the state attempts to recover payment for certain long-term care benefits and medical services that the recipient received through Medicaid. This repayment is called estate recovery and it is taken from the recipient's estate (resources owned at the time of their death). Hardship provisions to protect dependent heirs may apply. Collection only applies to property the Medicaid recipient owned or had an interest in at the time of death. It does not apply to property solely owned by a spouse or child.

*However*, federal law **exempts** enrolled Tribal members living on (or near) reservations from estate recovery, but not all states follow these rules. See the federal guidelines at <http://cms.hhs.gov/manuals/pub45pdf/sm3800.pdf>, page 3-9-5. In summary, Indian trust property, including real property and improvements, are not subject to the estate recovery program. Similarly, income derived from trust resources or trust property is also exempt. For example, income derived from a timber sale on trust property would be exempt from the estate recovery process. Some non-trust property is also exempt from the estate recovery process. Non-trust property located on a reservation or near a reservation as designated and approved by the BIA, or non-trust property located within the most recent boundaries of a prior Federal reservation, are also not subject to the estate recovery process, as long as the ownership is passed from an Indian to one or more relatives (including non-Indians and Indians not enrolled, so long as the deceased's cultural affiliation would nevertheless protect them as family members), or to a Tribe or Tribal organization, or to one or more Indians. Additionally, income left as a remainder in an estate derived from protected property as described above is exempt so long as the individual can clearly trace it as coming from the protected property. In addition, an exception is laid out for ownership interests or usage rights to items that have unique religious, spiritual, traditional and/or cultural significance, or rights that support subsistence or a traditional life style according to applicable Tribal law or custom. Estates that are handled by tribal courts, rather than state probate courts, are subject to tribal law. In practice, this means that most assets of enrolled Tribal members are probably exempt.

- ❖ ***Some Tribal councils propose nursing homes***, even when the economics and the need do not justify them. Most people know about nursing homes, so they naturally

come to mind when thinking about helping disabled elderly persons. But home care services can make even more sense to policy makers when the effect of home care services are described and the financing model explained. Other Tribes that successfully run home care programs, as well as state home care associations, can provide information and testimonials about the value of home care services.

In some communities snow and ice make consistent home care impractical during the winter. Some of them have constructed small independent-living senior housing in towns where elders who need help can move for the winter. If they need assistance with shopping or cleaning, home care services can be provided in the senior housing. The elders can then return to their more remote homesteads during the summer months, if they are able and interested.

- ❖ ***When there are not enough disabled elders to support a tribal agency*** there are other options. The Tribe can work with other providers in the area to assure that they employ enough Indian home care workers to provide appropriate care for the few Tribal members who need assistance. If a tribal social worker or CHR can assist Tribal members with the eligibility process for Medicaid home care services it is more likely that they will receive the level of care required. And finally, Tribes can encourage members to use the consumer-directed option (see page 5), if it is available in their state. This can increase care for the elders and provide employment for Tribal members, although it does not generate any revenue for the Tribal government.
- ❖ ***States may say they have used up available state funds and can not expand services for American Indians or Alaska Natives.*** The federal government has agreed to pay 100% of the cost of Medicaid services (i.e. no state money is needed) for Medicaid services provided by tribes and tribal organizations operating under PL 638 (Indian Self-Determination Act) compacts. This should give state governments incentives to expand tribally operated Medicaid services, but many states are not aware of this agreement. Minnesota recently expanded Medicaid long-term care programs on the White Earth reservation after the state government and legislature learned that the expansion would not cost the state additional funding. The original federal agreement can be found at <http://www.cms.hhs.gov/aian/oaofinal.pdf>.
- ❖ ***Urban Indian clinics*** can consider developing Medicaid home care programs, too. The issues will be different, since most urban areas (unlike rural areas) already have multiple Medicaid home care providers and competition for new clients may be more difficult.

## Assessment Tools

1. The National Resource Center on Native American Aging (see key contacts at end of this toolkit) has a program to assist tribes with conducting needs assessments of older persons. This involves collecting data which requires a modest investment of time and resources.
2. The U.S. Bureau of the Census also has information from the 2000 Census about the number of people who report self-care disabilities. This information will not be as detailed, and possibly not as accurate, as a special needs assessment, but the information is free and immediately available. Using the internet you can get information for persons by different age groups who live on federally recognized reservations or other geographic areas (such as counties or cities). The following provides step-by-step instructions for finding this information.
  - a. Go to <http://factfinder.census.gov>
  - b. In the middle of the page click on “2000 Summary File 3”
  - c. In the blue box towards the right, click on “Enter a table number”
    - i. A new box appears, enter P41 where it says “enter a table number”
    - ii. At the second bullet where it says “select a geographic type”, click on the small down marker (▼) and click on “American Indian Area/Alaska Native Area/Hawaiian Home Land”
    - iii. In the box under the third bullet where it says “Select one or more geographic areas...”, click on the small down marker (▼) until you reach your tribe. Click on the tribe to highlight it then click “add” below.
    - iv. To the right of the next box down, click “show result”
    - v. This table shows data from the 2000 Census for your tribal area for the number of people reporting different disabilities. The self-care disability is the closest to what Medicaid personal care provides, i.e. help with “dressing, bathing, or getting around inside the home.” Some assistance may also be provided to those with a physical disability, defined in the Census as substantial limits in one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying. NOTE: A person with both physical and self-care disabilities appears in both categories, so you *cannot* add the two categories together. The best idea is to use the self-care disability number as a low estimate and the physical disability as a high estimate of the number who could use assistance.
3. Note that there are likely to be eligible elders who live nearby but outside the tribal boundaries who would also like to be served by a tribal provider.

## **More about Medicaid**

Medicaid is a cooperative federal-state program that provides health insurance to low-income persons. Medicaid eligibility is limited to individuals who fall into one of over 25 different eligibility categories that fall into five broad coverage groups:

- Children
- Pregnant Women
- Adults in Families with Dependent Children
- Individuals with Disabilities
- Individuals age 65 or over

The federal government sets the overall program requirements and pays for a portion of total Medicaid costs, ranging from 50-77% depending on the per capita income of each state. While this places a disincentive on states to expand their Medicaid programs since they have to devote additional state funds for expansions, there is an exception for services provided by the Indian Health Service and compacting tribes. As of July 11, 1996, the Secretary approved HCFA's proposal to adopt an interpretation that section 1905(b) allows 100-percent FMAP [the amount of Medicaid spending paid by the federal government] for Medicaid services furnished to Medicaid eligible AIANs by any tribal facility operating under a 638 agreement (see p.2 <http://cms.hhs.gov/aian/moafinal.pdf>). While not all states currently take advantage of this complete federal subsidy, expanding Medicaid services for reservation populations served by compacting tribes *does not cost states any additional money*. This should eliminate a significant barrier when tribes want to work with state Medicaid programs to develop in-home Medicaid services.

While not all eligible tribal members are enrolled in Medicaid, there is a substantial base of AIANs in most states who are enrolled and who are currently eligible for needed services. Over one-half million American Indians and Alaska Natives were enrolled in the Medicaid program nationwide in 1998 (the last date that this information was published). The following states have 93% of all AIAN's in the program nationally.

State (1998 data)	Number of AIANs w/Medicaid	As Percent of All Persons w/ Medicaid
Alaska	34,922	39.7%
Arizona	92,322	14.2%
California	27,731	0.4%
Michigan	6,304	0.5%
Minnesota	27,012	4.8%
Montana	20,920	22.4%
Nebraska	8,578	4.1%
New Mexico	54,191	16.0%
New York	8,351	0.2%
North Carolina	20,514	1.7%
North Dakota	14,061	22.6%
Ohio	36,703	2.6%



Oklahoma (1997)	46,710	10.8%
Oregon	10,537	2.0%
South Dakota	30,455	36.6%
Texas	7,477	0.3%
Utah	10,604	5.3%
Washington	25,583	2.8%
Wisconsin	6,608	1.2%
Wyoming	4,273	8.3%
U.S. Total	529,304	1.3%

A long but useful “primer” that goes into detail about Medicaid services and eligibility is available at <http://aspe.hhs.gov/search/daltcp/Reports/primerpt.htm>.

## **Medicaid Eligibility**

### *Basic Rules*

The basic Medicaid eligibility rules are based on both income and assets. Income limits for persons age 65 and over, and blind and disabled people, are tied to the Supplemental Security Income (SSI) program, which is a cash-assistance program for aged, blind, and disabled people. The federal government establishes a minimum payment level for SSI, although many states pay above that line. In most states SSI recipients are automatically eligible for Medicaid, but in some the rules are more restrictive.

The general requirements for Medicaid for persons age 65 and over is that they have an income (in 2003) of no more than \$552 for an individual or \$829 for a couple. This varies somewhat between states and may be different for disabled persons. It is based on the Supplemental Security Income criteria.

Medicaid waiver home and community-based services often have less restrictive income criteria (typically three times the SSI levels noted above), and some states have special programs (outside Medicaid) that provide in-home care for those who are just above the Medicaid criteria in assets or income.

Assets (excluding the home the person lives in, and certain other assets) cannot exceed \$2,000 for a person living alone or \$3,000 for a couple in most states. Some states have higher limits. It is important to note that if the applicant transfers assets within 36 months of applying for Medicaid, those assets are “deemed” or assumed to be available for paying medical expenses.

Detailed eligibility data by state is available from the National Association of State Medicaid Directors at <http://www.nasmd.org/eligibility/default.asp>.

### *Additional Rules That Make More People Medicaid Eligible - Medically Needy*

Over half of all states allow a person to subtract their medical expenses from their income when they are calculating whether their income is low enough to qualify for Medicaid. When their remaining income is below the eligibility line they become eligible for Medicaid. This process is called a “spend down” and the recipient is considered “medically needy.” In effect, it is a deductible that the person has to pay (by paying for a certain amount of medical expenses out of pocket) before Medicaid takes over and pays the rest. This is particularly important for older persons who often have high on-going prescription medication and other medical costs. The income and asset limits can be different for the medically needy than for the “categorically needy” (i.e. those who meet the standard income/asset criteria), so it is important to check the current rules in each state.

The medically needy are covered for state plan personal care services in the following states: DC, KS, ME, MD, MA, MI, MN, MT, NE, NH, NJ, NY, NC, OK, OR, RI, UT, WV, WI (see <http://www.kff.org/medicaidbenefits/personalcare.html>).

In addition, many states use a higher income cut-off (typically 300% of the SSI level) for eligibility for waiver services. This means that even though an older person may not qualify for “regular” Medicaid because of their income, they may still qualify for waiver services such as homemaker or chore care. A summary of this information is available at <http://www.nasmd.org/waivers/waivers.htm> under the 1915(c) Waivers category, financial eligibility.

## **Selected Long Term Care Resources**

### **Home and Community Based Services (HCBS) Resource Network**

The Resource Network on Home and Community-Based Services is a partnership between the U.S. Department of Health and Human Services' Assistant Secretary for Planning and Evaluation ([ASPE](#))\*, [CMS](#) - Centers for Medicare & Medicaid Services (formerly HCFA)\*, state agencies that purchase and manage HCBS services, and consumers. The mission of the Resource Network is to work with states, the disability and aging communities, and others who are committed to high quality consumer-directed services in integrated settings through cost-effective delivery models.

<http://www.hcbs.org>

### **Indian Health Service's Elder Care Initiative**

The goal of the Elder Care Initiative is to promote the development of high-quality care for American Indian and Alaska Native elders by acting as a consultation and liaison resource for IHS, tribal, and urban Indian health programs.

<http://www.ihs.gov/medicalprograms/eldercare/index.asp>

### **National Indian Council on Aging (NICOA)**

Formed by a group of tribal chairmen in 1976, the National Indian Council on Aging (NICOA) has served as the nation's foremost nonprofit advocate for the nation's (est.) 296,000 American Indian and Alaska Native elders. NICOA strives to better the lives of the nation's indigenous seniors through advocacy, employment training, dissemination of information, and data support. They also offer technical assistance in developing long-term care programs.

[www.nicoa.org](http://www.nicoa.org)

### **National Resource Center on Native American Aging**

The National Resource Center on Native American Aging was established in 1994 at the University of North Dakota (UND). The resource center is collaboration between the UND Office of Native American Programs and the UND Center for Rural Health. The resource center's purpose is to work closely with the local service providers throughout the nation to address the needs of American Indian, Alaskan Native and Native Hawaiian elders. They can provide technical assistance in conducting needs assessments.

<http://www.med.und.nodak.edu/depts/rural/nrcnaa/index.html>

### **National Home Care Association**

NAHC is the nation's largest trade association representing the interests and concerns of home care agencies, hospices, home care aide organizations, and medical equipment suppliers. NAHC is dedicated to making home care and hospice providers lives easier. From professional development to fighting for better regulation, from knowing all angles of federal and state regulations to providing the latest information affecting home care and hospice, NAHC serves the needs of home care provider agencies.

<http://www.nahc.com/home.html>

# MAINE

<b>Contact Person</b>	Robert Gross Robert.E.Gross@maine.gov
<b>Demographics</b>	Number American Indians/Alaska Natives (2000 Census) –13,156 Number American Indians/Alaska Natives 65 and over (2000 Census) –794
<b>State Medicaid Spending &amp; Eligibles (persons enrolled in the Medicaid program)</b>	Spending, Personal Care (2002) - \$5,770,962 Spending, 1915(c) aged/disabled waiver (2002) – \$ 13,802,964 Total number persons enrolled in Medicaid (2000) – 214,093 Number “aged” persons enrolled in Medicaid (2000) – 24,532 Number “blind/disabled” persons enrolled in Medicaid (2000) – 48,780 Number persons served by 1915(c) aged or aged/disabled waiver (2000) –0 Number persons served by 1915(c) aged or aged/disabled waiver (1999) –1,395 Number AIAN persons enrolled in Medicaid (1998) –0 Number of AIAN persons receiving waiver services (2000-IHS) –17
<b>Services reimbursed by home and community based care programs (1915c waiver and state plan PCS)</b>	Elderly and Adults with Disabilities (single agency with Statewide responsibility for offering this service)  Adults with Physical Disabilities (consumer-directed model overseen by a single agency with Statewide responsibility for offering this service)
<b>Requirements for participation as a providing agency for those in-home non-medical services (e.g. homemaker).</b>	Elderly and Adults with Disabilities, a single nonprofit agency has a Statewide contract for providing this service.  Adults with Physical Disabilities, a single nonprofit agency has a Statewide contract for providing this service.
<b>Eligibility requirements for elders for those programs</b>	1. Elderly and Adults with Disabilities, nursing home level of disability 2. Adults with Physical Disabilities, nursing home level of disability
<b>Expected length of time from application to initiation of services for elders eligible for services</b>	Financial eligibility is determined within 45 days.
<b>Tribal organizations or programs currently serving as providers under those programs.</b>	<u>N/A</u>
<b>For further information about becoming providers for those programs</b>	MaineCare, Provider File, (207) 287-4082

<p><b><i>State Home Care Association</i></b></p>	<p><b><i>EXECUTIVE DIRECTOR</i></b>  Vicki Purgavie  <a href="#">Home Care Alliance of Maine</a>  20 Middle Street  Augusta, Maine 04330  207/623-0345  207/623-7141 fax  Email: <a href="mailto:vicki@homecarealliance.org">vicki@homecarealliance.org</a>  Web: <a href="http://www.homecarealliance.org">www.homecarealliance.org</a></p>	<p><b><i>PRESIDENT/CHAIRPERSON</i></b>  Donna DeBlois  Kno-Wal-Lin Home Care and Hospice  170 Pleasant Street  Rockland, Maine 04841  207/594-9561  207/594-2527 fax</p>
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NOTE: Please contact the State Medicaid office for the most recent information available concerning statistics as well as program eligibility and services.

## **Data Sources**

Persons working in each state's Medicaid office provided most of the narrative data in the state summaries. We obtained most of the statistical data from published sources, as noted below.

Spending, Personal Care (2002)

“Medicaid Long Term Care Expenditures, FY2002” provided by MEDSTAT at [http://www.hcbs.org/hcbs\\_data.htm](http://www.hcbs.org/hcbs_data.htm)

Spending, 1915(c) aged/disabled waiver (2002)

“Medicaid HCBS Waiver Expenditures, FY2002” Table 1, provided by MEDSTAT at [http://www.hcbs.org/hcbs\\_data.htm](http://www.hcbs.org/hcbs_data.htm)

Total number persons enrolled in Medicaid (2001)

MSIS statistical reports by state, Table 1, from CMS at <http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp>

Number “aged” persons in Medicaid (2001)

MSIS statistical reports by state, Table 1 (basis of eligibility), from CMS at <http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp>

Number “blind/disabled” persons in Medicaid (2001)

MSIS statistical reports by state, Table 1 (basis of eligibility), from CMS at <http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp>

Number persons served by 1915(c) aged or aged/disabled waiver (2000)

National Association of State Medicaid Directors, 1915c Waivers Enrollment and Cost, at <http://www.nasmd.org/waivers/waivers.htm>

Number persons served by 1915(c) aged or aged/disabled waiver (1999)

Kaiser Commission on Medicaid and the Uninsured, Table 1, 1915(c) Medicaid Waiver Program (from HCFA Form 372), at <http://www.hcbs.org/data/kaiser/WaiverTable1.pdf>

Number AIAN persons enrolled in Medicaid (1998)

From 2082 Table 30, Medicaid Eligibles by Race/Ethnicity, from CMS at <http://www.cms.hhs.gov/medicaid/msis/MCD98T30.pdf>

Number of AIAN persons receiving waiver services (2000-IHS)

Special data provided from MSIS by CMS