Understanding Your Options for Care

in a Nursing Home or Assisted Living Facility

2022

Please keep in mind that the following information does not substitute for the advice of an attorney. To discuss your specific situation, please contact a lawyer.

The following information is general in nature, and should be considered a broad overview. It does not include all Medicare, Medicaid, Veterans Administration and long-term care insurance requirements that must be met in order to qualify for payment of care in a nursing home or assisted living facility, and is not a guarantee that you will receive benefits under any of these programs.

This brochure has been written for people who live in Texas, and some of the information will not apply to people who live in other states. The income and resource limits are current as of 2022, and may change in 2023 and subsequent years. All information contained in this brochure is subject to change.

Let's get started.

Whether you're planning a short stay or a longer one, choosing a nursing home can be a tough decision. You're likely to have a lot of questions. How do you know that a nursing home is the best place to be? How do you know that a particular nursing home will be able to meet your needs? How do you pay for nursing home care?

Only you can make the decision that's best for you. But, as you decide, it's important to do your research. This booklet is written to provide you general information, and let you know about sources of more specific information.

What's best – your home, nursing home, or assisted living facility

Most people go into nursing homes or assisted living facilities because they can't get the care they need in the community. But how do you know what services are available in the community? Here are three not-for-profit agencies that can give you information about home-based services and programs:

- Your Area Agency on Aging, at 1-800-252-9240
- Your Aging and Disability Resource Center, at 1-855-YES-ADRC (1-855-937-2372)
- Area Information Center, at 2-1-1

How do I choose a good nursing home?

When you're choosing a nursing home, quality matters! You can't tell which nursing home has the best record of providing quality care by looking at the building. Gather as much information as you can from staff — as well as people who are not paid by the facility, and don't have a financial interest in your decision.

Medicare has prepared a helpful resource entitled "Your Guide to Choosing a Nursing Home or Other Long-Term Care." **https://www.medicare.gov/care-compare/en/assets/resources/nursing-home/02174-nursing-home-other-long-term-services.pdf.**

As you gather information from staff, you may want to ask about the following:

- Does the nursing home participate in Medicare? Medicaid? If so, are there waiting lists for Medicare/ Medicaid beds? If so, how long are the waiting lists?
- What charges will you be responsible for?
- What special training have employees received?
- How many certified nurse assistants work in the facility/portion of the facility where you might stay? How is the staffing different at night? Weekends?
- Is the facility near a bus line, so that employees who don't own cars can more easily get to work?
- What does the facility do exceptionally well? What care improvement goals is the facility working on?
- Can you set your own schedule for getting up/eating/taking a bath/going to bed?
- Will someone at the nursing home help you apply for Medicaid?

If you're interested in a particular facility, it's important to visit — and more than once, at different times of the day and/or days of the week. As you visit, talk to residents and family members to see how satisfied they are with the care they've received. Also, you can gather objective information from the State regulatory agency and independent long-term care ombudsman.

In Texas, nursing home issues are regulated by the Health and Human Services' Regulatory Services Division. You can see for yourself how a particular nursing home did during its most recent inspection. You can get inspection data directly from the nursing home, since it's required to post the findings in a visible place. Or you can access inspection results on-line, at: **https://www.medicare.gov/nursinghomecompare/search.html**

You can also speak with a long-term care ombudsman by calling 1-800-252-2412. Ombudsmen are resident advocates who make regular visits to nursing facilities. They can tell you about their observations and experiences at facilities you're considering.

How do I pay for nursing home care?

Good nursing home care is not cheap. In 2022 the average annual cost of nursing home care in Texas was $57,576 per year for a semi-private room and $78,480 per year for a private room. What can you do if you don't have enough money to pay for nursing home care? There are some government and private programs that can help pay, for those who qualify.

Will Medicare pay for my nursing home care?

Medicare can pay for skilled care in a nursing home. The way in which it pays may be different, depending on whether you have Original Medicare or a Medicare Advantage plan.

If you have Medicare Part A, and **Original Medicare,** Medicare may pay for your short-term stay in a skilled nursing facility if you meet all of the following conditions:

- You have been admitted to a hospital as an inpatient for at least 72 hours during the past 30 days and go into a skilled nursing facility within 30 days of leaving the hospital;
- Your doctor has ordered skilled care, such as nursing, physical therapy, occupational therapy, or speech therapy;

- You need skilled care on a daily basis; and
- You enter a skilled nursing facility that is certified by Medicare. (Tip: If you're looking for a nursing home that has Medicare beds, ask the hospital discharge planner, or call the long-term care ombudsman at 1-800-252-2412 for a list of Medicare facilities. Not all nursing homes participate in Medicare. Even those that do participate may not have an empty bed when you need it, so ask the nursing home that you're considering if it will have a Medicare bed available when you're ready for it.)

In general, Medicare will not pay for care in a skilled nursing facility if you need custodial care only. Custodial care includes help with walking, getting up from bed or a chair, taking a bath, getting dressed, grooming, using the toilet, and eating.

If you have a need for skilled care, and meet the requirements listed above, you can stay in a skilled nursing facility and get up to 100 days of Medicare coverage in a benefit period. A benefit period ends when you have not been in a skilled nursing facility or a hospital for at least 60 days in a row, or when you stay in a skilled nursing facility but do not receive skilled care there for at least 60 days in a row. If you have questions about when your benefit period begins and ends, you can call Medicare at 1-800-633-4227.

During the first 20 days in a skilled nursing facility, people who qualify for Medicare coverage don't have to pay for the care, since Medicare covers all of the cost. From day 21 through day 100 in the skilled nursing facility, people who qualify for Medicare must pay $194.50 per day, either out of pocket or through an insurance policy (e.g., Medicare supplement). This amount is

20% of the daily cost of care. After 100 days, Medicare coverage for that benefit period ends.

If you're enrolled in a **Medicare Advantage** (MA) plan, you get your health insurance from a private insurance company that's been approved by Medicare. Because your insurance company is private, your policy doesn't have to follow the same rules as Original Medicare. For example, some MA plans don't require a three-day prior hospitalization. While MA plans must have coverage for hospital and skilled nursing care, their deductibles, co-pays and insurance amounts can be different from the dollar amounts listed above.

If you're not sure what your MA pays for skilled nursing facility care, call it directly. Also, review your Annual Notice of Changes that's mailed to you in late September of each year.

Will Medicaid pay for my nursing home care?

Medicaid can pay for care in a nursing home, once a person who qualifies has been in a Medicaid-certified bed for at least 30 days in a row. Medicaid may pay for your nursing home care if you have a low income, limited resources, and a medical need for nursing home care. You must also be a United States citizen or a qualifying alien.

- Income: If you're not married, you can make up to $2,523 per month from all sources (or more, in some cases, as explained on page 7). If you are married, and your spouse also needs nursing home Medicaid, your combined income can be no more than $5,046 per month. Government checks, paychecks, interest and rental payments, annuities, mineral rights, and gifts are considered income.
- Resources: If you're not married, you can have no more than $2,000 in resources. If you are married, and your spouse also needs Medicaid to pay for care in a nursing home, your combined resources can be no more than $3,000. Resources include cash in checking and savings accounts, certificates of deposit, other liquid assets, and property other than your homestead or burial plot.

However, not all resources are taken into consideration when you apply for Medicaid. Here are some resources that are exempt in most cases:

  - A homestead with no more than $636,000 equity
  - One vehicle, regardless of value
  - A life insurance policy with no more than $1,500 cash value
  - A burial plot

- Medical Need for Nursing Home Care: To qualify for nursing home Medicaid, you must have specific medical needs. How do you know, or prove, that you meet the medical requirements? A nurse or other health care professional (often the director of nurses at the nursing home) assesses your health and then sends the assessment form to the Texas Medicare and Healthcare Partnership (TMHP) for review. TMHP decides whether you meet "medical necessity" requirements.

If your income, resources, and medical needs are within the Medicaid guidelines, Medicaid will begin to pay for your care in a nursing home.

You'll be expected to help pay for your care in the nursing home, usually by turning over your monthly income to the nursing home. In most cases, you will be allowed to keep $60 per month for incidental items. However, you may be able to keep an additional $90 per month if you're a veteran.

What if my monthly income is over the Medicaid limits? Can I still qualify?

Single people who make more than $2,523 per month and married couples who make more than $5,046 may qualify for nursing home Medicaid if they set up a qualifying income trust. A Qualified Income Trust (or QIT) may be used to reduce your income so it does not exceed Medicaid guidelines. It creates a special account where you can place some or all of your monthly

income. Although you don't have to put all of your income into the QIT, you do have to put all of your income from the same source into the QIT. For example, if you are single and receive a monthly Social Security check of $1,216 and a monthly annuity of $1,352, you can place your Social Security check of $1,216 into the QIT. Then, your monthly income would be considered $1,352 a month—which is below the Medicaid income limit. Each month, money that is deposited into the QIT is taken out to help pay the costs of your nursing home care.

Keep in mind that the QIT must be irrevocable (i.e., you can't alter or change it). And after you die, the State will take money out of your QIT that's equal to the amount that Medicaid paid for your care while you were living.

If you are married, and your spouse does not need nursing home Medicaid, it may be possible to divert some of your income to your spouse. The spousal impoverishment law allows the spouse who lives in the community to keep more of your combined income and more of your combined resources than Medicaid otherwise allows. This policy is intended to help the spouse continue to live in the community.

The spouse who lives in the community is allowed to have an income of up to $3,435 per month, called the Maximum Monthly Maintenance Needs Allowance (MMMNA), including his or her own income. Each dependent family member, as defined by Medicaid, is allowed an income of up to $2,177.50 per month. In addition, the community spouse is allowed a monthly housing allowance of $653.25. If the community spouse's income is less than $3,435, the nursing home spouse's income can be awarded to him or her, to bring him or her up to the $3,435 amount. This means it's possible that none of the nursing home spouse's income will be used to pay for nursing home care, and Medicaid may pay for all of it.

A lawyer should be consulted to set up a Qualified Income Trust. The area agency on aging may be able to arrange for legal consultation, in conjunction with the Legal Hotline for Texans. To contact the Area Agency on Aging, call 1-800-252-9240.

What if my resources are over the Medicaid limit? Can I still qualify?

The spousal impoverishment law also protects resources held by couples when one spouse applies for nursing home Medicaid and the other spouse lives at home. The spouse who stays at home gets to keep half of the couple's countable resources, or $27,480, whichever is more. The maximum protected amount for spouses is $137,400. Remember, the homestead with less than $603,000 in equity, one car, a burial policy with no more than $1,500 cash value and a life insurance policy with no more than $1,500 cash value are usually not counted as resources.

Let's look at a few examples to see how these protections work. Mr. and Mrs. Smith have $60,000 in combined resources, and Mrs. Smith applies for nursing home Medicaid. Mr. Smith, who continues to live at home, would be allowed to keep $30,000 in resources, or half of the Smiths' combined resource amount.

The Smiths would have at least one year after the date of initial Medicaid eligibility to transfer Mrs. Smith's resource to Mr. Smith, so that her resources would be no more than $2,000 (the resource limit for an individual). There is no transfer penalty for transfers made between spouses.

Now let's look at another example. Mr. and Mrs. Jones have $35,000 in combined resources, and Mr. Jones applies for nursing home Medicaid. Half of their combined resources is $17,500. But Mrs. Jones, who remains at home, would be allowed to keep $27,480 in resources, since that is the minimum resource amount protected under the Spousal Impoverishment law.

In contrast, Mr. and Mrs. Anderson have $400,000 in combined resources, and Mr. Anderson applies for nursing home Medicaid. Half of their combined resources is $200,000. Mrs. Anderson, at home, would be allowed to keep $137,400, since that is the maximum resource amount protected under the Spousal Impoverishment law.

In all of these cases, the spouse who goes into a nursing home must still “spend down” his or her portion of the assets to the $2,000 limit.

In most cases, if you are single, or you if are married and both you and your spouse require nursing home Medicaid, you will need to spend resources until they are at or below the Medicaid limits (i.e., $2,000 for a single person, and $3,000 for a couple). Spending your resources on your own care is the surest way to “spend down” according to Medicaid policy.

If you give your money away as gifts to other people and apply for Medicaid, your eligibility for Medicaid may be delayed. This is called the transfer of assets penalty and applies to gifts given in the past five years. In early 2022, divide the amount of a gift given within the past five years by $237.93 to calculate the number of days you will have to pay for nursing home care before Medicaid will begin.

You don’t have to hire an attorney to apply for Medicaid. But attorneys can be helpful, to make sure that you’re following the law and getting Medicaid benefits for which you qualify. This is especially important if you have a large amount of resources. There are certain types of annuities that are allowed under Medicaid law. Elder law attorneys should be familiar with these annuities.

For example, let’s assume that you’re single and have $12,000 in resources. You give $10,000 to your daughter, and have $2,000 remaining. Three years later you apply for Medicaid. Divide the amount of your gift, at $10,000, by $237.93, for a quotient of 42.03. In this example, you’ll have to pay for 43 days of nursing home before becoming financially eligible for Medicaid.

Will I have to give up my home in order to qualify for Medicaid?

You can have up to $636,000 equity in your homestead and still qualify for Medicaid. However, the State may have the right to recover some or all of the money that Medicaid has paid for your care after you die, under the federal Medicaid estate recovery provisions.

Medicaid estate recovery applies to people age 55 and over who apply for Medicaid long-term care services (i.e., care in a nursing home, and in certain community-based programs) after March 1, 2005. However, the state may not ask for money from your estate, even if you are over the age of 55 and have applied for Medicaid long-term care after March 1, 2005. There are a number of exemptions that can protect your estate from recovery.

You are likely to be exempted from Medicaid estate recovery if you have a spouse who survives you; if you have a surviving child who is under the age of 21; if you have a surviving child of any age who is blind or disabled; if you have a surviving, unmarried adult child who lived in your homestead for a year prior to your death; and/or if estate recovery would cause undue hardship for your survivors. In addition, the state will not ask for any money back from your estate if your home is valued at less than $100,000, or if recovery would not be cost effective.

Also, you can keep your home from being affected by Medicaid estate recovery if you execute a Transfer on Death Deed (TODD). A TODD allows you to designate a beneficiary who will receive your property after your death. For more information about the TODD, contact an elder law attorney. You can search for one at **www.naela.org/findlawyer?**

For general information about Medicaid estate recovery, call 1-855-845-1114 or go to **hhs.texas.gov/MERP**. You can email questions to merp@hhsc.state.tx.us. For information regarding a specific case, you can call 1-800-641-9356.

Will the Veterans Administration pay for my nursing home care?

The Veterans Administration (VA) can pay for short-term and long-term nursing home care. To see if you qualify, contact the VA Health Benefits Regional Office at 1-800-827-1000. Veterans are considered according to priority, such as having a service-connected disability, having been prisoners of war, having been exposed to toxic chemicals in Vietnam or in the American occupation of Hiroshima and Nagasaki, having served in World War I, World War II, Vietnam, or the Korean conflict and/or receiving a VA pension that is not adequate to cover the cost of nursing home care. Other veterans are considered on a case-by-case basis.

The VA owns some nursing homes that are for veterans only. In addition, the VA can pay for a veteran to receive care at a non-VA nursing home.

I don't think I'll qualify for any of these programs. Should I buy long-term care insurance?

Long-term care insurance is a good investment for some people, but not for everyone. You might want to buy a long-term care policy if you expect to have too much money or resources to qualify for Medicaid, and don't expect to have enough money to pay for nursing home care out of your own pocket. You may want to talk to a financial planner to see if buying a long-term care policy makes sense for you.

If you buy a long-term care insurance policy and later find out that you qualify for Medicaid, you may be eligible to receive Medicaid benefits.

Finding a long-term care insurance policy that's best for you can be hard. Unfortunately, policies are not standardized and you must read each one carefully to understand what kind of care it covers, how much it will cost, if the cost will increase, how much it will pay, how you will qualify for coverage, and what the limits on coverage are.

Your health is a factor in whether or not you buy a policy. Do you have any medical problems now? Are these likely to get worse over time? What is your family medical history?

As you look at long-term care insurance policies, ask the following questions:

- What types of care are covered, and in what setting? Will the policy pay for home health care, adult day care, care in an assisted living facility, and care in a nursing home? What about hospice and respite care?
- What will I have to prove in order to qualify for benefits? Must I need help with at least two or three activities of daily living (i.e., bathing, dressing, grooming, toileting, transferring, walking, and feeding)? What if I'm in good shape physically, but have problems with my memory? Will the policy pay if I need reminders and supervision, rather than hands-on care?
- How long is the elimination period, or time that I need to wait between qualifying for benefits and getting the insurance company to start paying for my care? Some policies will make you wait 30 or 60 days after you qualify for benefits before the policy will start paying. That means you will need money to pay privately for those days before your benefits begin.
- How much is the daily benefit for each type of care? Is the daily benefit set at a certain dollar amount, or will it go up as costs increase? Since the cost of long-term care is subject to inflation, it's risky to buy a policy with a daily benefit that's set at a certain dollar amount. If the daily benefit seems generous now, it may not be high enough to cover the costs when you're ready to use the policy.

- How long will benefits be paid? Is there a certain dollar limit on coverage, such as $100,000 in benefits? Or does the policy provide lifetime coverage?
- Does the policy have a waiting period for pre-existing conditions? If so, how long will I be asked to wait before I can start using the policy?
- If I cancel the policy, will I be able to get any of the money back that I've paid in premiums?
- Is the policy tax-qualified? That is, can I deduct part of the premiums I pay as medical expenses on my income tax?
- What special options are included in the policy?

If you need more information about long-term care insurance policies and the companies that offer them, you can call a benefits counselor at 1-800-252-9240.

Is assisted living right for me?

If you don't need nursing home care but don't feel comfortable living on your own, you might consider assisted living. Assisted living facilities provide levels of care that span the gap between nursing home and independent living. At a minimum, they provide some assistance with personal care. Like nursing homes, they are regulated by the Texas Health and Human Services' Regulatory Services Division.

However, assisted living facilities are different from nursing homes in many ways. Among these differences are the following:

- Medicare does not cover the cost of care in assisted living facilities.
- In some cases, Medicaid can cover the cost of care in assisted living facilities. However, few facilities participate in the Medicaid program, and those that do participate usually limit the number of Medicaid beds. As a result, there may be long waiting lists for Medicaid beds.

- Assisted living facilities have fewer regulations, and thus fewer consumer protections, than do nursing homes.
- The cost of care in assisted living facilities tends to be more variable. For this reason, read the admissions contract carefully to figure out what charges you will be responsible for. Ask how the charges might change, in case your care needs change.

In Texas there are three types of assisted living facilities:

- Type A: serve residents who are able to leave the building without assistance from staff in case of an emergency, who don't need routine assistance during the night, and who are capable of following directions in case of an emergency
- Type B: serve residents who may need assistance from staff in case of an emergency, who may need routine assistance during the night, and who may need assistance transferring from bed to a wheelchair
- Type C: have no more than four beds and are licensed as adult foster care facilities

How do I choose an assisted living facility?

The process for choosing an assisted living facility is similar to the process for choosing a nursing home. In both cases, it's important to do your research!

To find out which assisted living facilities are located in your community, call the Long-Term Care Ombudsman Program at 1-800-252-2412.

To narrow your search, consider whether you need a facility that participates in Medicaid, is able to care for residents who can't evacuate the building on their own, and/or is licensed to provide specialized care for individuals with Alzheimer's and related conditions. You'll need to contact the facility directly to obtain its admission requirements and pricing information.

As you're researching quality of care at assisted living facilities, you can get valuable information from long-term care

ombudsman at 1-800-252-2412. The ombudsman can let you know about a particular facility's performance.

Does Medicaid pay for assisted living?

Texas has a Medicaid waiver program – known as STAR+PLUS – that can pay for care in assisted living facilities. In order to qualify for services through STAR+PLUS – and get help with the costs of assisted living – an individual must meet all of the following criteria:

- Qualify for the Medicaid program, including having low income and limited resources;
- Qualify medically for nursing home care;
- Be approved for STAR+PLUS
- Move into an assisted living facility that has a contract with the managed care organization (MCO) that handles your Medicaid benefits and has a Medicaid bed available.

You'll be expected to help pay for your care in the assisted living facility. In most cases, you will be allowed to keep $85 per month for incidental items.

Does the Veterans Administration pay for assisted living?

The Veterans Administration has an Aid and Attendance program that can pay for care in assisted living facilities. In order to qualify, you must be a veteran or spouse of a veteran who served during a war and were honorably discharged. In addition, you must have a disability and relatively limited income. To see if you qualify, contact the Veterans Administration at 1-800-827-1000.

Helpful Resources for Long-Term Care Planning:

Aging and Disability Resource Centers:
1-855-937-2372 (1-855-YES-ADRC) *(general information about long-term services and supports)*

Area Agency on Aging Benefits Counseling Program:
1-800-252-9240 *(general information and counseling about public and private benefits)*

Centers for Medicare & Medicaid Services:
1-800-633-4227 *(information about Medicare coverage & claims)*

National Clearinghouse for Long-Term Care Information: **www.longtermcare.gov**
(a U.S.-sponsored website about long-term care planning)

Own Your Future, Texas: **www.ownyourfuturetexas.org**
(a State-sponsored website about long-term care)

Texas Department of Insurance: **1-800-252-3439** *(information about insurance products and companies)*

Texas Health and Human Services Commission: **2-1-1**
(information about Medicaid programs)

Texas Legal Services Center: **1-800-622-2520**
(legal information and advice about public and private benefits)

Texas Long-Term Care Regulatory: **1-800-458-9858**

Texas State Long-Term Care Ombudsman Program:
1-800-252-2412

North Central Texas Aging & Disability ResourceCenter
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Area Agency on Aging
OF NORTH CENTRAL TEXAS

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