GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Texas, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

Authors
Samuel Lau
Maya Fransz-Myers
David Knapp

Contributors
MaryBeth Musumeci
Jinkook Lee
Rachel Lobo
Drystan Phillips
Kanghong Shao
Michael Upchurch
Maya Wedemeyer

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/app/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Texas, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in Texas are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Texas, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, Texas' Medicaid LTC system has been subject to two major policy reforms: mandatory managed care enrollment with the phased-in implementation of STAR+PLUS in 1997, and the statewide expansion of STAR+PLUS in 2015.

Key Dates

First law: 1965

Major changes since 1992: 1997, 2015

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1996

Overview

Long-term care (LTC) benefits in Texas are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Texas is administered at the state level by the Texas Health and Human Services Commission (HHSC), and health plans are organized and administered at the service area level, which are geographic locations within the state where services are delivered by health plans and contracted providers. Enrollment in Medicaid is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Texas are mostly provided through state plan benefit programs (Primary Home Care - PHC, Nursing Facility Care), or from 1994, through federally approved home-and community-based services (HCBS) LTC programs (Community-Based Alternatives - CBA).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PHC provides home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the CBA program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC). Those applying for the CBA program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list.

Benefit programs vary in dependence requirements. PHC requires the individual to have a medical necessity for services and need some assistance with activities of daily living, while Nursing Facility and CBA beneficiaries must meet a nursing facility level of care (NFLOC) based on a medical necessity determination before admission.

In 1994, the CBA program was approved as a Medicaid HCBS program, serving individuals 65 and older and individuals with physical disabilities between the ages of 21 and 64 (CMS, 2023b).

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid

- 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)
- 42 Code of Federal Regulations (CFR), Public Health (Title 42 CFR, 2023)

Texas Law for Medicaid

- Texas Government Code, Title 4, Subtitle I (Texas Government Code)
  - Texas Human Resources Code Chapter 32
- Texas Administrative Code
  - Title 1, Part 15, Texas Health and Human Services Commission (1 TAC P.15)
  - Title 26, Part 1 Health and Human Services Commission (26 TAC P.1)
  - Title 40, Part 1, Department of Aging and Disability Services (40 TAC P.1)
    - Primary Home Care (PHC) —(Social Security Act 1905(a)(23); 40 TAC Chapter 47)
    - Nursing Facility Care —(Social Security Act 1905(a)(4)(A); Social Security Act 1919(a); 40 TAC 19)
    - Community-Based Alternatives (CBA) —(Social Security Act 1915(c); 40 TAC 40.1; 40 TAC 46; 40 TAC 62; 40 TAC 48, Subchapter J)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Texas Medicaid spending on beneficiaries in fiscal year 1992 was 64%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (64% in 1992), though there are exceptions for certain administrative functions that may receive a higher matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Texas Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Texas.

Eligibility for Medicaid in Texas for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount. In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2023c). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (Texas HHS, 2023f, I-2100).[1]
  - Citizenship/immigration requirements: The applicant must be a Texas resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[2] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident (SSA, 2023b). See SSA (2023) for additional information.
  - Other requirements
    - The individual must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3)).[3]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the federal SSI amount. In 1992, this was $1,266 for an individual. Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[4]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[5]

        - Asset transfer: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be a resident of a Texas LTC facility (e.g., Nursing Facility Care), or enrolled in or applying for an HCBS program.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Primary Home Care

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21, and their income may not exceed 100% of the federal SSI monthly benefit amount.

Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community-Based Alternatives (from 1994)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Living Assistance and Support Services for the Frail Elderly (CLASS)
- Day Activity and Health Services (DAHS)
- Program of All-Inclusive Care for the Elderly (PACE)

Benefit

Home care benefit

PHC

PHC provides:

- Personal care services
    - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
    - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Escort services, such as accompaniment to doctor's visits

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

CBA

CBA provides the following services in addition to those offered under the state plan, unless otherwise noted (Texas DHS, 2000):

- Personal care services (as described above under PHC)
- Skilled nursing services: Nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse

Semi-residential care

PHC, Nursing Facility Care, CBA

These programs do not provide semi-residential care during this policy period.

Residential care

PHC

PHC does not provide residential care during this policy period.

Nursing Facility Care

Texas Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (Texas DHS, 2000; Texas DAD, 2010; Texas HHS, 2022b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

CBA

CBA provides assisted living services, which include (ASPE, 2003):

- Personal care
- Homemaker and chore services
- Medication oversight
- Therapeutic, social, and recreational programming

Services are provided in a home-like environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Other benefits

Texas Medicaid provides additional benefits related to LTC (Texas HHS, 2022b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

CBA

CBA provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Durable medical equipment and supplies (as described above under the state plan)
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant (minor modifications)

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by Texas Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PHC

Attendants help individuals with activities of daily living, such as bathing, grooming, meal preparation and housekeeping. Attendants are trained and supervised by non-medical personnel. The attendant cannot be a legal or foster parent of a minor child who receives the service, or the service recipient's spouse. Community Care Services Eligibility (CCSE) staff, a supervisor, or a regional nurse can also limit the beneficiary's choice of attendants. For example, if they determine that the attendant is not providing adequate care (Texas HHS, 2023, Rule 4623).

Nursing Facility Care

Care in a nursing facility is provided by physicians, registered nurses, and nurse aides. Facilities are licensed and overseen by the Texas HHSC (26 TAC 554).

CBA

CBA recipients have a choice in service delivery options between the traditional agency option or the Consumer Directed Services (CDS) option. The CDS option allows recipients or their legally authorized representative to serve as the employer and assume responsibility for screening, hiring, training and dismissing providers (Texas DHS, 2010).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

PHC

The beneficiary must satisfy all of the following conditions (7 TexReg 3504, 1982; 11 TexReg 2828, 1986; 40 TAC 48.2907):

- Receive a score of at least 24 on the Needs Assessment Questionnaire and Task/Hour Guide
- Have a medical necessity for assistance with ADLs, shown through a signed physician's order
- Require at least 6 hours of services per week[6]

Nursing Facility Care

The beneficiary must have a medical necessity determination certifying the existence of a medical condition that requires daily skilled nursing care (Texas DHS, 2000).

CBA

The beneficiary must satisfy all of the following conditions (TDHS, 2000):

- Meet a nursing facility level of care (NFLOC); described above under Nursing Facility Care
- Have an ongoing need for care that cannot be delivered adequately by family, friends, other Medicaid-reimbursed services, or other sources

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

PHC

Unknown

Author's note: Authors have not yet identified this information.

Nursing Facility Care

Physicians are required to recertify the resident's necessity for continued nursing facility care every 6 months (40 TAC Rules 19.1210, 19.2405).

CBA

Level-of-care assessments and medical necessity determinations must be performed every 12 months (40 TAC 48.6005).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PHC, Nursing Facility Care

There is no age requirement.

CBA

The individual must be at least age 21.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

PHC

The Texas Department of Aging and Disability Services (DADS) uses a standardized assessment instrument, the Needs Assessment Questionnaire and Task/Hour Guide, to measure the person's ability to perform activities of daily living. This yields a score, which is a measure of the person's level of functional need. The Needs Assessment Questionnaire and Task/Hour Guide includes 24 items in Part A, a Functional Assessment of different tasks (Items 1-24) and Part B, a Task/Hour Guide Column that matches a daily number of minutes to conduct a task to an impairment score. The total impairment score is used to determine eligibility for personal care services (minimum score of 24). The hours and minutes required for each authorized task is then totaled to get the total weekly hours that are authorized (40 TAC 48.2918; Texas HHS, 2023g, H2060).

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC), meaning they require services comparable to care in an institution.

Author's note: The exact definition of dependence for this policy period corresponding to the required evaluation of dependence has not yet been identified.

CBA

Unknown

Author's note: Authors have not yet identified this information.

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

PHC

The Texas Department of Aging and Disability Services (DADS) uses the DADS Needs Assessment Questionnaire and Task/Hour Guide to determine an individual's functional need and unmet need for the PHC program (40 TAC 48.2907).

Author's note: Authors have not yet identified the DADS assessment form for this policy period. To view the assessment form for later policy periods, see Texas HHS (2023g, H2060).

Nursing Facility Care

We have not identified a standardized assessment for determining the medical necessity of nursing facility care in Texas for this policy period. However, there are federal guidelines all states must follow. The Social Security Act requires that nursing facilities conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The assessment must satisfy all of the following conditions (Social Security Act 1919(b)(3)):

- Describe the resident's capability to perform daily life functions and significant impairments in functional capacity
- Include a uniform minimum data set specified by the U.S. Department of Health and Human Services Secretary
- Use an instrument which is specified by the State
- Include the identification of medical problems

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

CBA
Unknown

Author's note: Authors have not yet identified this information.

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

PHC
Staff from the Texas Department of Human Resources conduct the functional assessment (7 TexReg 3504, 1982).

Nursing Facility Care
The recipient's attending physician and the nursing facility conduct the assessment for an individual's medical need for nursing facility care.

CBA
Unknown

Author's note: Authors have not yet identified this information.

Benefit limitations

Can you mix LTC benefits?

All Texas Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid
As required by federal law, Texas enforces Estate Recovery. The acceptance of Medicaid in Texas creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. Services Medicaid can recover the assistance paid for include Nursing Facility Care and HCBS (1 TAC Rule 373.105). This was codified March 1, 2005.

PHC
PHC program participants generally do not have copayments for eligible services, HHSC reimburses providers at an accepted hourly rate for their services according to 40 TAC 49.302 (codified September 1, 2014). If a participant received services before their eligibility was determined, they are entitled to be reimbursed by providers for any out-of-pocket payments made for eligible services, even if the payments exceed the amount HHSC will reimburse for those services according to 40 TAC 47.85 (codified June 1, 2004).

Author's note: Authors have not yet identified user charge provisions for this policy period, but have provided the information as of 2004.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the PNA was $30 per month (Texas HHS, 2023f, Appendix XXXI H-1500). See Table 3 for historical allowances.

CBA

Beneficiaries must pay a copayment, which is equal to the remaining income after all allowable expenses have been deducted. The copayment amount is applied only to the cost of HCBS which are funded through this HCBS program and specified on the client's individual plan of care. The copayment must not exceed the cost of services actually delivered. The amounts are documented in the Texas Department of Human Services copayment worksheet (40 TAC 48.6009).

Author's note: Authors have not yet located the copayment worksheet, as it is not available on the THHS website.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 1997-2014

Policy change in 1997
In 1997, the federal Balanced Budget Act, allowed states to require most Medicaid-eligible individuals to enroll in managed care without a Home and Community-Based Services (HCBS) program. The same year, managed care enrollment was made mandatory for those applying for Medicaid through eligibility track 1a (1 TAC 353.603).

During this time period, new programs were introduced, and others ended. In 1998, STAR+PLUS HCBS, a managed care HCBS program, was implemented in the Harris service area. Between 2007-2011, STAR+PLUS HCBS expanded to 5 additional service areas (Bexar, Travis, Nueces, Dallas, Tarrant) (Texas HHS, 2022b). In 2011, the Texas Administrative Code changed, requiring STAR+PLUS HCBS participants to enroll in STAR+PLUS managed care, the main managed care plan providing acute services to Medicaid beneficiaries (1 TAC 353.603, 2011). Starting September 1, 2014, the Community-Based Alternatives (CBA) program ended, transitioning former participants to STAR+PLUS managed care plans to receive these services (CMS, 2023).

In 2004, the Community Attendant Services (CAS) program was created. CAS is a state plan benefit program that provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). CAS has no age restrictions, and in 2007, PHC became limited only to individuals age 21 and older (THHS, 2017).

Other reforms during this period:

- (2014) The ACA required states to extend spousal impoverishment rules to individuals receiving LTC through HCBS programs, including STAR+PLUS HCBS. From 2014, additional income and asset disregards applied to the community spouse of an individual receiving Medicaid HCBS.

Overview

Long-term care (LTC) benefits in Texas are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Texas is administered at the state level by the Texas Health and Human Services Commission (HHSC), and health plans are organized and administered at the service area level, which are geographic locations within the state where services are delivered by health plans and contracted providers. Enrollment in Medicaid is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Texas are mostly provided through state plan benefit programs (Primary Home Care - PHC, Nursing Facility Care, and from 2004, Community Attendant Services - CAS), or through federally approved home-and community-based services (HCBS) LTC programs (Community-Based Alternatives - CBA, and from 1998, STAR+PLUS HCBS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. PHC and CAS provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the CBA program or STAR+PLUS HCBS are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC). Those applying for the CBA program are not immediately guaranteed care, as the program has a strict enrollment limit. If the program is at capacity, individuals are placed on a prioritized waiting list. There is no enrollment limit for the STAR+PLUS HCBS program, but eligible applicants must live in specified geographic locations.

Benefit programs vary in dependence requirements. PHC and CAS require the individual to have a medical necessity for services and need some assistance with activities of daily living, while Nursing Facility, CBA, and STAR+PLUS HCBS beneficiaries must meet a nursing facility level of care (NFLOC) based on a medical necessity determination before admission.

Statutory basis

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Eligible population

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Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[7] In 1997, the monthly federal benefit amount was $484 for an individual and $726 for a couple (SSA, 2023c). Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.

        - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (Texas HHS, 2023f, I-2100).[1]
        - Home equity limit: Beginning in January 2006, the equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services (Texas HHS, 2023f).[8] This figure increases annually with inflation. See Table 5 for historical home equity limits.
    - Citizenship/immigration requirements: The applicant must be a Texas resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
    - Other requirements
        - The individual must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3)).[3]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
    - Income requirements: Monthly income may not exceed 300% of the federal SSI amount. In 1997, this was $1,452 for an individual and $2,178 for a household of two. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[9]
    - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized (or receiving HCBS, as of 2014) and has a spouse residing in the community.[10]
        - Asset transfer & Home equity limit: Same as eligibility track 1a.
    - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - Other requirements
        - The applicant must be a resident of a Texas LTC facility (e.g., Nursing Facility Care), or enrolled in or applying for an HCBS program.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Primary Home Care

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21, and their income may not exceed 100% of the federal SSI monthly benefit amount.

Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Community-Based Alternatives (until 2014)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 21. If the program has reached enrollment capacity, the applicant will be placed on a waiting list until a spot becomes available.

STAR+PLUS HCBS

STAR+PLUS participants must meet the following criteria beyond minimum level of dependence requirements:

- At least age 65, or at least age 21 and disabled
- Live in the Harris service area (1998), or Bexar, Travis, Nueces, Dallas, and Tarrant (expanded to these areas from 2007-2011)

Community Attendant Services

Beyond meeting minimum level of dependence requirements, applicants' income may not exceed 300% of the federal SSI monthly benefit amount.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include (Texas DAD, 2010; Texas HHS, 2023e):

- Community Living Assistance and Support Services for the Frail Elderly (CLASS)
- Day Activity and Health Services (DAHS)
- Program of All-Inclusive Care for the Elderly (PACE)
- Community First Choice (CFC)

Benefit

Home care benefit

PHC, CAS

PHC and CAS provide:

- Personal care services
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Escort services, such as accompaniment to doctor's visits

CAS is limited to a maximum of 50 hours per week of care.

CBA (until 2014)

CBA provides the following services in addition to those offered under the state plan, unless otherwise noted (Texas DAD, 2010):

- Personal care services (as described above under PHC)
- Skilled nursing services: Nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

STAR+PLUS HCBS

STAR+PLUS HCBS provides the following services in addition to those offered under the state plan, unless otherwise noted (Texas HHS, 2022b):

- Personal care services (as described above under PHC)
- Nursing services (as described above under CBA)

Semi-residential care

PHC, Nursing Facility Care, CBA (until 2014), CAS

These programs do not provide semi-residential care during this policy period.

STAR+PLUS HCBS

STAR+PLUS HCBS provides Adult Day Health Care (ADHC). In Texas, ADHC is called Day Activity and Health Services (DAHS). This service includes:

- Personal care services
- Medication administration
- Skilled nursing services
- Social activities

Participants can receive care 5 days per week, up to 10 hours per day, dependent on need.

Residential care

PHC, CAS

These programs do not provide residential care during this policy period.

Nursing Facility Care

Texas Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (Texas DHS, 2000; Texas DAD, 2010; Texas HHS, 2022b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

CBA (until 2014), STAR+PLUS HCBS

CBA and STAR+PLUS HCBS provide assisted living services, which include (ASPE, 2003; Texas HHS, 2022b):

- Personal care services (as described above under PHC's home care benefit)
- Medication oversight
- Therapeutic, social, and recreational programming

Services are provided in a home-like environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Other benefits

Texas Medicaid provides additional benefits related to LTC (Texas HHS, 2022b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

CBA (until 2014)

CBA provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Durable medical equipment and supplies (as described above under the state plan)
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant (minor modifications)

STAR+PLUS HCBS

STAR+PLUS HCBS provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Durable medical equipment and supplies (as described above under the state plan)[1]
- Home-delivered meals (as described above under CBA)
- PERS (as described above under CBA)
- Respite (as described above under CBA)
- Home improvement or adaptations (as described above under CBA)
- Transitional assistance services: Pays for non-recurring, set-up expenses for members transitioning from nursing facilities to a home in the community —this service is available on a one-time only basis and is not available to residents moving from a nursing facility who are approved for assisted living or adult foster care services

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by Texas Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

PHC, CAS

Attendants help individuals with activities of daily living, such as bathing, grooming, meal preparation and housekeeping. Attendants are trained and supervised by non-medical personnel. The attendant cannot be a legal or foster parent of a minor child who receives the service, or the service recipient's spouse. Community Care Services Eligibility (CCSE) staff, a supervisor,

or a regional nurse can also limit the beneficiary's choice of attendants. For example, if they determine that the attendant is not providing adequate care (Texas HHS, 2023, Rule 4623).

Nursing Facility Care

Care in a nursing facility is provided by physicians, registered nurses, and nurse aides. Facilities are licensed and overseen by the Texas HHSC (26 TAC 554).

CBA

CBA recipients have a choice in service delivery options between the traditional agency option or the Consumer Directed Services (CDS) option. The CDS option allows recipients or their legally authorized representative to serve as the employer and assume responsibility for screening, hiring, training and dismissing providers (Texas DHS, 2010).

STAR+PLUS HCBS

Program participants receive their benefits through their managed care organization (MCO) plan, which has a network of healthcare providers. Participants have the option to self-direct some of their benefits by choosing caregivers outside the MCO plan network of providers.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the five largest programs are summarized below.

PHC, CAS

The beneficiary must satisfy all of the following conditions (7 TexReg 3504, 1982; 11 TexReg 2828, 1986; 40 TAC 48.2907):

- Receive a score of at least 24 on the Needs Assessment Questionnaire and Task/Hour Guide
- Have a medical necessity for assistance with ADLs, shown through a signed physician's order
- Require at least 6 hours of services per week[11]
- Have a functional limitation with at least one personal care task based on a medical condition

Nursing Facility Care

The beneficiary must have a medical necessity determination certifying the existence of a medical condition that requires daily skilled nursing care (Texas DHS, 2000). Individuals qualifying for Medicaid coverage under eligibility track 2a must be continuously certified for nursing facility care by a physician. From 2008, individuals must require medical or nursing services on a regular basis that are ordered by a physician and require the skills of a registered or licensed vocational nurse (40 TAC 19.2401, 2008).

CBA

The beneficiary must satisfy all of the following conditions (40 TAC 48.6003):

- Meet a nursing facility level of care (NFLOC); described above under Nursing Facility Care
- Meet at least two of the Nursing Facility Risk Criteria (for initial applicants only)
  - Need assistance with at least one ADL
  - Have a functional decline in the past 90 days
  - Have a history two or more falls in the past 180 days
  - Have a neurological diagnosis of Alzheimer's, Head Trauma, Multiple Sclerosis, Parkinsonism, or Dementia
  - Have a history of nursing facility placement within the last five years
  - Have multiple episodes of urine incontinence daily
  - Leaves one's residence one or fewer days a week

STAR+PLUS HCBS

The beneficiary must have a medical necessity determination for the program, meaning the individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care (Texas MHP, 2019).

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the five largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

PHC, CAS

PHC and CAS eligibility is redetermined every 12 months.

Nursing Facility Care

Reassessments are required on an annual basis, but at least 90 days before the end of the service plan (26 TAC Rule 554.2405). Individuals qualifying for Medicaid coverage under eligibility track 2a. Institutional Rules must be continuously certified for nursing facility care by a physician every 30 days, known as the 30-consecutive-day stay requirement) (Texas HHS, 2023f, Rule B-7400).

CBA

Level-of-care assessments and medical necessity determinations must be performed every 12 months (40 TAC 48.6005).

STAR+PLUS HCBS

There is no standard reassessment timeline. Managed care health plans conduct assessments for continued eligibility in accordance with timeframes outlined in their managed care contracts (1 TAC Rule 353.1153).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

PHC

Before 2007, there is no age requirement. From 2007, PHC beneficiaries must be at least age 21 (THHS, 2017).

CBA

The individual must be at least age 21.

Nursing Facility Care, CAS

There is no age requirement.

STAR+PLUS HCBS

The individual must be at least age 65, or at least age 21 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the five largest programs are summarized below.

PHC, CAS

The Texas Health and Human Services (Texas HHS) department uses a standardized assessment instrument, the Needs Assessment Questionnaire and Task/Hour Guide, to measure the person's ability to perform activities of daily living. This yields a score, which is a measure of the person's level of functional need. The Needs Assessment Questionnaire and Task/Hour Guide includes 24 items in Part A, a Functional Assessment of different tasks (Items 1-24) and Part B, a Task/Hour Guide Column that matches a daily number of minutes to conduct a task to an impairment score. The total impairment score is used to determine eligibility for personal care services (minimum score of 24). The hours and minutes required for each authorized task is then totaled to get the total weekly hours that are authorized, which cannot exceed 50 hours for all CAS members (40 TAC 48.2918; Texas HHS, 2023g, H2060).

Nursing Facility Care

Applicants must meet a nursing facility level of care (NFLOC), meaning that a physician has certified that the applicant has a medical condition that requires daily skilled nursing services (Texas DHS, 2000).

As of 2008, Texas has codified a specific definition of dependence for a nursing facility level of care (NFLOC). medical necessity is determined using conditions outlined in 26 TAC Rule 554.2401 and 40 TAC 19.2401, detailed below (codified in September 1, 2008).

- The individual must demonstrate a medical condition that satisfies all of the following conditions:
  1. Individual's needs exceed the routine care which may be given by an untrained person
  2. Requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution
- The individual must require medical or nursing services that satisfy all of the following conditions:
  1. Ordered by a physician
  2. Dependent upon the individual's documented medical conditions
  3. Require the skills of a registered or licensed vocational nurse
  4. Provided either directly by or under the supervision of a licensed nurse in an institutional setting
  5. Required on a regular basis

CBA

Applicants must meet an NFLOC, defined above under Nursing Facility Care (40 TAC 19.2401, 48.6003).

STAR+PLUS HCBS

Applicants must meet an NFLOC, meaning an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care (Texas MHP, 2019). This is determined through the Medical Necessity and Level of Care assessment (MN/LOC) detailed further in the *Evaluation of Dependence* section of this policy period (chapter).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the five largest programs are summarized below.

PHC, CAS

A Community Care Services Eligibility (CCSE) case worker conducts a face-to-face interview with the individual to conduct the functional assessment of the applicant using the Needs Assessment Questionnaire and Task/Hour Guide. The assessment includes 24 items in Part A, a Functional Assessment of different tasks (Items 1-24) and Part B, a Task/Hour Guide Column that matches a daily number of minutes to conduct a task to an impairment score. To view the full assessment form, see Texas HHS (2023g, H2060). Tasks that applicants are scored on include bathing, dressing, exercising, feeding, grooming, routine hair and skin care, and balance. Impairment scores are assigned according to the following scale:

- 0 = None: No functional impairment. The applicant/member is able to conduct activities without difficulty and has no need for assistance
- 1 = Mild: Minimal/mild functional impairment. The applicant/member is able to conduct activities with minimal difficulty and needs minimal assistance
- 2 = Severe: Extensive/severe functional impairment. The applicant/member has extensive difficulty carrying out activities and needs extensive assistance
- 3 = Total functional impairment: The applicant/member is completely unable to carry out any part of the activity

Additionally, a service arrangement is assigned (C = Caregiver, S = Self, P = Purchased, A = Other Agency, N/A = Not Applicable) and a corresponding support score for personal care is assigned. Each support score is scored according to the following scale:

- 1 = It is very likely that the task would be done even if the attendant does not show up
- 2 = The task will probably be done if the attendant does not show up
- 3 = The task will probably not be done if the attendant does not show up
- 4 = It is very unlikely the task will be done if the attendant does not show up

Nursing Facility Care

Beneficiaries must be assessed for medical necessity and level of care prior to admission. Factors assessed include (CMS, 2012):

- Diagnoses
- Medications and dosage
- Physician's evaluation
- Rehabilitative services
- Activities of daily living (ADLs)

- Sensory/perception status
- Behavioral status
- Restraints/safety devices
- Therapeutic interventions

The level of care is determined by combining an ADL score with assessments of the medical condition, rehabilitation, nursing care, and confusion or behavioral problems. The ADL score is calculated by combining scores for transferring, eating, and toileting. A low ADL score indicates greater independence. Texas Medicaid and Healthcare Partnership (TMHP) systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the assessment will then be sent to a nurse for manual review. There is no particular score that indicates that an individual meets the nursing facility level of care.

Author's note: The assessment information detailed above is from 2012 program information. Authors have not yet identified the level of care assessment instrument and corresponding ADL scores for this policy period (chapter).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

CBA

The assessment instrument described above for nursing facility care is used to determine level of care for CBA.

STAR+PLUS HCBS

Managed care health plan staff conduct an in-person or remote interview and assessment using the Medical Necessity and Level of Care Assessment. See Box 6 for more details on the assessment. The tool considers an applicant's ability to complete ADLs, as well as an assessment of behavioral and cognitive issues.

Evaluators

Evaluators vary by LTC health benefit program. The details of the five largest programs are summarized below.

PHC, CAS

A Texas Health and Human Services Community Care Services Eligibility (CCSE) case worker conducts the functional assessment.

Nursing Facility Care

The recipient's attending physician and the nursing facility conduct the assessment for an individual's medical need for nursing facility care.

CBA

A state-licensed registered nurse conducts the medical necessity and level of care assessment (CMS, 2012).

STAR+PLUS HCBS

Staff from the individual's managed care health plan conduct the medical necessity assessment and determine the individual's service plan (Texas HHS, 2023j, 3312.1).

Benefit limitations

Can you mix LTC benefits?

All Texas Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Texas enforces Estate Recovery. The acceptance of Medicaid in Texas creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. Services Medicaid can recover the assistance paid for include Nursing Facility Care and HCBS (1 TAC Rule 373.105). This was codified March 1, 2005.

PHC, CAS

PHC and CAS program participants generally do not have copayments for eligible services, HHSC reimburses providers at an accepted hourly rate for their services according to 40 TAC 49.302 (codified September 1, 2014). If a participant received services before their eligibility was determined, they are entitled to be reimbursed by providers for any out-of-pocket payments made for eligible services, even if the payments exceed the amount HHSC will reimburse for those services according to 40 TAC 47.85 (codified June 1, 2004).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1997, the PNA was $30 per month (Texas HHS, 2023f, Appendix XXXI H-1500). See Table 3 for historical allowances.

CBA

Beneficiaries must pay a copayment, which is equal to the remaining income after all allowable expenses have been deducted. The copayment amount is applied only to the cost of HCBS which are funded through this HCBS program and specified on the client's individual plan of care. The copayment must not exceed the cost of services actually delivered. The amounts are documented in the Texas Department of Human Services copayment worksheet (40 TAC 48.6009).[12]

Author's note: Authors have not yet located the copayment worksheet, as it is not available on the THHS website.

STAR+PLUS HCBS

A participant may have cost sharing for services covered by their health plan (1 TAC 353.409). Members who are eligible for Medicaid under eligibility track 2a may be required to participate in cost sharing. The amount is determined using the Medicaid for the Elderly and People with Disabilities (MEPD) copayment worksheet for the STAR+PLUS program (Texas HHS, 2023j, 3236).

Author's note: Authors have not yet located the copayment worksheet, as it is not available on the THHS website.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2015-2023

Policy change in 2015
In 2015, Texas expanded STAR+PLUS managed care statewide, leading to the coverage of almost all older adults and disabled individuals under managed care. Coinciding with this expansion, Texas implemented mandatory STAR+PLUS enrollment for certain populations (1 TAC 353.603, 2015; Texas HHS, 2023f). The following groups were required to enroll:

- Individuals at least age 21 that are residing in nursing facilities
- Individuals at least age 21 that are residing in a community based ICF-IID
- Individuals receiving services from a home and community based services (HCBS) program
- Individuals eligible for Medicaid through eligibility track 2a (Institutional rules)

Overview

Long-term care (LTC) benefits in Texas are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Texas is administered at the state level by the Texas Health and Human Services Commission (HHSC), and health plans are organized and administered at the service area level, which are geographic locations within the state where services are delivered by health plans and contracted providers. Enrollment in Medicaid is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Texas are mostly provided through state plan benefit programs (Nursing Facility Care, Community Attendant Services - CAS), or through federally approved home-and community-based services (HCBS) LTC programs (STAR+PLUS HCBS).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. CAS provides home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by STAR+PLUS HCBS are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care (ADHC).

Benefit programs vary in dependence requirements. CAS requires the individual to have a medical necessity for services and need some assistance with activities of daily living, while Nursing Facility and STAR+PLUS HCBS beneficiaries must meet a nursing facility level of care (NFLOC) based on a medical necessity determination before admission.

It is important to note that while the personal care state plan health benefit program (Primary Home Care - PHC) still existed, the statewide transition to managed care dramatically reduced enrollment in the traditional, fee-for-service state plan programs, and most of the population began receiving these services through capitated managed care plans (e.g., STAR+PLUS HCBS). For this reason, this program will not be detailed in this policy period (chapter). For information on PHC eligibility criteria, please see previous policy periods (chapters).

Statutory basis

Federal Law for Medicaid

- 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023d)
- 42 Code of Federal Regulations (CFR), Public Health (Title 42 CFR, 2023)

Texas Law for Medicaid

- Texas Government Code, Title 4, Subtitle I (Texas Government Code)
  - Texas Human Resources Code Chapter 32
- Texas Administrative Code
  - Title 1, Part 15, Texas Health and Human Services Commission (1 TAC P.15)
    - STAR+PLUS HCBS —(1 TAC 353.1153)
  - Title 26, Part 1 Health and Human Services Commission (26 TAC P.1)
  - Title 40, Part 1, Department of Aging and Disability Services (40 TAC P.1)
    - Primary Home Care (PHC) —(Social Security Act 1905(a)(23); 40 TAC Chapter 47)
    - Nursing Facility Care —(Social Security Act 1905(a)(4)(A); Social Security Act 1919(a); 40 TAC 19)
    - Community-Based Alternatives (CBA) —(Social Security Act 1915(c); 40 TAC 40.1; 40 TAC 46; 40 TAC 62; 40 TAC 48, Subchapter J)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Texas Medicaid spending on beneficiaries in fiscal year 2015 was 58.05%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (58.05% in 2015), though there are exceptions for certain administrative functions that may receive a higher matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Texas Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Texas.

Eligibility for Medicaid in Texas for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[7] In 2015, the monthly federal benefit amount was $733 for an individual and $1,100 for a couple (SSA, 2023c). Eligibility for this track is generally determined as a household of one. Couple limits only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (Texas HHS, 2023f, I-2100).[1]
    - Home equity limit: The equity interest in the individual's home may not exceed $552,000, or else they will be ineligible for LTC services (Texas HHS, 2023f).[8] This figure increases annually with inflation. See Table 5 for historical home equity limits.
  - Citizenship/immigration requirements: The applicant must be a Texas resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2023) for additional information.
  - Other requirements

        * The individual must be at least age 65, blind, or disabled (42 USC 1382c(a)(1-3)).[3]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules
  - Income requirements: Monthly income may not exceed 300% of the federal SSI amount. In 2015, this was $2,199 for an individual and $3,300 for a household of two. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[13]
  - Asset requirements: Resources may not exceed $2,000 for an individual. Eligibility for this track is generally determined as a household of one. Couples are limited to $3,000 in assets, but they only apply in the relatively rare occurrence that both spouses are applying for institutional benefits (CMS, 2021). Additional asset disregards exist if a person is institutionalized or receiving HCBS and has a spouse residing in the community.[14]
    * Asset transfer & Home equity limit: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    * The applicant must be a resident of a Texas LTC facility (e.g., Nursing Facility Care), or enrolled in or applying for an HCBS program.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

STAR+PLUS HCBS

STAR+PLUS HCBS participants must meet the following criteria beyond minimum level of dependence requirements:

- At least age 65, or at least age 21 and disabled
- Live in the Harris service area (1998), or Bexar, Travis, Nueces, Dallas, and Tarrant (expanded to these areas from 2007-2011) —this requirement was removed as of 2015, when the program expanded statewide

Community Attendant Services

Beyond meeting minimum level of dependence requirements, applicants' income may not exceed 300% of the federal SSI monthly benefit amount.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include (Texas DAD, 2010; Texas HHS, 2023e):

- Community Living Assistance and Support Services for the Frail Elderly (CLASS)
- Day Activity and Health Services (DAHS)
- Program of All-Inclusive Care for the Elderly (PACE)
- Community First Choice (CFC)
- Primary Home Care (PHC)

Benefit

Home care benefit

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

STAR+PLUS HCBS

STAR+PLUS HCBS provides the following services in addition to those offered under the state plan, unless otherwise noted (Texas HHS, 2022b):

- Personal care services
  - Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Skilled nursing services: Nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse

CAS

CAS provides personal care services, as described above under STAR+PLUS. CAS is limited to a maximum of 50 hours per week of care.

Semi-residential care

Nursing Facility Care, CAS

These programs do not provide semi-residential care during this policy period.

STAR+PLUS HCBS

STAR+PLUS HCBS provides Adult Day Health Care (ADHC). In Texas, ADHC is called Day Activity and Health Services (DAHS). This service includes:

- Personal care services
- Medication administration
- Skilled nursing services
- Social activities

Participants can receive care 5 days per week, up to 10 hours per day, dependent on need.

Residential care

Nursing Facility Care

Texas Medicaid covers residential care in a nursing facility. Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs (Texas DHS, 2000; Texas DAD, 2010; Texas HHS, 2022b). Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

STAR+PLUS HCBS

STAR+PLUS HCBS provides assisted living services, which include (Texas HHS, 2022b):

- Personal care services (as described above under CAS' home care benefit)
- Medication oversight
- Therapeutic, social, and recreational programming

Services are provided in a home-like environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

CAS

CAS does not provide residential care during this policy period.

Other benefits

Texas Medicaid provides additional benefits related to LTC (Texas HHS, 2022b):

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

STAR+PLUS HCBS

STAR+PLUS HCBS provides the following services in addition to those offered under the state plan, unless otherwise noted:

- Durable medical equipment and supplies (as described above under the state plan)
- Home-delivered meals: Delivers healthy meals to the beneficiary's home
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Home improvement or adaptations: Physical adaptations to the home, which are necessary to assure the health, welfare and safety of the participant (minor modifications)
- Transitional assistance services: Pays for non-recurring, set-up expenses for members transitioning from nursing facilities to a home in the community —this service is available on a one-time only basis and is not available to residents moving from a nursing facility who are approved for assisted living or adult foster care services

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by Texas Health and Human Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Nursing Facility Care

Care in a nursing facility is provided by physicians, registered nurses, and nurse aides. Facilities are licensed and overseen by the Texas HHSC (26 TAC 554).

STAR+PLUS HCBS

Program participants receive their benefits through their managed care organization (MCO) plan, which has a network of healthcare providers. Participants have the option to self-direct some of their benefits by choosing caregivers outside the MCO plan network of providers.

CAS

Attendants help individuals with activities of daily living, such as bathing, grooming, meal preparation and housekeeping. Attendants are trained and supervised by non-medical personnel. The attendant cannot be a legal or foster parent of a minor child who receives the service, or the service recipient's spouse. Community Care Services Eligibility (CCSE) staff, a supervisor, or a regional nurse can also limit the beneficiary's choice of attendants. For example, if they determine that the attendant is not providing adequate care (Texas HHS, 2023, Rule 4623).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

The beneficiary must require medical or nursing services on a regular basis that are ordered by a physician and require the skills of a registered or licensed vocational nurse (40 TAC 19.2401, 2008). Individuals qualifying for Medicaid coverage under eligibility track 2a must be continuously certified for nursing facility care by a physician (Texas HHS, 2023f, Rule B-7400).

STAR+PLUS HCBS

The beneficiary must satisfy all of the following conditions (Texas HHS, 2023j, Rule 3240):

- Have a medical necessity determination for the program, meaning the individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care (Texas MHP, 2019)
- Services must be at or below the established cost limit, which is 202% of the cost of care the state would pay if the member was served in a nursing facility

- Have an unmet need for at least one STAR+PLUS service

CAS

The beneficiary must satisfy all of the following conditions (7 TexReg 3504, 1982; 11 TexReg 2828, 1986; 40 TAC 48.2907):

- Receive a score of at least 24 on the Needs Assessment Questionnaire and Task/Hour Guide
- Have a medical need for assistance with ADLs, shown through a signed physician's order
- Require at least 6 hours of services per week[15]
- Have a functional limitation with at least one personal care task based on a medical condition

Duration of benefit

Reassessments of eligibility vary by LTC health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the five largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

Nursing Facility Care

Reassessments are required on an annual basis, but at least 90 days before the end of the service plan (26 TAC Rule 554.2405). Individuals qualifying for Medicaid coverage under eligibility track 2a. Institutional Rules must be continuously certified for nursing facility care by a physician every 30 days, known as the 30-consecutive-day stay requirement) (Texas HHS, 2023f, Rule B-7400).

STAR+PLUS HCBS

There is no standard reassessment timeline. Managed care health plans conduct assessments for continued eligibility in accordance with timeframes outlined in their managed care contracts (1 TAC Rule 353.1153).

CAS

CAS eligibility is redetermined every 12 months (Texas HHS, 2023, Rule 4678.2).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Nursing Facility Care, CAS

There is no age requirement.

STAR+PLUS HCBS

The individual must be at least age 65, or at least age 21 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

Medical necessity is determined using conditions outlined in 26 TAC Rule 554.2401 and 40 TAC 19.2401, detailed below (codified in September 1, 2008).

- The individual must demonstrate a medical condition that satisfies all of the following conditions:
  1. Individual's needs exceed the routine care which may be given by an untrained person
  2. Requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution
- The individual must require medical or nursing services that satisfy all of the following conditions:
  1. Ordered by a physician
  2. Dependent upon the individual's documented medical conditions
  3. Require the skills of a registered or licensed vocational nurse
  4. Provided either directly by or under the supervision of a licensed nurse in an institutional setting

5. Required on a regular basis

STAR+PLUS HCBS

Applicants must meet a nursing facility level of care (NFLOC), meaning an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician's planned regimen for total care (Texas MHP, 2019). This is determined through the Medical Necessity and Level of Care assessment (MN/LOC) detailed further in the *Evaluation of Dependence* section of this policy period (chapter).

CAS

The Texas Health and Human Services (Texas HHS) department uses a standardized assessment instrument, the Needs Assessment Questionnaire and Task/Hour Guide, to measure the client's ability to perform activities of daily living. This yields a score, which is a measure of the client's level of functional need. The Needs Assessment Questionnaire and Task/Hour Guide includes 24 items in Part A, a Functional Assessment of different tasks (Items 1-24) and Part B, a Task/Hour Guide Column that matches a daily number of minutes to conduct a task to an impairment score. The total impairment score is used to determine eligibility for personal care services (minimum score of 24). The hours and minutes required for each authorized task is then totaled to get the total weekly hours that are authorized, which cannot exceed 50 hours for all CAS members (Texas HHS, 2023g, H2060).

Evaluation of dependence

Evaluations of dependence vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

Beneficiaries must be assessed for medical necessity and level of care prior to admission. Factors assessed include (CMS, 2012):

- Diagnoses
- Medications and dosage
- Physician's evaluation
- Rehabilitative services
- Activities of daily living (ADLs)
- Sensory/perception status
- Behavioral status
- Restraints/safety devices
- Therapeutic interventions

The level of care is determined by combining an ADL score with assessments of the medical condition, rehabilitation, nursing care, and confusion or behavioral problems. The ADL score is calculated by combining scores for transferring, eating, and toileting. A low ADL score indicates greater independence. Texas Medicaid and Healthcare Partnership (TMHP) systems automatically review specific criteria on the assessments. If the criteria are appropriately met, the assessment is automatically approved. If not, the assessment will then be sent to a nurse for manual review. There is no particular score that indicates that an individual meets the nursing facility level of care.

Author's note: Authors have not yet identified the level of care assessment instrument and corresponding ADL scores for this policy period (chapter).

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 1 for more information on the PASRR, and Box 2 for the MDS.

STAR+PLUS HCBS

Managed care health plan staff conduct an in-person or remote interview and assessment using the Medical Necessity and Level of Care Assessment. See Box 6 for more details on the assessment. The tool considers an applicant's ability to complete ADLs, as well as an assessment of behavioral and cognitive issues.

CAS

A Community Care Services Eligibility (CCSE) case worker conducts a face-to-face interview with the individual to conduct the functional assessment of the applicant using the Needs Assessment Questionnaire and Task/Hour Guide. The assessment includes 24 items in Part A, a Functional Assessment of different tasks (Items 1-24) and Part B, a Task/Hour Guide Column that matches a daily number of minutes to conduct a task to an impairment score. To view the full assessment form, see Texas HHS (2023g, H2060). Tasks that applicants are scored on include bathing, dressing, exercising, feeding, grooming, routine hair and skin care, and balance. Impairment scores are assigned according to the following scale:

- 0 = None: No functional impairment. The applicant/member is able to conduct activities without difficulty and has no need for assistance
- 1 = Mild: Minimal/mild functional impairment. The applicant/member is able to conduct activities with minimal difficulty and needs minimal assistance
- 2 = Severe: Extensive/severe functional impairment. The applicant/member has extensive difficulty carrying out activities and needs extensive assistance
- 3 = Total functional impairment: The applicant/member is completely unable to carry out any part of the activity

Additionally, a service arrangement is assigned (C = Caregiver, S = Self, P = Purchased, A = Other Agency, N/A = Not Applicable) and a corresponding support score for personal care is assigned. Each support score is scored according to the following scale:

- 1 = It is very likely that the task would be done even if the attendant does not show up
- 2 = The task will probably be done if the attendant does not show up
- 3 = The task will probably not be done if the attendant does not show up
- 4 = It is very unlikely the task will be done if the attendant does not show up

Evaluators

Evaluators vary by LTC health benefit program. The details of the three largest programs are summarized below.

Nursing Facility Care

The recipient's attending physician and the nursing facility conduct the assessment for an individual's medical need for nursing facility care.

STAR+PLUS HCBS

Staff from the individual's managed care health plan conduct the medical necessity assessment and determine the individual's service plan (Texas HHS, 2023j, 3312.1).

CAS

A Texas Health and Human Services Community Care Services Eligibility (CCSE) case worker conducts the functional assessment.

Benefit limitations

Can you mix LTC benefits?

All Texas Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Individuals enrolled in managed care may receive state plan and additional benefits through capitated managed care plans. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Texas enforces Estate Recovery. The acceptance of Medicaid in Texas creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. Services Medicaid can recover the assistance paid for include Nursing Facility Care and HCBS (1 TAC Rule 373.105). This was codified March 1, 2005.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2015, the PNA was $50 per month (Texas HHS, 2023f, Appendix XXXI H-1500). See Table 3 for historical allowances.

STAR+PLUS HCBS

A participant may have cost sharing for services covered by their health plan (1 TAC 353.409). Members who are eligible for Medicaid under eligibility track 2a may be required to participate in cost sharing. The amount is determined using the Medicaid for the Elderly and People with Disabilities (MEPD) copayment worksheet for the STAR+PLUS program (Texas HHS, 2023j, 3236).

Author's note: Authors have not yet located the copayment worksheet, as it is not available on the THHS website.

CAS

CAS program participants generally do not have copayments for eligible services, HHSC reimburses providers at an accepted hourly rate for their services (40 TAC 49.302). If a participant received services before their eligibility was determined, they are entitled to be reimbursed by providers for any out-of-pocket payments made by the participant to the provider for eligible services, even if the payments exceed the amount HHSC will reimburse for those services (40 TAC 47.85).

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Texas Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	64.18%
1993	64.44
1994	64.18
1995	63.31
1996	62.30
1997	62.56
1998	62.28
1999	62.45
2000	61.36
2001	60.57
2002	60.17
2003	61.56
2004	62.43
2005	60.87
2006	60.66
2007	60.78
2008	60.53
2009	69.03
2010	70.94
2011	66.00
2012	58.22
2013	59.30
2014	58.69
2015	58.05
2016	57.13
2017	56.18
2018	56.88
2019	58.19
2020	65.54
2021	68.01
2022	67.00
2023[1]	64.85

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201). [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: Historical Texas Medicaid Income and Asset Limits

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	MMMNA (Monthly)	CSRA
1992	$422	$633	$1,266	$1899	$1,718	$68,700
1993	434	652	1,302	1,956	1,769	70,740
1994	446	669	1,338	2,007	1,817	72,660
1995	458	687	1,374	2,061	1,871	74,820
1996	470	705	1,410	2,115	1,919	76,740
1997	484	726	1,452	2,178	1,976	79,020
1998	494	741	1,482	2,223	2,019	80,760
1999	500	751	1,500	2,253	2,049	81,960
2000	513	769	1,539	2,307	2,103	84,120
2001	531	796	1,593	2,388	2,175	87,000
2002	545	817	1,635	2,451	2,232	89,280
2003	552	829	1,656	2,487	2,267	90,660
2004	564	846	1,692	2,538	2,319	92,760
2005	579	869	1,737	2,607	2,378	95,100
2006	603	904	1,809	2,712	2,489	99,540
2007	623	934	1,869	2,802	2,541	101,640
2008	637	956	1,911	2,868	2,610	104,400
2009	674	1,011	2,022	3,033	2,739	109,560
2010	674	1,011	2,022	3,033	2,739	109,560
2011	674	1,011	2,022	3,033	2,739	109,560
2012	698	1,048	2,094	3,144	2,841	113,640
2013	710	1,066	2,130	3,198	2,898	115,920
2014	721	1,082	2,163	3,246	2,931	117,240
2015	733	1,100	2,199	3,300	2,981	119,220
2016	733	1,100	2,199	3,300	2,981	119,220
2017	735	1,103	2,205	3,309	3,023	120,900
2018	750	1,125	2,250	3,375	3,090	123,600
2019	771	1,157	2,313	3,471	3,161	126,420
2020	783	1,175	2,349	3,525	3,216	128,640
2021	794	1,191	2,382	3,573	3,260	130,380
2022	841	1,261	2,523	3,783	3,435	137,400
2023	914	1,371	2,742	4,113	3,715	148,620

Source: SSA (2023c); Texas HHS, Rule J-7400 (2023f)

Notes: Supplemental Security Income (SSI) amounts and related percentages, Maximum Monthly Maintenance Needs Allowances (MMMNAs), and Community Spouse Resource Allowances (CSRAs) for individuals and couples are monthly.

Box 1: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Table 3: Historical Texas Medicaid Personal Needs Allowance

Dates	Dependent Allowance
Before September 1, 1999	$30
September 1, 1999 to August 31, 2001	45
September 1, 2001 to August 31, 2003	60
September 1, 2003 to December 31, 2005	45
January 1, 2006 and onwards	60

Source: Texas HHS, 2023f, Appendix XXXI

Box 3: Primary Home Care (PHC) Dependence Exceptions

An applicant may require less than 6 hours per week if they fall within one of 3 groups:

1. Applicants who score 30 or above on the client needs assessment and PHC is essential to provide respite care to the caregiver or to enable the applicant/participant to remain in the community
2. Applicants who live in the same household as another individual receiving family care from PHC
3. Applicants who also receive congregate or home-delivered meals, adult day health care services, or special services to persons with disabilities in adult day care

Source: 11 Texas Register 2828 (1986)

Box 4: Primary Home Care (PHC) Dependence Exceptions

An applicant may require less than 6 hours per week if they fall within one of 6 groups:

1. Applicants who score 30 or above on the client needs assessment and PHC is essential to provide respite care to the caregiver or to enable the applicant/participant to remain in the community
2. Applicants who live in the same household as another individual receiving family care of PHC
3. Applicants who also receive congregate or home-delivered meals, day activity and health services, special services to persons with disabilities in adult day care
4. Applicants who receive aid-and-attendance benefits from the Veterans Administration
5. Applicants who receive services through the department's In-home and Family Support Program
6. Applicants who receive services through the Medically Dependent Children Program (MDCP)

Source: 40 TAC 48.2918 (2023).

Box 5: Primary Home Care (PHC) and Community Attendant Services (CAS) Dependence Exceptions

An applicant may require less than 6 hours per week if they fall within one of 7 groups:

1. Applicants who score 30 or above on the client needs assessment and PHC is essential to provide respite care to the caregiver or to enable the applicant/participant to remain in the community
2. Applicants who live in the same household as another individual receiving family care of PHC
3. Applicants who also receive congregate or home-delivered meals, day activity and health services, or special services to disabled adults day care
4. Applicants who receive aid-and-attendance benefits from the Veterans Administration
5. Applicants who receive services through the department's In-home and Family Support Program
6. Applicants who receive services through the Medically Dependent Children Program (MDCP)
7. Applicants who are determined, based upon the functional assessment, to be at high risk of institutionalization without PHC or CAS

Source: 40 TAC 48.2918 (2023).

Table 4: Historical Texas Medicaid Spousal Impoverishment Dependent Allowances

Dates	Dependent Allowance
July 1, 2011 to June 30, 2012	$1,839
July 1, 2012 to June 30, 2013	1,892
July 1, 2013 to June 30, 2014	1,939
July 1, 2014 to June 30, 2015	1,967
July 1, 2015 to June 30, 2016	1,992
July 1, 2016 to June 30, 2017	2,003
July 1, 2017 to June 30, 2018	2,030
July 1, 2018 to June 30, 2019	2,058
July 1, 2019 to June 30, 2020	2,114
July 1, 2020 to June 30, 2021	2,155
July 1, 2021 to June 30, 2022	2,178
July 1, 2022 to present	2,289

Source: Texas HHS, 2023f, Rule J-7400

Table 5: Historical Texas Medicaid Home Equity Limit

Dates	Home Equity Limit
Jan. 1, 2006 to Dec. 31, 2010	$500,000
Jan. 1, 2011 to Dec. 31, 2011	506,000
Jan. 1, 2012 to Dec. 31, 2012	525,000
Jan. 1, 2013 to Dec. 31, 2013	536,000
Jan. 1, 2014 to Dec. 31, 2014	543,000
Jan. 1, 2015 to Dec. 31, 2015	552,000
Jan. 1, 2016 to Dec. 31, 2016	552,000
Jan. 1, 2017 to Dec. 31, 2017	560,000
Jan. 1, 2018 to Dec. 31, 2018	572,000
Jan. 1, 2019 to Dec. 31, 2019	585,000
Jan. 1, 2020 to Dec. 31, 2020	595,000
Jan. 1, 2021 to Dec. 31, 2021	603,000
Jan. 1, 2022 to Dec. 31, 2022	636,000
Jan. 1, 2023 to Present	688,000

Source: Texas HHS, 2023f, Appendix XXXI

Box 6: Texas HHS - Medical Necessity and Level of Care Assessment for STAR+PLUS HCBS

The MN/LOC Assessment includes 18 sections and is used to determine medically necessity for individuals and categorize the care needs of an individual. The assessment includes the following sections

- Section A: Identification Information
- Section B: Hearing, Speech, and Vision
- Section C: Cognitive Patterns
- Section D: Mood
- Section E: Behavior
- Section G: Functional Status
- Section H: Bladder and Bowel
- Section I: Active Diagnosis
- Section J: Health Conditions
- Section K: Swallowing/Nutritional Status
- Section L: Oral/Dental Status
- Section M: Skin Conditions
- Section N: Medications
- Section O: Special Treatments and Procedures
- Section P: Restraints
- Section Q: Participation in Assessment and Goal Setting
- Section Z: Assessment Administration
- LTC Medicaid Information: Texas Specific Items

The look back period for all items in the assessment is 7 days unless otherwise noted. Within each of the 18 sections there are some standardized assessments such as the Brief Interview for Mental Status (BIMS), Individual Mood Interview (PHQ-9), Caregiver Assessment of Individual Mood (PHQ-9-OV), as well as an inventory of behavioral symptoms, activities of daily living (ADL) assistance, and health statuses/conditions (Section I-P). The full MN/LOC Assessment and guide may be found at: https://www.tmhp.com/programs/ltc/forms.

Source: Texas MHP (2019)

Sources

This section records key sources consulted when we collected the institutional details reported in this document. Archived versions of these sources are available at the Gateway Policy Explorer website (http://g2aging.org/app/policy-explorer).

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of daily living (ADL): A common set of activities related to personal care used to assessed independence. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Adult Day Health Care (ADHC): Adult Day Health Care, known as Day Activity and Health Services (DAHS) in Texas, is an optional state plan, community-based, long-term care benefit program. ADHC is offered during the day, Monday through Friday, to clients residing in the community. Services provided at licensed day activity and health services centers include nursing and personal care, meals, transportation, and social and recreational activities. This program is not detailed as a separate program in the policy document because according to Texas HHS caseloads, the program served on average less than 20,000 monthly average clients between 2011 and 2022. However, it is listed as a covered benefit under STAR+PLUS.

Assisted Living: Services provided in a home-like environment in a licensed community facility in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

Balanced Budget Act (BBA): Federal legislation that allowed states to implement mandatory managed care enrollment without a federally approved waiver.

Blind: The Social Security Administration defines blindness as having central visual acuity for distance of 20/200 or less in your better eye with use of a correcting lens, or having visual field limitation in your better eye, such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

Capitation: A payment arrangement for health care services where an entity (e.g., a managed care organization - MCO) receives a risk adjusted amount of money for each Medicaid beneficiary enrolled in the plan. States typically pay MCOs for managed care services through fixed, periodic payments (capitation payments) for a defined package of benefits.

Community Attendant Service (CAS): A Texas Medicaid state plan program authorized under Title XIX, Section 1929(b) of the Social Security Act that provides personal attendant services to an eligible individual (Texas Administrative Code Rule 47.3)

Community Based Alternatives (CBA): A Texas Medicaid 1915(c) Home and Community-Based Services (HCBS) program that provides services and supports for older people and those who have disabilities as an alternative to living in a nursing facility. Services include adaptive aids, medical supplies, dental, adult foster care, assisted living/residential care, emergency response, nursing, minor home modifications, occupational therapy, personal assistance services, home delivered meals, physical therapy, respite care, speech pathology, and transition assistance services. This program ended in 2014.

Community First Choice (CFC): CFC is a federal option that allows states to provide home and community-based attendant services and supports to Medicaid recipients with disabilities. However, Texas did not adopt the federal option. Instead, the State received approval from the federal government to operate a CFC program with different eligibility criteria. In Texas, CFC services are only available to individuals with an institutional level of care that are already enrolled in a home and community-based services (HCBS) program (e.g., CLASS).

Community Living Assistance and Support Services (CLASS): A Texas Medicaid 1915(c) Home and Community-Based Services (HCBS) program that provides home and community-based services to people with related conditions as an alternative to placement in an intermediate care facility for individuals with an intellectual disability or a related condition. A related condition is a disability, other than an intellectual disability, that originated before age 22 and that affects a person's ability to function in daily life. This program is not detailed in the home care benefit section because according to Texas HHS caseloads, the program served on average less than 20,000 monthly average clients between 2011 and 2022.

Community Spouse Resource Allowance (CSRA): Upper limit on disregarded assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

DADS Needs Assessment Questionnaire and Task/Hour Guide: Texas Medicaid form used to evaluate an individual's need for PHC or CAS benefits based on their impairment and service arrangements for completing necessary daily tasks such as grooming, hygiene, eating, and cleaning. A minimum score of 24 is required for benefit eligibility. The questionnaire also includes guidelines for purchasing assistance with these daily tasks through long-term care benefits.

Deaf Blind with Multiple Disabilities (DBMD): A Texas Medicaid 1915(c) Home and Community-Based Services (HCBS) program that provides community-based services to people who are deaf and blind and also have a third disability (e.g., an intellectual disability), as an alternative to institutional care in an intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID). This program is not detailed in the home care benefit section because according to Texas HHS caseloads, the program served on average less than 20,000 monthly average clients between 2011 and 2022.

Department of Aging and Disability Services (DADS): Texas agency that administers and regulates provisions for long-term care services for individuals who are aging and for individuals with physical, intellectual, or developmental disabilities.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track: Requirements for an individual to start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level: Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs (e.g., Medicaid). The Federal Poverty Levels (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the

FPL, meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility).

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed. This was the dominant form of long-term care service delivery until Texas' transition to managed care under STAR+PLUS.

Home and Community-Based Services (HCBS) programs: Home and Community Based Services (HCBS) programs approved by the federal government allow states to provide HCBS as an alternative for people who meet eligibility criteria for care in an institution. Under these programs, a state can waive certain Medicaid program requirements, such as targeting only specific groups or providing benefits outside of the standard state plan package. In Texas, these have included Community Based Alternatives (CBA), Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Home and Community-based Services (HCS), STAR+PLUS HCBS, and Texas Home Living (TxHmL).

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid mandatory health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary. This benefit is not detailed as a separate program, as it is not a commonly used benefit for long-term care.

Instrumental activities of daily living (IADL): A common set of activities used to evaluate a person's ability to live independently in their community. They include being able to prepare hot meals, shop of groceries, take medication, manage money, use a phone, or use a map.

Intermediate Care Facility for Individuals with an Intellectual Disability or related condition (ICFIID): Intermediate care facilities for individuals with an intellectual disability or related condition (ICFs/IID) provide ongoing evaluation and individual program planning—as well as 24-hour supervision, coordination, and integration of health or rehabilitative services—to help individuals with an intellectual disability or related condition function. This program is not detailed in the residential care benefit section because according to Texas HHS caseloads, the program served on average less than 20,000 monthly average clients between 2011 and 2022.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. Beneficiaries receiving long-term care through Medicaid managed care in TX are enrolled in STAR+PLUS HCBS.

Mandatory Categorically Needy: Groups that states are required to cover through Medicaid, which include low-income families, pregnant women, low-income children, and individuals receiving Supplemental Security Income (SSI).

Maximum Monthly Maintenance Need Allowance (MMMNA): Upper limit on disregarded income for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management

in nursing homes.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community and needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs, such as the Community Based Alternatives (CBA) program.

Optional Categorically Needy: Groups that states may choose to cover through Medicaid, which may include aged and disabled individuals not receiving SSI and some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Primary Home Care (PHC): An optional Texas Medicaid State Plan program that provides services to assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), such as eating, bathing, and cooking.

Program of All-Inclusive Care for the Elderly (PACE): PACE provides comprehensive medical and social services to some older adults still living in the community. Most of the participants who are in PACE are dually eligible for both Medicare and Medicaid. However, enrollment in PACE programs is typically capped at a relatively low number of participants.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Skilled Nursing Services: Services that must be provided by a registered nurse or licensed practical nurse under the supervision of an RN. Examples include administration of intravenous medication, colostomy and ileostomy care, and complex wound care.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

STAR+PLUS HCBS: STAR+PLUS is a Texas Medicaid managed care program that includes Home and Community-based Services (HCBS), known as STAR+PLUS HCBS. STAR+PLUS HCBS is an HCBS program delivered through managed care that provides an alternative to living in a nursing facility for individuals who are elderly or who have disabilities. STAR+PLUS allows individuals to receive acute and long-term care services through their managed care plan.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In Texas, optional state supplements are provided to all SSI recipients residing in nursing or intermediate care facilities for individuals with intellectual disabilities and whose countable income is less than a specified amount.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible

low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means. SSI provides monthly payments made by the Social Security Administration (SSA).

Temporary Assistance for Needy Families (TANF): A federal program providing monthly cash assistance to low-income families.

Texas Health and Human Services (Texas HHS): Health and Human Services System in Texas, which includes the Texas Health and Human Services Commission (HHSC) and the Texas Department of State Health Services.

Texas Health and Human Services Commission (Texas HHSC): An agency within the Texas Health and Human Services (Texas HHS). Also referred to in the past as the Department of Aging and Disability Services (DADS) and the Texas Department of Human Services (DHS).

Texas Home and Community-Based Services Program (HCS): A Texas Medicaid 1915(c) Home and Community-Based Services (HCBS) program that provides individualized skills and socialization, respite, supported employment, adaptive aids, audiology, occupational therapy, physical therapy, prescribed drugs, speech and language pathology, financial management services, support consultation, behavioral support, cognitive rehabilitation therapy, dental treatment, dietary services, employment assistance, minor home modifications, nursing, residential assistance (host home/companion care/supervised living/residential support services), social work, supported home living, and transition assistance services to individuals with intellectual disabilities or developmental disabilities ages 0 or older who meet an ICF/IID level of care.

Texas Home Living (TxHML): A Texas Medicaid 1915(c) Home and Community-Based Services (HCBS) program that provides selected essential services and supports to people with intellectual and developmental disabilities who live in their family homes or their own homes. This program is not detailed in the home care benefit section because according to Texas HHS caseloads, the program served on average less than 10,000 monthly average clients between 2011 and 2022.

Texas Medicaid and Healthcare Partnership (TMHP): A group of contractors that administer Texas Medicaid and other state health care programs on behalf of the Texas Health and Human Services Commission. They also processes claims for Medicaid services provided in the traditional, fee-for-service system. TMHP does not process claims for services provided by Medicaid managed care organizations (MCOs)

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
2. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees) (SSA, 1998).
3. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023) for more information on these requirements.
4. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the maximum MMNA as the community spouse's income. In 1992, the MMNA in Texas was $1,718 per month. See Table 2 for historical MMMNA amounts.

5. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992. Countable assets/property are real and personal property that are counted to determine eligibility.
6. An applicant may require less than 6 hours per week if they fall within one of 3 groups detailed in Box 3.
7. From 1999, some SSI recipients may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. See THHS (2023) for more information.
8. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the maximum MMNA as the community spouse's income. In 1997, the MMNA in Texas was $1,976 per month. See Table 2 for historical MMMNA amounts. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving Medicaid HCBS. Authors were not able to verify whether Texas extended these rules to HCBS recipients prior to 2014.
10. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $79,020 in 1997. Countable assets/property are real and personal property that are counted to determine eligibility. From 2014, the ACA required states to extend spousal impoverishment rules to spouses of individuals receiving Medicaid HCBS. Authors were not able to verify whether Texas extended these rules to HCBS recipients prior to 2014.
11. An applicant may require less than 6 hours per week if they fall within one of 6 groups detailed in Box 4.
12. In calculating a participant's countable income for copayment, there are specific expenses participants may deduct from their countable income. These include guardianship fees, dependent allowance, incurred medical expenses, deduction for home maintenance (e.g., rent, mortgage, utilities, repairs), the MMMNA spousal allowance ($1,976 in 1997), the spousal impoverishment dependent allowance ($1,839 from Jul 1, 2011 to Jun 30, 2012; see Table 4 for historical allowances), spousal guardianship fees, and spousal incurred medical expenses (Texas HHS, 2023f, Rules H-1550, H-1600, H-1700, H2000, J-7400).
13. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or receiving HCBS and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the maximum MMNA as the community spouse's income. In 2015, the MMNA in Texas was $2,981 per month. See Table 2 for historical MMMNA amounts.
14. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which was $119,220 in 2015. Countable assets/property are real and personal property that are counted to determine eligibility.
15. An applicant may require less than 6 hours per week if they fall within one of 7 groups detailed in Box 5.

Version information

Current Version: 1.0 (September 2023)

Version History

- 1.0 (September 2023): First version.