Sec. 242.047. ACCREDITATION REVIEW TO SATISFY INSPECTION OR CERTIFICATION REQUIREMENTS. (a) The department shall accept an annual accreditation review from the Joint Commission on Accreditation of Health Organizations for a nursing home instead of an inspection for renewal of a license under Section 242.033 and in satisfaction of the requirements for certification by the department for participation in the medical assistance program under Chapter 32, Human Resources Code, and the federal Medicare program, but only if:

(5) the department has:
(A) determined whether a waiver or authorization from a federal agency is necessary under federal law, including for federal funding purposes, before the department accepts an annual accreditation review from the joint commission:
(i) instead of an inspection for license renewal purposes;
(ii) as satisfying the requirements for certification by the department for participation in the medical assistance program; or
(iii) as satisfying the requirements for certification by the department for participation in the federal Medicare program; and
(B) obtained any necessary federal waivers or authorizations.

FACILITY CONSTRUCTION RULE §19.302 Waivers
The Texas Department of Human Services (DHS) may grant a waiver for certain provisions of the physical plant and environment which, in DHS’s opinion, would be impractical for the facility to meet. In granting the waiver, DHS will determine that there will be no adverse effect on resident health and safety and the requirement, if not waived, would impose an unreasonable hardship on the facility. DHS may require offsetting or equivalent provisions in granting a waiver.

RULE §19.344 Plans, Approvals, and Construction Procedures
At the option of the applicant, the Texas Department of Human Services (DHS) will review plans for new buildings, additions, conversion of buildings not licensed by DHS, or remodeling of existing licensed facilities. DHS will, within 30 days, inform the applicant in writing of the results of the review. If the plans comply with DHS’s architectural requirements, DHS may not subsequently change the architectural requirement applicable to the project unless the change is required by federal law or the applicant fails to complete the project within two years. DHS may grant a waiver of this two-year period for delays due to unusual circumstances. There is no time limit to complete a project, only a time limit for completing a project using requirements that have been revised after the project was reviewed.

NURSING SERVICES RULE §19.1001 Nursing Services
The facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Nursing services to children must be provided by staff who have been instructed and have demonstrated competence in the care of children. Care and services are to be provided as specified in §19.901 of this title (relating to Quality of Care).

(3) Waiver of requirement to provide licensed nurses on a 24-hour basis. (A) To the extent that a facility is unable to meet the requirements of paragraphs (1)(B) and (2)(A) of this section, the state may waive these requirements with respect to the facility, if:
(i) the facility demonstrates to the satisfaction of the Texas Department of Human Services (DHS) that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;
(ii) DHS determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;
(iii) the state finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility; and
(iv) the waived facility has a full-time registered or licensed vocational nurse on the day shift seven days a week. For purposes of this requirement, the starting time for the day shift must be between 6 a.m. and 9 a.m. The facility must specify in writing the schedule that it follows.
(B) A waiver granted under the conditions listed in this paragraph is subject to annual state review.
(C) In granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.
(D) The state agency granting a waiver of these requirements provides notice of the waiver to the state long term care ombudsman (established under §307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the state for the mentally ill and mentally retarded.
(E) The nursing facility that is granted a waiver by the state notifies residents of the facility (or, when appropriate, the guardians or legal representatives of the residents) and members of their immediate families of the waiver.
(4) Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week in a Medicare skilled nursing facility (SNF).
(A) The secretary of the U.S. Department of Health and Human Services (secretary) may waive the requirement that a Medicare SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (2) of this section, if the secretary finds that:
(i) the facility is located in a rural area and the supply of Medicare SNF services in the area is not sufficient to meet the needs of individuals residing in the area;
(ii) the facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
(iii) the facility either has:

(I) only residents whose physicians have indicated (through physician's orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hour period; or

(II) made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

(B) The secretary provides notice of the waiver to the state long term care ombudsman (established under §307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(C) The SNF that is granted a waiver by the state notifies residents of the facility (or, when appropriate, the guardians or legal representatives of the residents) and members of their immediate families of the waiver.

(D) A waiver of the registered nurse requirement under subparagraph (A) of this paragraph is subject to annual renewal by the secretary.

(5) Request for waiver concerning staffing levels. The facility must request a waiver through the local DHS Long Term Care-Regulatory unit, in writing, at any time the administrator determines that staffing will fall, or has fallen, below that required in paragraphs (1) and (2) of this section for a period of 30 days or more out of any 45 days.

The following information must be included in the request/notification:

beginning date when facility was/is unable to meet staffing requirements;

type waiver requested (24-hour licensed nurse or seven-day-per-week RN);
(iii) projected number of hours per month staffing reduced for 24-hour licensed nurse waiver or seven-dayper-week RN waiver; and

(iv) staffing adjustments made due to inability to meet staffing requirements.

(B) Waivers for licensed-only or certified facilities will be granted by Long Term Care-Regulatory staff. Waivers for a Medicare SNF receive final approval from the Health Care Financing Administration.

(C) If a facility, after requesting a waiver, is later able to meet the staffing requirements of paragraphs (1) and

(2) of this section, Long Term Care-Regulatory staff must be notified, in writing, of the effective date that staffing meets requirements.

(D) Verification that the facility appropriately made a request and notification will be done at the time of survey.

(E) Amounts paid to Medicaid-certified facilities in the per diem payment to meet the staffing requirements of paragraphs (1) and (2) of this section may be adjusted if staffing requirements are not met.

(6) Duration of waiver. Approved waivers are valid throughout the facility licensure or certification period, unless approval is withdrawn. During the relicensure or recertification survey, the determination is made for approval or denial for the next facility licensure or certification period if a waiver continues to be necessary. The facility requests a redetermination for a waiver from the Long Term Care-Regulatory staff at the time the survey is scheduled. At other times if a request is made, the Long Term Care-Regulatory staff may schedule a visit for waiver determination.

(7) Requirements for waiver approval. To be approved for a waiver, the nursing facility must meet all of the requirements stated in this subchapter and the requirements specified throughout this chapter. In some instances, the survey agency may require additional conditions or arrangements such as:

- an additional licensed vocational nurse on day-shift duty when the registered nurse is absent;
- modification of nursing services operations; and
- modification of the physical environment relating to nursing services.

(8) Denial or withdrawal of a waiver. Denial or withdrawal of a waiver may be made at any time if any of the following conditions exist:

requirements for a waiver are not met on a continuing basis;
the quality of resident care is not acceptable; or
justified complaints are found in areas affecting resident care.

(9) Requirement that SNFs be in a rural area. A SNF (Medicare) must be in a rural area for waiver consideration, as specified in paragraph (4) of this section. A rural area is any area outside the boundaries of a standard metropolitan statistical area. Rural areas are defined and designated by the federal Office of Management and Budget; are determined by population, economic, and social requirements; and are subject to revisions.

NURSING SERVICES RULE §19.1004 Director of Nursing Services
If a nursing facility, as a result of waivered status, employs a licensed vocational nurse to supervise and direct nursing services, the facility must have an agreement with a registered nurse who must provide the vocational nurse at least four hours of consultation in the facility per week.

**RULE §19.1701 Physical Environment**

The facility must be designed, constructed, equipped, and maintained to protect the health and ensure the safety of residents, personnel, and the public.

1. Life safety from fire

   (B) After consideration of the findings of the Texas Department of Human Services (DHS) for Medicare/Medicaid certified facilities, the Health Care Financing Administration (HCFA) may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship on the facility, but only if the waiver does not adversely affect the health and safety of residents or personnel.

**RULE §19.2108 Emergency Suspension and Closing Order**

(E) if absolutely necessary, to prevent transport over substantial distances, DHS will grant a waiver to a receiving facility to temporarily exceed its licensed capacity, provided the health and safety of residents is not compromised and the facility can meet the increased demands for direct care personnel and dietary services. A facility may exceed its licensed capacity under these circumstances, monitored by DHS staff, until residents can be transferred to a permanent location;

**RULE §19.2111 Suspension of Admissions**

(a) If the commissioner finds that a nursing facility has committed an act for which a civil penalty may be imposed under §242.065, Health and Safety Code, the commissioner may order the nursing facility to immediately suspend admissions. For the purpose of this remedy, the Texas Department of Human Services defines an admission as the entry into a facility of a new resident or of a resident who has been absent from the facility for 24 or more hours.

1. A waiver to allow a resident to be admitted may be considered by the commissioner or his designee.

   (2) In determining whether to grant a waiver under paragraph (1) of this subsection, factors that the commissioner or his or her designee may consider include, but are not limited to:

   - the reason(s) for which admissions at the facility are suspended;
   - the facility's ability to correct the reasons for which admissions at the facility are suspended;
   - the relation between the reasons for which admissions at the facility are suspended and the health care needs of the resident who seeks to return to the facility;
   - whether the resident who wants to return to the facility has a spouse or relative in the facility; or
   - the effect that barring the resident's return to the facility or other alternative placement will have on the ability of the resident to maintain contact with the resident's
attending physician, family, responsible party, and agent (if any) under a medical power of attorney.

RULE §19.2322 Medicaid Bed Allocation Requirements

(a) Definitions. The words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

(1) Applicant--The entity requesting a bed allocation waiver or exemption.

(2) Assignment of rights--The conveyance of all rights to a specific number of allocated Medicaid beds from a nursing facility or entity to another entity for purposes of constructing a new nursing facility or for any other use as authorized by these rules.

(3) Bed allocation--The process by which the Texas Department of Human Services (DHS) controls the number of nursing facility beds that are eligible to become Medicaid-certified in each nursing facility.

(4) Bed certification--The process by which DHS certifies compliance with state and federal Medicaid requirements for a specified number of Medicaid beds within a nursing facility.

(5) Licensee--The entity, which includes controlling persons, that is:

   (A) an applicant for licensure by DHS under Chapter 242 of the Texas Health and Safety Code and Medicaid certification;

   (B) licensed by DHS under Chapter 242 of the Texas Health and Safety Code; or

   (C) licensed under Chapter 242 of the Texas Health and Safety Code and holds the contract to provide Medicaid services.

(6) Lien holder--The entity that holds a lien against the physical plant.

(7) Multiple-facility owner--An entity that owns, controls, or operates under lease two or more nursing facilities within or across state lines.

(8) Occupancy rate--The number of residents occupying certified Medicaid beds divided by the number of certified Medicaid beds in a nursing facility.

(9) Physical plant--The land and attached structures to which beds are allocated or for which an application for bed allocation has been submitted.

(10) Property owner--The person or entity that owns a physical plant.

(11) Transfer of beds--The conveyance of a specific number of allocated Medicaid beds from a nursing facility or entity to an existing licensed nursing facility. The nursing facility may use the transferred Medicaid beds to increase the number of Medicaid-certified beds currently licensed or to increase the number of Medicaid certified beds when additional licensed beds are added to the nursing facility in the future.
(b) Purpose. The purpose of this section is to control the number of Medicaid beds for which DHS contracts, to improve the quality of resident care by selective and limited allocation of Medicaid beds, and to promote competition.

(c) Bed allocation general requirements. The allocation of Medicaid beds represents an opportunity for the property owner or the lessee of a nursing facility to obtain a Medicaid nursing facility contract for a specific number of Medicaid-certified beds.

(1) Medicaid beds are allocated to a nursing facility and remain at the physical plant to which they originally were allocated, unless beds are assigned or transferred in accordance with these requirements.

(2) When Medicaid beds are allocated to a nursing facility as a result of actions by the licensee, the beds remain allocated to the physical plant, even when the licensee ceases operating the nursing facility, unless the beds are subsequently assigned or transferred in accordance with these requirements.

(3) Notwithstanding any language in subsections (f) and (g) of this section and the fact that applicants for bed allocation waivers and exemptions may be licensees or property owners, beds are allocated to the physical plant and the rights to all allocated Medicaid beds belong to the property owner, subject to any and all valid physical plant liens.

(d) Control of beds. Except as specified in this section, DHS does not accept applications for a Medicaid contract for nursing facility beds from any nursing facility that was not granted:

a valid certificate of need (CON) by the Texas Health Facilities Commission before September 1, 1985;

a waiver by DHS before January 1, 1993; or

(3) other valid order that had the effect of authorizing the operation of the nursing facility at the bed capacity for which participation is sought.

(e) Quality of care. Unless specifically exempted from this requirement, applicants for Medicaid bed allocation waivers or exemptions and any controlling persons must demonstrate a history of providing quality care.

(1) In determining if an applicant or a controlling person has a history of providing quality care, DHS may consider the provisions detailed in §19.214(a) of this title (relating to Criteria for Denying a License or Renewal of a License).

(A) Additionally, DHS will determine an applicant to have demonstrated a history of quality of care if, within the preceding 24 months, an applicant has not received any of the following sanctions:

termination of Medicaid and/or Medicare certification;

termination of Medicaid contract;

(iii) denial, suspension, or revocation of nursing facility license;

cumulative Medicaid and/or Medicare civil monetary penalties totaling more than $5,000 per facility;

civil penalties pursuant to §242.065 of the Texas Health and Safety Code; or
denial of payment for new admissions; and 

(B) DHS finds no clear pattern of substantial or repeated licensing and Medicaid sanctions, including administrative penalties and/or other sanctions.

(2) Nursing facilities that have received any of the sanctions listed under paragraph (1) of this subsection within the previous 24 months are not eligible for an allocation of additional Medicaid beds. In the case of sanctions that are appealed, either administratively or judicially, an application will be suspended until the appeal has been resolved. Sanctions that have been administratively withdrawn or were subsequently reversed upon administrative or judicial appeal will not be considered.

(3) When the applicant for an allocation of additional Medicaid beds is a multiple-facility owner or a multiple-facility owner owns an applicant nursing facility, the multiple-facility owner must demonstrate an overall record of providing quality care in addition to the applicant facility’s meeting the quality-of-care requirements in this subsection.

(4) When a licensee has operated a nursing facility for less than 24 months, the nursing facility must establish at least a 12-month compliance record in which the nursing facility has not received any of the sanctions listed under paragraph (1) of this subsection.

(5) When the applicant has no history of operating nursing facilities, DHS will review the compliance record of health-care facilities operated, managed, or otherwise controlled by controlling parties of the applicant. If the controlling parties or the applicant has never operated, managed, or otherwise controlled any health-care facilities, a compliance review will not be required.

(6) The commissioner, or the commissioner’s designee, may make an exception to any of the requirements in this subsection if it is determined the needs of Medicaid recipients in a local community will be served best by granting a Medicaid bed allocation waiver or exemption. In determining whether to make an exception to the quality-of-care requirements, the commissioner or the commissioner’s designee may consider the following:

(A) the overall compliance record of the waiver or exemption applicant;

(B) the current availability of Medicaid beds in facilities providing a high quality of care in the local community;

the level of support for the waiver or exemption from the local community;

how a waiver or exemption will improve the overall quality of care for nursing facility residents; and

the age and condition of nursing facility physical plants in the local community.

(f) Exemptions. Under the following circumstances, DHS may grant an exemption of the policy stated in subsection (d) of this section. All exemption actions must comply with the requirements in this subsection and with requirements of the Centers for Medicare and Medicaid Services (CMS) regarding bed additions and reductions. When a bed allocation exemption is approved, the licensee must comply with the requirements contained in §19.201 of this title (relating to Criteria for Licensing) at the time of licensure and/or
Medicaid certification of the new beds or nursing facility.

(1) Replacement Medicaid nursing facilities and beds. Currently allocated Medicaid beds may be replaced through the construction of one or more new nursing facilities.

(A) The applicant must either own the physical plant to which the beds are allocated or possess a valid assignment of rights to the Medicaid beds.

(B) Assignment of the Medicaid beds to the replacement nursing facility must be approved by all lien holders of the physical plant to which the beds are allocated.

(C) Replacement nursing facility applicants, including those who obtained the rights to the beds through a valid assignment of rights, must comply with the history of quality-of-care requirements in subsection (e) of this section, unless the applicant for a replacement nursing facility is the current property owner.

(D) Replacement facilities will be granted an increase of up to 25% of the currently allocated Medicaid beds, if the applicant complies with the history of quality-of-care requirements in subsection (e) of this section. The additional allocation of beds may not be transferred or assigned until they are certified at the replacement facility.

(E) The replacement nursing facility must be located in the same county in which the Medicaid beds currently are allocated.

(2) Transfer of Medicaid beds. Allocated Medicaid beds currently certified or certified previously may be transferred to another physical plant.

(A) The applicant must own the physical plant to which the beds are allocated or must present DHS with one of the following:

(i) a valid Medicaid bed transfer agreement that specifies the number of additional Medicaid beds to be allocated to the receiving nursing facility; or

(ii) a valid assignment of rights to currently allocated Medicaid beds that specifies the number of additional Medicaid beds to be allocated to the receiving nursing facility.

(B) If the Medicaid beds currently are allocated to a specific physical plant, the current property owner and all current lien holders must approve the transfer agreement.

(C) The receiving licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.

(D) Both facilities must be located in the same county.

(3) High-occupancy facilities. Medicaid-certified nursing facilities with high occupancy rates may periodically receive bed allocation increases.

(A) The occupancy rate of the Medicaid beds of the applicant nursing facility must be at least 90% for nine of the previous 12 months.

(B) The application for additional Medicaid beds may be no greater than 10% (rounded to the nearest whole number) of the current number of Medicaid-certified nursing facility beds.
(C) The applicant nursing facility must comply with the history of quality-of-care requirements in subsection (e) of this section.

(D) The applicant nursing facility may reapply for additional Medicaid beds no sooner than nine months from the date of the previous allocation increase.

(E) Medicaid beds allocated to a nursing facility under this requirement may only be certified at the applicant facility. The additional allocation of beds may not be transferred or assigned until they are certified at the applicant facility.

(4) Non-certified nursing facilities. Licensed nursing facilities that do not have Medicaid-certified beds may receive an initial allocation of Medicaid beds.

(A) The application for Medicaid beds may be no greater than 10% (rounded to the nearest whole number) of the current licensed nursing facility beds.

(B) The applicant licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.

(C) After the applicant receives an allocation of Medicaid beds, the licensee may reapply in accordance with provisions of paragraph (3) of this subsection.

(D) Facilities that have Medicaid beds allocated under provisions of the Alzheimer’s waiver may apply for general Medicaid beds in accordance with paragraph (3) or (4) of this subsection. The beds allocated under the Alzheimer’s waiver provisions will be excluded from this computation; for example, a 120-bed nursing facility with 60 Alzheimer waiver beds would be eligible for 10% of the 60 remaining beds or six additional Medicaid beds.

(5) Low-capacity facilities. For purposes of efficiency, nursing facilities with a Medicaid bed capacity of less than 60 may receive additional Medicaid beds to increase their capacity up to a total of 60 Medicaid beds.

(A) The nursing facility must be licensed for less than 60 beds and have a current certification of less than 60 Medicaid beds.

(B) The nursing facility must have been Medicaid-certified before June 1, 1998.

(C) The applicant licensee must comply with the history of quality-of-care requirements in subsection (e) of this section.

(D) Facilities that have a Medicaid capacity of less than 60 beds due to the loss of Medicaid beds under provisions in subsection (h) of this section are not eligible for this exemption.

(6) Spend-down Medicaid beds. Licensed nursing facilities may receive temporary spend-down Medicaid beds for residents who have "spent down" to become eligible for Medicaid, but for whom no Medicaid bed is available. Approval of spend-down Medicaid beds allows a nursing facility to exceed temporarily its allocated Medicaid bed capacity.
(A) The applicant nursing facility must have a Medicaid contract. If the nursing facility is not currently Medicaid-certified, the licensee must be approved for Medicaid certification and obtain a Medicaid contract.

(B) All Medicaid or dually certified beds must be occupied by Medicaid or Medicare recipients at the time of application.

(C) The application for a spend-down Medicaid bed must include documentation that the person for whom the spend-down bed is requested:

(i) was not eligible for Medicaid at the time of the resident’s most recent admission to the nursing facility; and

(ii) was a resident of the nursing facility for at least the immediate three months before becoming eligible for Medicaid, excluding hospitalizations.

(D) The nursing facility is eligible to receive Medicaid benefits effective the date the resident meets Medicaid eligibility requirements.

(E) The nursing facility must assign a permanent Medicaid bed to the resident as soon as one becomes available.

(F) Facilities with multiple residents in spend-down beds must assign permanent Medicaid beds to those residents in the same order the residents were admitted to spend-down beds.

(G) The assignment of residents in spend-down beds to permanent Medicaid beds must precede the admission of new residents to permanent beds.

(H) The nursing facility must notify DHS immediately upon the death or permanent discharge of the resident or transfer of the resident to a permanent Medicaid bed. Failure of the nursing facility to notify DHS of these occurrences in a timely manner is basis for denying applications for spend-down Medicaid beds.

(I) The nursing facility is not required to comply with quality-of-care requirements in subsection (e) of this section.

(g) Waivers. The commissioner or the commissioner’s designee may grant a waiver of the policy stated in subsection (d) of this section under certain conditions. Applicants must meet the following conditions to be eligible for the specific waivers in subsection (h) of this section.

The applicant must meet the quality-of-care requirement stated in subsection (e) of this section.

Every waiver application must include identification of all controlling parties of the applicant entity.

(3) At the time of licensure and/or Medicaid certification of the allocated beds, the licensee must comply with the requirements contained in §19.201 of this title.

(4) Approved waivers may be assigned by the applicant to another entity under the following circumstances.

(A) Waivers may be assigned to another entity controlled by the majority owners
of the waiver.

(B) Waivers may be assigned to the entity that owns the facility at the time of certification. Assignment of the waiver under these circumstances will be approved by DHS only if the entity that owns the facility at the time of certification complies with subsection (e) of this section and the waiver applicant is the licensee of the new facility. Control of the allocated beds after initial Medicaid certification is subject to subsection (c) of this section.

(C) Assignment of waivers under circumstances listed in subparagraphs (A) and (B) of this paragraph must be reported to DHS.

(5) Any additional controlling parties of the new entity must be reported to DHS. The validity of the waiver will be contingent on the new controlling parties’ compliance with the quality-of-care requirements in subsection (e) of this section.

(6) Waiver applicants who submit false information will not be eligible for a waiver. Waivers issued based on false information provided by the applicant are void.

(7) Waiver applications will be considered in the order in which they are received.

(h) Specific waivers. Waivers may be granted if it is determined that Medicaid beds are necessary for the following circumstances.

(1) Community needs waiver. A community needs waiver is designed to meet the needs of communities that do not have reasonable access to quality nursing facility care.

(A) The applicant must submit a study, prepared by an independent professional experienced at preparing demographic studies, that documents:

an immediate need for additional Medicaid beds in the community;

Medicaid residents in the community do not have reasonable access to quality nursing facility care; and

(iii) substantial community support for the new nursing facility or beds.

(B) Applicants must disclose if they have served as a trustee of a nursing facility within the previous 24 months.

(2) Criminal justice waiver. The criminal justice waiver is designed to meet the needs of the Texas Department of Criminal Justice (TDCJ). The applicant must document that:

(A) the waiver is needed to meet the identified and determined nursing facility needs of TDCJ; and

(B) the new nursing facility is approved by TDCJ to serve persons under their supervision who have been released on parole, mandatory supervision, or special needs parole under the Code of Criminal Procedure, Article 42.18.

(3) Under-served minority waiver. The under-served minority waiver is designed to meet the needs of minority communities that do not have adequate nursing facility care. For purposes of this waiver, the term minority means black, Hispanic, Asian or Pacific Islander,
American Indian, or Alaskan native. The applicant must submit a study, prepared by an independent professional experienced at preparing demographic studies, that documents:

(A) the new nursing facility or beds will serve a ZIP code that has a minority population greater than 50% according to the most recent U.S. census; and

(B) minority residents in the ZIP code in which the nursing facility or beds will be located do not have reasonable access to quality nursing facility care.

(4) Alzheimer's waiver. The Alzheimer's waiver is designed to meet the needs of communities that do not have reasonable access to Alzheimer's nursing facility services. The applicant must document that:

the nursing facility is affiliated with a medical school operated by the state;

(ii) the nursing facility will participate in ongoing research programs for the care and treatment of persons with Alzheimer's disease;

(iii) the nursing facility will be designed to separate and treat residents with Alzheimer's disease by stage and functional level;

(iv) the nursing facility will obtain and maintain voluntary certification as an Alzheimer's nursing facility in accordance with §§19.2204, 19.2206, 19.2208 of this title (relating to Voluntary Certification of Facilities for Care of Persons with Alzheimer's Disease; General Requirements for a Certified Facility; and Standards for Certified Alzheimer's Facilities); and

(v) only residents with Alzheimer's disease or related dementia will be admitted to the Alzheimer's Medicaid beds.

(B) The applicant must submit a study, prepared by an independent professional experienced at preparing demographic studies, that documents the need for the number of Medicaid Alzheimer's beds requested.

(5) Teaching nursing facility waiver. A teaching nursing facility waiver is designed to meet the statewide needs for providing training and practical experience for health-care professionals. The applicant must submit documentation that the nursing facility:

is affiliated with a state-supported medical school;

is located on land owned or controlled by the state-supported medical school; and

serves as a teaching nursing facility for physicians and related health-care professionals.

(6) Rural county waiver. A rural county waiver is designed to meet the needs of rural areas of the state that do not have reasonable access to quality nursing facility care. For purposes of this waiver, a rural county is one that has a population of 100,000 or less according to the most recent census, and has no more than two Medicaid-certified nursing facilities. DHS will approve no more than 120 additional Medicaid beds per county per year and no more than 500 additional Medicaid beds statewide in a calendar year under this waiver provision. The waivers will be considered on a first-come, first-served basis. Requests received in a year in which the 500-bed limit has been met will be carried over to the next year. The waiver must be requested by the county commissioner's court.
(A) The commissioner’s court must notify DHS of its intent to consider a rural county waiver and obtain verification from DHS that the county complies with the definition of rural county.

(B) The commissioner's court must publish a notice in the Texas Register and in a newspaper of general circulation in the county. The notice must seek:

   (i) comments on whether a new Medicaid nursing facility should be requested; and

   (ii) proposals from persons or entities interested in providing additional Medicaid-certified beds in the county, including persons or entities currently operating Medicaid-certified facilities with high occupancy rates. Persons or entities that submit false information will be eliminated from the process.

(C) The commissioner's court must determine whether to proceed with the waiver request after considering all comments and proposals received in response to the notices provided under subparagraph (B) of this paragraph. In determining whether to proceed with the waiver request, the commissioner’s court must consider:

   the demographic and economic needs of the county;

   the quality of existing Medicaid nursing facilities in the county;

   (iii) the quality of the proposals submitted, including a review of the past history of care provided, if any, by the person or entity submitting the proposal; and

   (iv) the degree of community support for additional Medicaid nursing facility services.

(D) The commissioner’s court must document the comments received, proposals offered and factors considered in subparagraph (C) of this paragraph.

(E) The commissioner’s court, if it decides to proceed with the waiver request, must submit a recommendation that DHS issue a waiver to a person or entity who submitted a proposal for new or additional Medicaid beds. The recommendation must include:

   (i) the name, address, and telephone number of the person or entity recommended for contracting for the Medicaid beds;

   (ii) the location, if the commissioner’s court desires to identify one, of the recommended nursing facility;

   (iii) the number of beds recommended; and

   (iv) the information listed in subparagraph (D) of this paragraph used to make the recommendation.

(7) State veterans homes. State veterans homes, authorized and built under the auspices of the State Veterans Land Board, must meet all requirements for Medicaid participation.

(i) Time Limits and Extensions.
(1) With the exception of transferred Medicaid beds and temporary Medicaid beds, all beds approved under the exemption provisions of subsection (f) of this section must be constructed, licensed, and certified within 24 months of the exemption approval.
(2) Medicaid beds transferred in accordance with subsection (f)(2) of this section must be certified within six months of the exemption approval.

(3) Time limits applicable to temporary Medicaid beds are specified in subsection (f)(6) of this section.

(4) All facilities and beds approved in accordance with waiver provisions of subsection (h) of this section must be constructed, licensed, and certified within 24 months of the waiver approval.

(5) With the exception of transferred Medicaid beds and temporary Medicaid beds, applicants for exemptions and waivers must submit a progress report every 12 months after approval of the exemption or waiver. The exemption or waiver may be declared void if the applicant fails or refuses to provide the progress report as required or if the progress report contains false information.

(6) At the discretion of the commissioner or the commissioner's designee, deadlines specified in this section may be extended. The applicant must submit evidence of good-faith efforts to meet the deadline and/or evidence that delays were beyond the applicant's control.

(7) Applicants who receive an extension of their waiver of exemption must submit a progress report every six months after approval of the extension until the nursing facility beds are certified. The exemption or waiver may be declared void if the applicant fails or refuses to provide the progress report as required or if the progress report contains false information.

(8) Failure to meet the requirements of this section is grounds for loss of the Medicaid bed allocation.

(j) Loss of Medicaid Beds.

(1) Loss of Medicaid beds based on sanctions.

(A) A Medicaid nursing facility operated by the person or entity who also owns the property will lose the allocation of all Medicaid beds assigned to the nursing facility property if the nursing facility's license is denied or revoked.

(B) A Medicaid nursing facility operated by one person or entity and owned by another person or entity will lose the allocation of Medicaid beds if two or more of the following actions occur within a 42-month period:
    - licensure denial;
    - licensure revocation; or
    - (iii) Medicaid termination.

(C) DHS may waive this loss of allocation of Medicaid beds in order to facilitate a change of ownership or other actions that would protect the health and safety of residents or assure reasonable access to quality nursing facility care.

(2) Voluntary decertification of Medicaid beds.
(A) Facilities may request to voluntarily decertify Medicaid beds.

(B) The licensee must submit written approval of the Medicaid bed reduction signed by the property owner and all physical plant lien holders.

(C) Medicaid beds voluntarily decertified will result in reduction of allocated Medicaid beds equal to the number of beds decertified.

(D) Facilities that voluntarily decertify Medicaid beds are eligible to receive an increased allocation of Medicaid beds if the facility qualifies for a bed allocation waiver or exemption.

(3) Nursing facility ceases to operate.

(A) The property owner of a nursing facility that closes or ceases to participate in the Medicaid program must inform DHS in writing of the intended future use of the Medicaid beds within 90 days of closure.

(B) Unless the Medicaid beds will be used for a replacement nursing facility, the allocated beds must be recertified within 12 months of the date the Medicaid contract was terminated.

(C) Time limits in subparagraphs (A) and (B) of this paragraph may be extended in accordance with subsection (i)(6) of this section.

(D) Failure to meet the requirements of this paragraph is grounds for loss of the Medicaid bed allocation.

(k) Informal review procedures.

(1) Applicants may request an informal review of DHS actions regarding bed allocations. The request must be submitted within 30 days of notification of the action.

(2) The request for the informal review and all documentation or evidence that forms the basis for the informal review must be submitted in writing.

(3) The commissioner or the commissioner’s designee will conduct the informal review.

(l) Loss of Medicaid beds based on low occupancy.

(1) DHS may review Medicaid bed occupancy rates annually for the purpose of de-allocation and decertifying unused Medicaid beds. The Medicaid bed occupancy reports for the most recent six-month period that DHS has validated will be used to determine the bed occupancy rate of each nursing facility.

(2) Medicaid beds will be de-allocated and decertified in facilities that have an average occupancy rate below 70%. The number of beds to be decertified is calculated by subtracting the preceding six-month average occupancy rate of Medicaid-certified beds from 70% of the number of allocated certified beds and dividing the difference by 2, rounding the final figure down if necessary. For example, for a facility with 100 Medicaid-certified beds and a 50% occupancy rate, the difference between 70% (70 beds) and 50% (50 beds) is 20 beds, divided by 2, is 10 beds to be decertified.
(3) Medicaid beds in a nursing facility that has obtained a replacement nursing facility exemption are not subject to the de-allocation and decertification process.

(4) Medicaid beds in a new or replacement physical plant or a newly constructed wing of an existing physical plant will be exempt from this de-allocation and decertification process until the new physical plant or new wing has been certified for two years.

(5) Medicaid beds that have been subject to a change of ownership within the past 24 months are exempt from the de-allocation and decertification process.

(6) Medicaid beds allocated to a closed nursing facility are exempt from this de-allocation and decertification process.

(7) Nursing facilities that lose Medicaid beds through this process are eligible to receive an additional allocation of Medicaid beds at a later date if the facility qualifies for a bed allocation waiver or exemption.

(8) The de-allocation and decertification of unused beds does not affect the licensed capacity of the nursing facility.

(m) Medicaid occupancy reports.

(1) Medicaid nursing facilities must submit occupancy reports to DHS each month.

(A) The occupancy data must be reported on a form prescribed by DHS. The form must be completed in accordance with instructions and the occupancy data must be accurate and verifiable. The completed report must be submitted to DHS no later than the fifth day of the month following the reporting period.

(B) The Medicaid occupancy rate will be determined by calculating the monthly average of the number of persons who occupy Medicaid beds.

(C) All persons residing in Medicaid-certified beds, including Medicaid recipients, Medicare recipients, private-pay residents, or residents with other sources of payment, will be included in the calculation.

(D) Failure or refusal to submit accurate occupancy reports in a timely manner may result in the nursing facility's vendor payment being held in abeyance until the report is submitted.

(2) DHS will determine nursing facility and county occupancy rates based on the data submitted by the nursing facilities.

(A) The occupancy data will be used to determine eligibility for and/or compliance with waiver and exemption requirements. The occupancy data also will be used to determine if Medicaid beds should be decertified based on low occupancy.

(B) The occupancy data will be made available to nursing facilities, licensees, property owners, waiver or exemption applicants, and others in accordance with public disclosure requirements.

(C) Inaccurate or falsified occupancy data is grounds to disqualify facilities from eligibility for bed allocation exemptions and waivers. DHS may refuse to accept corrections
to bed occupancy data submitted more than six months after the due date of the occupancy report.

(n) School-age residents. Any bed allocation waiver or exemption applicant that serves or plans to serve school-age residents must provide written notice to the affected local education agency (LEA) of its intent to establish or expand a nursing facility within the LEA's boundary.

**Selection and Contracting Procedures for Adding Medicaid Beds in High-Occupancy Areas**

(a) Definitions. The words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

1) County occupancy rate--The number of residents occupying certified Medicaid beds in a county divided by the number of Medicaid beds allocated in the county. This calculation includes Medicaid beds that currently are certified and Medicaid beds that have been allocated but are not currently certified. In the four most populous counties, the occupancy rate will be calculated for each county-commissioner precinct.

2) Open solicitation period--A time period in which licensees, property owners and other entities may apply for an allocation of Medicaid beds in high-occupancy counties or precincts.

3) Applicants for the secondary waiver process must demonstrate a history of quality care as specified in §19.2322(e) of this title.

4) Applicants must provide the name and address of the applicant entity, the name, address, and telephone number of the contact person, the name and address of all controlling parties of the applicant entity and the number of Medicaid beds requested.

5) At the end of the secondary solicitation period, DHS will determine if any applicant is eligible for additional Medicaid beds. If multiple applicants are eligible, the applicant that will receive the allocation of beds will be chosen by a lottery selection. Applicants who submit false information are not eligible for the allocation of Medicaid beds. Medicaid beds allocated based on false information are not eligible for Medicaid certification and the allocation is revoked.

6) Medicaid beds allocated under this provision may only be transferred to another entity controlled by the same majority owners. Transfers under these circumstances must be reported to DHS.