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TITLE 40

SOCIAL SERVICES AND ASSISTANCE

PART 1

DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 19

NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER X

REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES

RULE §19.2301

Conditions for Participation as a Medicaid-Certified Facility

(a) The facility must meet the following conditions to be approved by the Texas Department of Human Services (DHS) for participation in the Title XIX Texas Medical Assistance program and receive state and federal reimbursement for services to Title XIX residents:

(1) the facility has been certified by DHS as meeting the conditions of participation, including the requirement to have a license from DHS, in the Title XIX Texas Medical Assistance program;

(2) the entity licensed to operate the facility has filed a complete application with the Provider Enrollment Section of DHS for participation as a nursing facility in the Title XIX Texas Medical Assistance program; and

(3) the beds for which the facility wishes to contract meet the requirements of §19.2322 of this title (relating to Medicaid Bed Allocation Requirements).

(b) Only a facility with a fully executed current contract with DHS may receive state and federal reimbursement for services to Title XIX recipients.

Source Note: The provisions of this §19.2301 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective July 1, 2001, 26 TexReg 3824; amended to be effective November 1, 2002, 27 TexReg 9154

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(a) This section applies to nursing facilities (NFs) that have been licensed and certified as eligible for participation under Title XIX.

(b) Each nursing facility (NF) must comply with the state requirements for participation and the facility's contract on a continuing basis.

(c) Each NF must comply with the Texas Health and Human Services Commission's (HHSC's) utilization review requirements as provided in 1 TAC §371.212 (relating to Minimum Data Set Assessments) and §371.214 (relating to Resource Utilization Group Classification System).

(d) A facility may not participate in the Texas Medical Assistance Program if it has restrictive policies or practices, including:

- (1) requiring the resident to make a will, with the facility named as legatee or devisee;
- (2) requiring the resident to assign his life insurance to the facility;
- (3) requiring the resident to transfer property to the facility;
- (4) requiring the resident to pay a lump sum entrance fee or make any other payment or concession to the facility beyond the recognized rate for board, room, and care as a condition for entry, departure, or continued stay;
- (5) controlling or restricting the resident, the resident's guardian, or responsible party in the use of the resident's personal needs allowance;
- (6) restricting the resident from leaving the facility at will except as provided by state law;
- (7) restricting the resident from applying for Medicaid for a specified period of time;
- (8) denying appropriate care to an individual on the basis of his race, religion, color, national origin, sex, age, disability, marital status, or source of payment; and
- (9) preventing terminally ill adult residents from exercising their will in making written or unwritten directives to reject life-sustaining procedures.

(e) If DADS has documentation showing good cause, it reserves the right to reject the facility's participation or to cancel an existing contract if the facility charges the Title XIX resident, any member of his family, or any other

source for supplementation or for any item except as allowed within DADS policies and regulations.

(f) If DADS suspends a facility's vendor payments or proposes to terminate a facility's contract, the facility may request an administrative hearing to challenge the action. If a facility requests a hearing, the facility must make the request in accordance with HHSC rules at 1 TAC Chapter 357, Subchapter I.

(g) DADS' interpretations of the requirements for participation or the contract may not be appealed to HHSC's hearings department unless the interpretation has caused an adverse action for the facility.

(h) Facilities must allow representatives of DADS, the Medicaid Fraud Control Unit, and the Department of Health and Human Services to enter the premises at any time to make inspections or to privately interview the residents receiving assistance from DADS.

(i) Facilities must supply DADS complete information according to federal and state requirements about the identity of:

- (1) each person who directly or indirectly owns interest of 5% or more in the facility;
- (2) each owner (in whole or in part) of any property, assets, mortgage, deed of trust, note, or other obligation secured by the facility;
- (3) each officer and director, if the facility is organized as a corporation;
- (4) each partner, if the facility is organized as a partnership (A copy of the partnership agreement is required, but the dollar amount of capital contributions of the partners may be omitted); and
- (5) any director, officer, agency, or managing employee of the institution, agency, or organization, who has ever been convicted of a criminal offense related to the person's involvement in programs established by Title XVIII, XIX, and XX (Effective dates for disclosure of any convictions are July 1, 1966, for Medicare, and January 1, 1969, for Medicaid.)

(j) If a profit-making corporation operates the facility, a copy of the following material is required:

- (1) certificate of incorporation (for Texas corporations only);
- (2) certificate of authority to do business in Texas (for out-of-state corporations only);
- (3) a resolution from the board of directors authorizing a specific person or officer to sign contracts between DADS and the corporation; and
- (4) any management contract for the facility. If no stockholder owns, directly or beneficially, 5.0% or more of the corporate stock, the president and secretary of the corporation should state this on the department form.

(k) If a nonprofit corporation operates the facility, a copy of the following material is required:

- (1) certificate of incorporation (for Texas corporations only);
- (2) certificate of authority to do business in Texas (for out-of-state corporations only);

(3) a resolution from the board of directors authorizing a specific person or officer to sign contracts with DADS; and

(4) a copy of any management contract for the facility.

(l) Facilities other than those described in subsections (j) and (k) of this section must furnish a copy of:

(1) charter or other legal basis for the organization which owns the facility;

(2) any management contract or agreement for the facility;

(3) by-laws of the organization (if applicable); and

(4) other information required by DADS to determine the status of the legal entity that owns the facility.

(m) Facilities must disclose business transaction information. A facility must send to DADS, within 35 days after the date of a written request, complete information on:

(1) the ownership of a subcontractor with whom the facility has had, during the previous 12 months, business transactions totaling more than \$25,000; and

(2) any business transactions between the facility and any wholly owned supplier, or between the facility and any subcontractor during the five-year period ending on the date of the request.

(n) The facility must report changes in the required information promptly to DADS.

(o) Failure to provide this information may result in suspension, termination, or other contract action, including holding vendor funds. Payment to the facility is denied beginning on the day after the date information was due, and ending on the day before the date the information is received by DADS.

(p) Each facility must comply with Government Code, §531.116. A facility that furnishes services under the Medicaid program is subject to Occupations Code, Chapter 102. The facility's compliance with that chapter is a condition of the facility's eligibility to participate as a facility under those programs.

Source Note: The provisions of this §19.2302 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective January 1, 2002, 26 TexReg 10389; amended to be effective June 1, 2004, 29 TexReg 5416; amended to be effective August 31, 2004, 29 TexReg 8140; amended to be effective September 1, 2008, 33 TexReg 7264

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RULE §19.2304

Contract Requirements

- (a) The Texas Department of Human Services (DHS) may enter into contracts with the facility.
- (b) Nursing facilities (NFs) must comply with all state and federal requirements for participation.
- (c) The contracting nursing facility agrees to:
 - (1) comply with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), §504 of the Rehabilitation Act of 1973 (Public Law 93-112), the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990 (Public Law 101-336), the Safe Medical Devices Act of 1990, and all amendments to each, and all requirements imposed by the regulations issued pursuant to these acts. In addition, the contractor agrees to comply with Chapter 73 of this title (relating to Civil Rights). These provide in part that no persons in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion be excluded from participation in, or denied, any aid, care, service or other benefits provided by federal and/or state funding, or otherwise be subjected to discrimination;
 - (2) comply with Texas Health and Safety Code, Chapter 85, Subchapter E (concerning workplace and confidentiality guidelines regarding AIDS and HIV);
 - (3) comply with 42 Code of Federal Regulations, Part 455, Program Integrity: Medicaid.

Source Note: The provisions of this §19.2304 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.2306**Effective Dates of Provider Contracts**

(a) The effective date of the provider contract for an initial certification is the date the on-site survey is completed if the facility meets:

- (1) all federal health and safety standards; and
- (2) any other requirements imposed by the Texas Department of Human Services (DHS).

(b) If the facility does not meet any of the requirements specified for an initial certification, the contract is effective on the earlier of the following dates:

- (1) the day the facility meets all requirements; or
- (2) the day the facility's correction plan, approvable waiver request, or both are accepted by DHS. The facility must have met all requirements imposed by DHS.

Source Note: The provisions of this §19.2306 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) Definition. An ownership change is defined in §19.210(c) of this title (relating to Temporary Change of Ownership). For purposes of this section, prior owner is defined as the legal entity with a Medicaid contract for the facility before the change of ownership. The new owner is the legal entity to which DADS has assigned the contract (in accordance with 42 CFR §442.14 and subsection (d) of this section). The effective date of the ownership change is the effective date of the new owner's license for the facility.

(b) Notice of ownership change. The prior owner must give DADS written notice of a change of ownership at least 30 days before the effective date of the change. If written notice of the change is not received 30 days before the agreed change date, DADS is not responsible for payments made to the prior owner or new owner that do not reflect the established change date. DADS will not make a duplicate payment. It is the responsibility of the prior and new owner to make arrangements between themselves for such contingencies.

(c) Vendor holds based on a change of ownership.

(1) Holds on payments due to a prior owner.

(A) When DADS receives information about a proposed or actual change of ownership, DADS may place vendor payments to the prior owner on hold. Vendor payments will not be released until the Texas Health and Human Services Commission notifies DADS that the prior owner meets the final reporting requirements as specified in 1 TAC §355.306 (relating to Cost Finding Methodology) and 1 TAC §355.308(f)(1)(A) (relating to Direct Care Staff Rate Component).

(B) Once the final reporting requirements in subparagraph (A) of this paragraph are met, vendor payments may still be held so that money owed to DADS can be recouped from the funds placed on hold. Vendor payments will be released after:

(i) completion of a billing and claims reconciliation, or the passing of a time period of 12 months after the effective date of the change of ownership, whichever is sooner; or

(ii) the prior owner provides, at DADS' option, either of the following documents in a format acceptable to DADS to cover possible liabilities of the prior owner:

(I) a surety bond or an irrevocable letter of credit as described in §19.2312 of this title (relating to Surety Bonds or Letters of Credit); or

(II) written authority by the prior owner to withhold and retain funds normally due the prior owner from other Medicaid contracts the prior owner may have with DADS.

(2) Waiving holds on payments due to a prior owner.

(A) DADS may waive placing vendor payments to the prior owner on hold, if, at least 60 days before the effective date of the change of ownership:

(i) the prior owner notifies DADS of the change of ownership;

(ii) the new owner provides DADS with a signed and notarized contract application;

(iii) DADS receives information sufficient to verify that the ownership change is a reorganization of the prior owner's ownership structure and that the new owner's ownership structure:

(I) consists of individuals who owned at least 51% of the ownership in the prior owner and own at least 51% of the ownership in the new owner;

(II) does not consist of a change in a general partner, if the prior owner's ownership structure was a limited partnership; and

(III) retains control of the prior owner's financial records; and

(iv) the prior owner returns to DADS the nontransferable DADS Successor Liability Agreement (provided by DADS) signed by the prior and new owners indicating that the new owner has agreed to pay DADS for any liabilities that exist or may be found to exist during the period of the prior owner's contract with DADS.

(B) Meeting the conditions in subparagraph (A) of this paragraph but not meeting the 60-day time frame may result in DADS placing vendor payments to the prior owner on hold; however, once all of the conditions listed in subparagraph (A) of this paragraph are met, the hold will be released.

(3) Holds on payment due to the new owner.

(A) During the period between the issuance of the temporary change of ownership license and the inspection or survey of the nursing facility, DADS may not place a hold on vendor payments to the temporary license holder.

(B) If the nursing facility fails to pass the inspection or survey or fails to meet the requirements in §19.201 of this title (relating to Criteria for Licensing), DADS may place a hold on vendor payments to the new owner.

(d) Contract assignment. When a change in ownership occurs, DADS automatically assigns the agreement to the new owner by issuing a new contract. By signing the contract, the new owner is representing to DADS that the new owner meets the requirements of the contract and the requirements for participation in the Medicaid program. The new owner's contract is subject to the prior owner's contract terms and conditions that were in effect at the time of transfer of ownership, including the following:

(1) any plan of correction;

(2) compliance with health and safety standards;

(3) compliance with the ownership and financial interest disclosure requirements of 42 CFR §§455.104, 455.105, and 1002.3;

(4) compliance with civil rights requirements in 45 CFR Parts 80, 84, and 90;

(5) compliance with additional requirements imposed by DADS; and

(6) any sanctions as specified in this chapter relating to remedies for violations of Title XIX nursing facility provider agreements, including deficiencies, vendor holds, compliance periods, accountability periods, monetary penalties, notification for correction of contract violations, probationary contracts, and history of deficiencies.

(e) Medical assistance payments nontransferable. Neither medical assistance nor amounts payable to vendors out of public assistance funds are transferable or assignable at law or in equity. DADS will not allow non-split agreements in the case of ownership changes. Non-split agreements are arrangements where DADS does not interrupt payments to prior and new owners but continues reimbursements as though no ownership change has occurred. A split in pay agreement ensures that payments to the prior owner stop on a certain date and payments for services thereafter go to the new owner.

(f) Owner agreements. The new owner and the prior owner of a nursing facility may reach any agreement they wish, but DADS will not participate in a non-split procedure which would allow the new owner to receive the prior owner's accrued vendor payments.

(g) Financial records. The prior owner of the facility may remove the financial records pertaining to his period of ownership from the facility, but must maintain them for the time period prescribed by law or until such time as all audit exceptions are reconciled, whichever period is the longer. The original copies of the trust fund records, including ledger cards, may be removed by the prior owner if an exact duplicate of the trust fund records, including ledger cards, remains with the new owner.

Source Note: The provisions of this §19.2308 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective April 1, 1996, 21 TexReg 1432; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective April 1, 2002, 27 TexReg 2060; amended to be effective February 1, 2003, 27 TexReg 12009; amended to be effective April 2, 2007, 32 TexReg 1916

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RULE §19.2310

Nursing Facility Ceases to Participate

A nursing facility may lose its status as a participating facility if any of the following conditions are met:

(1) the facility withdraws voluntarily from the program. The participation agreement for facilities which voluntarily withdraw from the program remains in effect with respect to services provided to residents residing in the facility the day before the effective date of the withdrawal, in accordance with Section 1919(c)(2)(F) of the Social Security Act. The owner and administrator must request withdrawal, in writing, from the Texas Department of Human Services (DHS) at least 30 days before the withdrawal date;

(2) DHS terminates certification of the facility;

(3) DHS denies a license (new or renewed) to the facility or revokes the facility's license and cancels the facility's status as a participating facility;

(4) the nursing facility (NF) is a Title XIX/XVIII provider of services, and Medicare (Title XVIII) terminates the contract because of contract violation; or

(5) DHS cancels the contract because DHS determines that the nursing facility is in breach of the contract.

Source Note: The provisions of this §19.2310 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective August 1, 2000, 25 TexReg 6779

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(a) If the facility has a change in ownership or termination of a contract (voluntary or involuntary), the prior owner's and/or the new owner's vendor payments may be held. Usually, the amount held is equal to the facility's average monthly payments.

(b) At its sole option, the Texas Department of Human Services (DHS) may allow the prior owner to obtain a surety bond or an irrevocable letter of credit (collateral) and release the vendor payments on hold. Money owed DHS by the prior owner for any reason will be recovered through the surety bond or the letter of credit. Usually, the surety bond equals the average monthly vendor payments paid to the facility. Facilities terminating a contract for long-term care services may furnish a surety bond or letter of credit only if:

(1) all required long-term care facility cost reports have been filed with the Texas Health and Human Services Commission (HHSC) Rate Analysis Department;

(2) all required long-term care facility staffing and compensation reports have been filed with HHSC's Rate Analysis Department; and

(3) funds identified for recoupment from 1 TAC §355.308(n) or (o) or both (relating to Direct Care Staff Rate Component) have been repaid to HHSC or its designee.

(c) If an acceptable surety bond or letter of credit is presented to DHS, the vendor payments may be released. Facilities must ensure that this bond or irrevocable letter of credit is in a format acceptable to DHS, and does not include requirements that DHS, as a condition of receiving payment, either:

(1) return the original bond or letter; or

(2) submit to any draft requirement of an irrevocable letter of credit or surety bond, in addition to DHS's letter demanding payment.

Source Note: The provisions of this §19.2312 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective April 1, 1996, 21 TexReg 1432; amended to be effective October 15, 1998, 23 TexReg 10496; amended to be effective August 31, 2004, 29 TexReg 8140

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(a) The Texas Department of Human Services (DHS) may audit all facilities, including facilities' trust fund accounts, periodically. A facility is notified of audit plans and is given a report of the final audit findings. If vendor payment problems are found, Provider Enrollment requests that the Nursing Facility Billing Unit work with the facility to reconcile the discrepancies. If the findings show that refunds are due residents or their responsible parties, Provider Enrollment requests that the regional staff assist the facility in reconciling the audit findings. Facilities which fail to provide documentation for audit exceptions or evidence of federally-mandated surety bonds or fail to keep other records required for audit are subject to the withholding of vendor payments until such problems are resolved. Money owed to DHS will be recouped from the funds placed on hold.

(b) Upon receipt of an audit exception, the facility must provide additional documentation, reach a final agreement, make restitution within 60 days, or request a hearing within 15 days. Requests for an informal hearing are to be directed to DHS, Provider Enrollment. Requests for a formal hearing are to be directed to DHS's Hearings Department, P.O. Box 149030 (W-613), Austin, Texas 78714-9030.

(c) If the facility does not pay the amount due the resident within the specified time frame, DHS may withhold other funds due the facility beginning on the 60th day without providing advance notice. DHS releases funds when the facility produces documentation that it has refunded the proper amount to the resident or responsible party.

(d) DHS may require the facility to pay the resident refund amount to DHS plus any anticipated cost, including personnel salaries, which is incurred by DHS in making the refund to the proper party.

Source Note: The provisions of this §19.2314 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective April 1, 1996, 21 TexReg 1432.

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RULE §19.2316**Collection of Applied Income**

-
- (a) Nursing facilities may collect from the recipient only the applied income that is specified on the recipient's payment plan forms, except when that amount exceeds the monthly vendor rate. In this event, the facility may collect only an applied-income amount equal to the maximum monthly Medicaid vendor rate.
- (b) If a payment plan appears incorrect, the facility administrator should contact the local Texas Department of Human Services (DHS) worker to correct the plan. Even if a recipient's income increases, the administrator must not collect an increased payment until the plan is changed. The administrator should not collect an increased payment in anticipation of a payment plan increase.
- (c) If an admitted recipient does not have a payment plan, the administrator should contact the local worker for help in determining how much applied income is owed. If the forthcoming forms indicate a lesser payment, the administrator should refund the excess immediately and notify the worker.
- (d) Facilities that collect payments (part applied income, part Medicaid) in excess of the vendor rate are in violation of DHS regulations and of Public Law 95-142 which makes "solicitation of supplementation" a felony.
- (e) Regional DHS staff must report any violations. If an investigation shows that the facility has violated this standard, a recommendation for withholding vendor payments, contract termination, referral to the courts, or other contract action may be made.
- (f) The nursing facility must refund the recipient's prorated applied income money when the recipient has paid in advance for the full month and is discharged from the facility any time during the month. The facility must make the refund within 30 calendar days from and including the date of discharge, even when vendor payment has not been received from DHS.

Source Note: The provisions of this §19.2316 adopted to be effective May 1, 1995, 20 TexReg 2393.

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RULE §19.2318

Computation of Daily Reimbursement Rate for Recipients with Applied Income

(a) Reimbursement is computed by multiplying the established daily rate by the number of days in the month. The recipient's applied income is then subtracted and the result is divided by the number of days in the month.

(b) A facility may not collect more than the applied income reported on the payment plan form in a 31-day month.

Source Note: The provisions of this §19.2318 adopted to be effective May 1, 1995, 20 TexReg 2393.

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(a) The nursing facility is responsible for providing normal transportation for the recipient to medical services outside the facility. The attending physician must have ordered the medical services.

(b) Normal transportation is to and from the medical care provider of the recipient's choice, who is generally available and used by recipients of the locality for medical care included under the Texas Medical Assistance program. If a Title XIX provider is not in the locality, transportation is to and from the nearest appropriate Title XIX provider if the recipient so chooses. The term "locality" means the service area surrounding the nursing facility from which individuals ordinarily come or are expected to come for inpatient or outpatient services.

(c) Transportation charges, including non-emergency, routine ambulance services, involved in the certification or recertification of a recipient are the responsibility of the nursing facility.

(d) The facility may not charge the state's Medicaid health insuring agent, the recipient, the family, or responsible party for normal transportation as defined in this section. Normal transportation charges are covered in the monthly vendor rate. The facility may not use the state's Medicaid community-based Title XIX medical transportation program except to transport recipients for renal dialysis treatments.

(e) Charges for the following medically necessary ambulance services, when provided by a Medicaid-enrolled provider, are not the responsibility of the nursing facility, but are payable by the state's Medicaid health insuring agent as a Medicaid benefit:

(1) emergency transport, which is ambulance service for a Medicaid recipient with an emergency medical condition. Emergency medical condition is defined as one which manifests itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in placing the recipient's health in serious jeopardy; and

(2) nonemergency transport, under the following conditions:

(A) the recipient is severely disabled, which is defined as a condition which limits mobility and requires confinement to bed at all times, prevents sitting unassisted at all times, or requires the monitoring of life support systems, including oxygen or intravenous infusion;

(B) the severely disabled recipient cannot be transported by any means other than an ambulance without endangering the health or safety of the recipient; and

(C) the nonemergency ambulance transportation of the severely disabled recipient is to or from a scheduled medical appointment and authorization has been received from the Texas Department of Health or its designee.

If payment under the medical assistance program is denied because the facility failed to obtain prior authorization, the facility must pay for the service if presented a copy of the bill for which payment was denied.

(f) If ambulance services are reimbursable by the state's Medicaid health insuring agent, they are not the responsibility of the recipient, the family, or the responsible party.

(g) Nursing facilities are encouraged to use family, friends, sponsors, civic groups, or charitable organizations as resources for transportation services. If normal transportation is not obtainable from these sources, the facility must provide or purchase the appropriate services.

Source Note: The provisions of this §19.2320 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective March 1, 1998, 23 TexReg 1314; amended to be effective June 1, 2004, 29 TexReg 5416; amended to be effective August 31, 2004, 29 TexReg 8141

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AND MEDICAID CERTIFICATION****SUBCHAPTER X****REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES****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:

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

(2) 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:

(i) termination of Medicaid and/or Medicare certification;

(ii) termination of Medicaid contract;

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

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

(v) civil penalties pursuant to §242.065 of the Texas Health and Safety Code; or

(vi) 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;

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

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

(E) 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.

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(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.

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

(2) 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:

(i) an immediate need for additional Medicaid beds in the community;

(ii) 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.

(A) The applicant must document that:

(i) 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

(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:

(A) is affiliated with a state-supported medical school;

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

(C) 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:

(i) the demographic and economic needs of the county;

(ii) 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.

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(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:

(i) licensure denial;

(ii) 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 re-certified 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-allocating 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.

Source Note: The provisions of this §19.2322 adopted to be effective November 1, 2002, 27 TexReg 9154

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AND MEDICAID CERTIFICATION****SUBCHAPTER X****REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES****RULE §19.2324****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.

(b) Primary selection process.

(1) DHS will monitor monthly Medicaid occupancy rates. When DHS determines that the occupancy rate for any county, or any precinct in the four most populous counties, equals or exceeds 90% for six consecutive months, a public notice will be placed in the *Texas Register* and the Electronic State Business Daily (ESBD) to announce an open solicitation period.

(2) The public notice will announce that DHS will allocate additional Medicaid beds to eligible nursing facilities. The notice will specify that the solicitation is limited to currently licensed nursing facility beds that may be converted to Medicaid-certified beds and that the number of beds allocated will be limited to the number necessary to reduce the county or precinct occupancy rate to 85%.

(3) The public notice will identify the county and/or precinct, the six-month occupancy average for the county or precinct and the beginning and end dates of the open solicitation period. The notice also will include the DHS address to which the application for additional Medicaid beds must be submitted and will specify that the application must be received by DHS before the close of business on the end date of the solicitation period.

(4) Current licensees and/or property owners of licensed facilities that choose to apply for the allocation of additional Medicaid beds must demonstrate a history of quality care as specified in §19.2322(e) of this title (relating to Medicaid Bed Allocation Requirements).

(5) Applicants must provide the name and address of the nursing facility, the name, address, and telephone number of the contact person, the number of licensed beds available and the number of additional Medicaid beds requested.

(6) At the end of the solicitation period, DHS will determine if any applicant is eligible for additional Medicaid beds and if the number of eligible licensed beds is adequate to reduce the county or precinct occupancy rate to below 90%. DHS will allocate the number of Medicaid beds necessary to reduce the occupancy rate to below 90%. If eligible nursing facilities have additional licensed beds available for conversion to Medicaid beds, DHS will allocate additional beds, but not more than the number of beds necessary to reduce the occupancy rate to 85%.

(7) If more than one nursing facility is eligible for additional Medicaid beds, the beds will be allocated equally to each facility.

(8) The additional allocation of Medicaid beds may not be transferred or assigned until they are certified at the applicant facility.

(9) Medicaid beds allocated under this provision must be certified within six months of allocation and must comply with time limit and extension requirements specified in §19.2322(i) of this title.

(c) Secondary selection process.

(1) When the primary selection process does not result in the allocation of additional Medicaid beds necessary to reduce the occupancy rate to below 90%, DHS will place a second notice in the *Texas Register* and the ESD. The second notice will announce that additional Medicaid beds may be allocated to eligible applicants that desire to construct a new nursing facility or to construct an addition to an existing nursing facility. In counties with 1,500 or more Medicaid beds, the notice will specify that the allocation is limited to no more than 120 beds. In counties with fewer than 1,500 Medicaid beds, the notice will specify that the allocation is limited to no more than 90 beds.

(2) The second notice will identify the county and/or precinct, the six-month occupancy average for the county or precinct and the beginning and end dates of the solicitation period. The notice also will include the DHS address to which the application for additional Medicaid beds must be submitted and will specify that the application must be received by DHS before the close of business on the end date of the solicitation period.

(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.

(7) If no application for the secondary waiver process is received or if no applicant meets the requirements in

this section, no further solicitations will occur.

(8) In counties with no licensed nursing facilities, DHS will implement the secondary selection process when it is determined that the county population exceeds 5,000. Since those counties contain no licensed beds eligible for the primary selection process, DHS will omit that part of the process.

(9) Medicaid beds allocated under this provision must be constructed, licensed and certified within 24 months of allocation and must comply with time limit and extension requirements specified in §19.2322(i) of this title.

(d) Informal review procedures.

(1) Applicants may request an informal review of DHS actions in this section. The request must be submitted within 30 days of notice 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.

Source Note: The provisions of this §19.2324 adopted to be effective November 1, 2002, 27 TexReg 9154

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[<<Prev Rule](#)**Texas Administrative Code**[Next Rule>>](#)**TITLE 40****SOCIAL SERVICES AND ASSISTANCE****PART 1****DEPARTMENT OF AGING AND DISABILITY SERVICES****CHAPTER 19****NURSING FACILITY REQUIREMENTS FOR LICENSURE
AND MEDICAID CERTIFICATION****SUBCHAPTER X****REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES****RULE §19.2326****Medicaid Swing Bed Program for Rural Hospitals**

(a) Program description. DADS operates the Medicaid Swing Bed Program for rural hospitals located in counties with populations of 100,000 or less. The Medicaid Swing Bed Program is modeled on Medicare's Swing Bed Program. The Medicaid Swing Bed Program permits participating rural hospitals to use their beds interchangeably to furnish both acute hospital care and nursing facility care to Medicaid recipients, when no care beds are available in nursing facilities (NFs) in the area. When a participating rural hospital furnishes NF nursing care to Medicaid recipients, DADS makes payment to the hospital using the same procedures and the same Resource Utilization Group daily rates that the Texas Health and Human Services Commission authorizes for reimbursing NFs participating in the Texas Medicaid Nursing Home Program.

(b) Application to participate. Rural hospitals apply to DADS to participate in the Medicaid Swing Bed Program. Each applicant must be located in a county with a population of 100,000 or less and must meet the qualifying requirements of the Medicare Swing Bed Program. Hospitals approved for participation enter into swing bed provider agreements with DADS.

(c) Parallel participation in Medicare. A rural hospital participating in the Medicaid Swing Bed Program must:

(1) have a Medicare hospital provider agreement; and

(2) be Medicare-certified by the Department of State Health Services (DSHS) as a swing bed hospital in the Medicare Swing Bed Program.

(d) Applicability of Medicare requirements. Each participating rural hospital must satisfy all the requirements of the Medicare Swing Bed Program, except that Medicare's five-weekday transfer requirement, as stated in §482.66(b)(i)-(ii), 42 Code of Federal Regulations, and 15% payment limitation do not apply for Medicaid reimbursement purposes.

(e) Applicability of NF requirements. From day one of the resident's stay, a rural hospital participating in the Medicaid Swing Bed Program must meet the requirements set forth in §19.101 of this title (relating to Definitions); §19.2304(c) of this title (relating to Contract Requirements); §§19.300 - 19.314 and 19.316 of this title (relating to General Requirements; Applicable Codes and Standards; Waivers; Emergency Power; Space and Equipment; Resident Rooms; Toilet Facilities; Resident Call System; Dining and Resident Activities; Other Environmental Conditions; Site and Grounds; Fire Service and Access; Means of Egress; Interior Finishes - Walls, Ceilings, and Floors; Fire Alarms, Detection Systems, and Sprinkler Systems; and Subdivision of Building Spaces - Smoke Barriers); §§19.1901 - 19.1914 and 19.1917 of this title (relating to Administration; Governing Body; Required Training of Nurse Aides; Proficiency of Nurse Aides; Staff Qualifications; Use of Outside Resources; Medical Director; Laboratory Services; Radiology and Other

Diagnostic Services; Clinical Records; Contents of the Clinical Record; Additional Clinical Record Service Requirements; Clinical Records Service Supervisor; Disaster and Emergency Preparedness; and Quality Assessment and Assurance); §§19.2601-19.2608 and 19.2610 of this title (relating to Subchapter AA, Vendor Payment); Subchapter Y of this title (relating to Medical Necessity Determinations); and Appendix B, Cost Determination Process, and Appendix C, Reimbursement Methodology for Nursing Facilities, of DADS' *Nursing Facility Requirements for Licensure and Medicaid Certification Handbook*.

(f) Rural hospital (Medicaid swing bed facility) licensure and certification requirements. Pursuant to Texas Health and Safety Code §§222.021, 222.024, and 222.025 concerning the duplication of health care inspections and licensing, a rural hospital participating in the Medicaid Swing Bed Program satisfies licensure and certification requirements referenced in this section when it is currently licensed and certified as a hospital by DSHS. However, in accordance with Texas Human Resources Code, §32.024, if the rural hospital's swing beds are used for more than one 30-day length of stay per year, per resident the hospital must comply with the full Nursing Facility Requirements.

(g) Rural hospital (Medicaid swing bed facility) administrator. The governing body of a rural hospital participating in the Medicaid Swing Bed Program satisfies the requirement to appoint a qualified full-time nursing facility administrator, found at §19.1902(b) of this title (relating to Governing Body), when it appoints a hospital administrator as its official representative and designates the administrator's responsibilities and authority, subject to the following exception. If the swing beds are used for more than one 30-day length of stay per year, per resident, the hospital's governing body must appoint a full-time licensed nursing facility administrator.

(h) Rural hospital (Medicaid swing bed facility) staff development requirements. A rural hospital participating in the Medicaid Swing Bed Program satisfies the staff development requirements found at §19.1929 of this title (relating to Staff Development) if the swing beds are used for no more than one 30-day length of stay per year, per resident.

(i) Rural hospital (Medicaid swing bed facility) transfer agreement. A rural hospital participating in the Medicaid Swing Bed Program is not required to have a transfer agreement with another hospital, as required by §19.1915 of this title (relating to Transfer Agreement).

(j) Rural hospital geographic region. The phrase "a participating rural hospital's geographic region" refers to an area that includes nursing facilities with which the hospital normally arranges transfers and all other nursing facilities in similar proximity to the hospital. If a hospital has no previous transfer practices on which to base a determination, the phrase "geographic region" refers to an area that includes all nursing facilities within 50 miles of the hospital except for facilities that the hospital demonstrates to be inaccessible to its patients.

Source Note: The provisions of this §19.2326 adopted to be effective May 1, 1995, 20 TexReg 2393; amended to be effective July 1, 1996, 21 TexReg 4408; amended to be effective September 1, 2008, 33 TexReg 7264

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