Long-Term Care Regulation Provider Letter

Number: PL 2022-12
Title: Revised Instructions for Medicaid Bed Allocation Requests
Provider Types: Nursing Facility (NF)
Date Issued: May 3, 2022

1.0 Subject and Purpose

This provider letter (PL) describes procedures related to Medicaid bed allocation in Texas Administrative Code, Title 26 (26 TAC), Part 1, Section §554.2322 and replaces all previous procedures and instructions related to Medicaid bed allocation, including PL 01-39, PL 17-30, and PL 18-02.

To improve efficiency, the Health and Human Services Commission (HHSC) has made major changes to the Medicaid bed allocation process for nursing facilities. HHSC removed the opportunity for the applicant to provide a rebuttal to nursing facility comments and no longer allows the applicant and opponents to review and provide feedback on the detailed recommendation along with the basis for that recommendation prior to approval or denial. Neither of these changes negate the applicant's ability to request an informal review if the application is denied.

2.0 General Information Concerning Allocated Medicaid Beds

2.1 Control of Medicaid Beds

Per 26 TAC §554.2322(c)(3), HHSC allocates beds to the physical plant; the owner of that property controls the Medicaid beds subject to HHSC rules and requirements and all valid physical plant liens.

2.2 Level of Acceptable Care

HHSC determines whether a Medicaid bed allocation waiver or exemption applicant or a controlling person of a waiver or exemption applicant complies with level of acceptable care requirements in accordance with 26 TAC §554.2322(e).

3.0 Medicaid Bed Waiver Application

HHSC has updated the Medicaid bed waiver application, Form 3709. An applicant for a community needs, economically disadvantaged, small house, rural county, Alzheimer's, or high occupancy Medicaid bed waiver must complete the Form 3709 in accordance with HHSC instructions and submit it to HHSC in order to apply for a waiver to add Medicaid beds.

In addition to the requirement to complete and submit the updated waiver application form, the Medicaid bed allocation policies in sections 3.1 through 3.5 of this document apply.

3.1 High Occupancy Waiver

The high occupancy waiver rules are found at 26 TAC §554.2322(h)(1). Instructions for submitting an application for a high occupancy waiver are included in the public notice posted in the *Texas Register* and in the Electronic State Business Daily that announces the open solicitation period. Per 26 TAC §554.2322(h)(1)(F), if multiple applicants are eligible for a high occupancy waiver at the end of the open solicitation period, the applicant who will receive the allocation of beds is chosen by an agency approved lottery selection process.

3.2 Community Needs Waiver

The community needs waiver rules are found at 26 TAC §554.2322(h)(2). A community needs waiver is designed to meet the needs of communities that do not have reasonable access to acceptable nursing facility care. Rules applicable to community needs waivers do not define the term "community." HHSC considers a county to be a "community" except for the four most populous counties in Texas, which are Dallas, Tarrant, Bexar, and Harris counties. When the county is the community, HHSC considers countywide demographic, occupancy, and other relevant data during the community needs waiver review process.

HHSC considers a county commissioner's court precinct to be a "community" in the four most populous counties in Texas. In these counties, HHSC considers all factors relevant to the corresponding precinct during the community needs waiver review process.

An applicant also may select a specific city, municipality, or ZIP code within a county as a "community." In those cases, during the community needs waiver review process, HHSC considers demographic, occupancy, and other relevant data specific to the selected city, municipality, or ZIP code and the nearby surrounding area, including other nearby cities, municipalities, or ZIP codes, whether those cities, municipalities, or ZIP codes are located within the county or not.

3.3 Small House Waiver

The small house waiver rules are found at 26 TAC §554.2322(h)(9). A small house waiver is designed to promote the construction of smaller nursing facility buildings that provide a homelike environment. An applicant for a small house waiver must identify on the application the county in which the facility will be located. In addition, an applicant for a small house waiver in Dallas, Tarrant, Bexar, or Harris county must identify on the application the county commissioner's precinct in which the facility will be located. An applicant must also submit a schematic building plan of the proposed facility with sufficient detail to demonstrate the proposed project meets the requirements in 26 TAC §554.345.

HHSC does not approve more than 16 beds for a small house facility or for a household in a facility that is granted a small house waiver. HHSC approves the replacement or transfer of beds certified at a small house nursing facility only to another small house or household facility.

A facility that has Medicaid beds allocated under a small house waiver may apply for general Medicaid beds under another applicable exemption or waiver. HHSC does not count the beds allocated under a small house waiver in determining the allowable bed allocation increase for the non-small house Medicaid beds. For example, a 120-bed nursing facility with 60 small house waiver beds in the small house portion of the facility and 60 non-certified beds in a more traditional

portion of the facility would be eligible for an additional allocation of 10 percent of the 60 non-certified beds via the non-certified nursing facility exemption.

3.4 Economically Disadvantaged Waiver

The economically disadvantaged waiver rules are found at 26 TAC §554.2322(h)(4). The economically disadvantaged waiver is designed to meet the needs of residents of ZIP codes located in communities where a majority of residents have an average income below the countywide average income and do not have reasonable access to acceptable nursing facility care. HHSC considers demographic, occupancy, and other relevant data specific to the selected ZIP code during the economically disadvantaged waiver review process. An applicant for an economically disadvantaged waiver must demonstrate that the ZIP code in which the new nursing facility will be constructed has a population with an income that is at least 20 percent below the average income of the county according to the most recent U.S. census or more recent census projection.

3.5 Rural County Waiver

The rural county waiver rules are found at 26 TAC §554.2322(h)(7). A rural county waiver is designed to meet the needs of rural areas of the state that do not have reasonable access to acceptable nursing facility care. A county with a population 100,000 or less, according to the most recent census, and no more than two Medicaid-certified nursing facilities may apply for a rural county waiver. HHSC considers county wide demographic, occupancy, and other relevant data submitted by the commissioner's court during the rural county waiver review process.

4.0 General Policies for Waivers

The guidance in this PL applies only to the waivers described in section 3.0. The TAC describes the procedures for requesting other types of waivers. These additional waivers are the criminal justice waiver, state veterans' home waiver, Alzheimer's waiver, teaching nursing facility waiver, and high occupancy waiver. For more information concerning these waivers, please

contact the HHSC Licensing and Credentialing section at Medicaid_Bed_Allocation@hhs.texas.gov or call 512-438-2630 Option 4.

4.1 Receipt of Waiver Application by HHSC

Per 26 TAC §554.2322(g)(5), the HHSC Long-term Care Regulation Licensing and Credentialing section processes most waiver applications in the order in which they are received. For purposes of this rule, Licensing and Credentialing receives an application when it takes delivery of:

- a completed application form; and
- any additional information the waiver type requires, such as a demographic study, documentation of substantial community support for a new NF or additional Medicaid beds, or a schematic building plan of the proposed small house NF.

HHSC processes rural county waivers, small house waivers, and high occupancy waivers after the application is complete and not in the order received relative to other waiver types. Per 26 TAC §554.2322(g)(6) HHSC gives priority to a small house waiver application over a pending community needs waiver application submitted for the same county. If approved, HHSC includes the small house facility beds when determining the need for a community needs waiver.

Licensing and Credentialing considers an application for a community needs waiver, an economically disadvantaged waiver, or a small house waiver withdrawn if it is not completed within 90 days after submission.

4.2 Notice to Other NFs of Receipt of Application

When Licensing and Credentialing receives an application for a community needs, economically disadvantaged, or small house waiver, Licensing and Credentialing notifies by mail or email all NFs in the county or, in the four most populous counties, the county commissioner's precinct that:

- Licensing and Credentialing has received a waiver application;

- a NF or its representative may request copies of the application documents via an open records request; and
- a NF or its representative may comment on the application.

4.3 Comments on a Waiver Application

If a notified NF has comments on a waiver application, the NF or its representative may submit information and data regarding the application. Licensing and Credentialing must receive this information in writing no later than 30 calendar days after the date of the notification provided by Licensing and Credentialing. Licensing and Credentialing may extend the 30-day response time at its discretion. Licensing and Credentialing will not consider comments from a NF that failed to submit timely comments unless an extension has been granted which would apply to all NFs notified.

4.4 Recommendation for Action on Application

Licensing and Credentialing reviews information relevant to the waiver application and makes a final recommendation on whether to grant the waiver. HHSC then makes a final decision and sends notice of approval or denial to the waiver applicant and opponents. A waiver applicant that is denied a waiver may request an informal review of the denial in accordance with 26 TAC §554.2322(k).

If a county commissioner's court in a rural county recommends that HHSC issue a rural county waiver to a person or entity the court selects in accordance with 26 TAC §554.2322(h)(7), the selectee must complete and submit the new waiver application form but the application is not subject to the waiver opposition process described above.

4.5 Assignment of Waivers

Under 26 TAC §554.2322(g)(2), a waiver recipient may ask HHSC to assign a waiver under certain circumstances. A waiver recipient may request HHSC approval of only one assignment, and the assignee must meet the level of acceptable care requirements.

A request for an assignment must include a copy of each agreement and document related to the assignment. Both parties to the assignment must attest that all agreements and documents directly or indirectly related to the assignment have been disclosed. Financial terms or terms related to the purchase price, if any, of the waiver assignment transaction between the parties may not be redacted from the documents.

Under 26 TAC §554.2322(g)(2)(A), the assignee must not have an owner or controlling person who was not an owner or controlling person of the waiver recipient. A waiver recipient entity may remove a controlling person from ownership of the entity, but the waiver recipient entity must not add an owner after the waiver is approved by HHSC. A change to the ownership of the waiver recipient entity or the waiver assignment entity must be reported to HHSC.

To establish compliance with 26 TAC §554.2322(g)(2)(A), a request for a waiver assignment must also include documentation showing that the individuals who were originally granted the waiver or the individuals who owned an entity when the entity was originally granted a waiver are the majority owners and have management control over the assignee entity. However, submitting only evidence that the individuals who were originally granted the waiver or the individuals who owned the entity when the entity was originally granted the waiver are the majority owners of the assignee entity is not sufficient to comply with the requirement. The request must also include documentation showing majority control over the assignee entity.

In addition to reviewing the evidence provided by the waiver recipient to show compliance with the assignment requirements, HHSC will confirm compliance with the Secretary of State when the waiver assignment request is submitted for HHSC approval and again when the license and certification application is submitted to HHSC to ensure that the ownership and control circumstances reported during the assignment transaction remain unchanged. HHSC will also confirm whether the assignee meets the level of acceptable care requirements at the time of the assignment. Failure to comply with these waiver assignment requirements is grounds to deny an assignment request. HHSC, at its sole discretion, may invalidate an assignment if HHSC

determines an assignment was approved on the basis of false information or the assignor or assignee failed to disclose all documents directly or indirectly related to the assignment.

5.0 Security Bond, Letter of Credit

An applicant that is granted a high occupancy waiver, community needs waiver, economically disadvantaged waiver, rural county waiver, or small house waiver must provide to HHSC a performance bond, a surety bond, or an irrevocable letter of credit in the amount of $500,000 payable to HHSC. The purpose of the bond or letter of credit is to ensure that the Medicaid beds granted to the applicant under the waiver are certified within the time periods required by 26 TAC §554.2322(i)(4)(G), including any extensions granted under 26 TAC §554.2322(i)(6). HHSC will revoke a waiver if the performance bond, surety bond, or irrevocable letter of credit is not provided within 90 days after HHSC approves the waiver application. No extensions will be granted. A bond or letter of credit must remain in place until the new beds are licensed and certified. It is the applicant's responsibility to provide updated documents prior to the expiration of the performance bond, surety bond, or irrevocable letter of credit. Failure to maintain an active performance bond, surety bond, or irrevocable letter of credit is basis for HHSC to revoke the waiver.

6.0 Construction Benchmarks

A recipient of a waiver or replacement exemption must provide HHSC with evidence of compliance with the time limits and extensions per 26 TAC §554.2322(i)(4) on or before the due date. The applicant may request an extension of the time limits by sending an email to Medicaid_Bed_Allocation@hhs.texas.gov. The applicant must substantiate every element of its extension request with evidence of good faith efforts to meet the benchmark and construction deadlines or evidence that delays were beyond the applicant's control. Failure to provide documentation or request an extension on or before the due date may result in the revocation of the waiver or replacement exemption. HHSC at its sole discretion approves or denies the request for an extension.

The construction benchmarks are as follows:

- Land Under Contract - the land must be under contract within 12 months after HHSC approves the waiver or replacement.

- An architect or engineer must be under contract to prepare final construction documents within 15 months after HHSC approves the waiver or replacement.
- The facility's preliminary plans must be completed within 18 months after HHSC approves the waiver or replacement.
- The land must be purchased and a progress report submitted to HHSC within 24 months after HHSC approves the waiver or replacement.
- Entitlements, including municipality, planning and zoning, building permit, and the facility's foundation must be completed within six months after land purchase or 30 months after HHSC approves the waiver or replacement, whichever is later.
- Facility construction must be active and ongoing, as evidenced by a construction progress report submitted to HHSC, within 12 months after land purchase or 36 months after HHSC approves the waiver or replacement, whichever is later.
- The facility must be constructed, licensed, and certified within 18 months after land purchase or 42 months after HHSC approves the waiver or replacement, whichever is later.

7.0 Exemptions

HHSC may grant an exemption from the requirements in §554.2322(d) relating to control of beds. All exemption actions must comply with the requirements in 26 TAC §554.2322(f) and with requirements of the Centers for Medicare and Medicaid Services (CMS) regarding bed capacity increases and decreases. When a bed allocation exemption is approved, the licensee must comply with the requirements in 26 TAC §554.201 of this chapter (relating to Criteria for Licensing) at the time of licensure and Medicaid certification of the new beds or nursing facility.

7.1 Replacement Exemption

The replacement exemption rules are found at 26 TAC §554.2322(f)(1). Replacement exemptions are for the construction of one or more new nursing facilities only. Once Medicaid beds are put into replacement status they cannot be certified at an existing facility. The replacement nursing facility must be located in the same county in which the Medicaid beds currently are allocated. Requests for replacement exemptions must be submitted via email to Medicaid_Bed_Allocation@hhs.texas.gov.

7.2 High Occupancy Exemption

The high-occupancy exemption rules are found at 26 TAC §554.2322(f)(3). If a nursing facility qualifies for a high-occupancy exemption, it may request up to a 10% increase in its Medicaid bed allocation via Form 3711. To qualify for a high occupancy exemption, a nursing facility must demonstrate that it has had an occupancy rate of at least 90 percent for nine of the 12 months prior to the application. A nursing facility may not rely on data for any month before a previous increase. See the following two examples:

> A nursing facility submits a request for additional Medicaid beds on February 15, 2020 to become effective on April 1, 2020. The request demonstrates that the nursing facility had an occupancy rate of at least 90 percent in seven of the 12 months preceding the request. The nursing facility assumed its bed occupancy data for February and March 2020 would demonstrate a rate of over 90 percent when it sent the request. HHSC will deny the nursing facility's request because at the time of the request the data did not demonstrate the required occupancy rate for at least nine months prior to the application. HHSC will not hold the request until the February and March data is reported.
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> A nursing facility submits a request for additional Medicaid beds on February 15, 2020, to become effective on April 1, 2020. The nursing facility's last allocation increase became effective on July 1, 2019. The nursing facility submitted nine consecutive months of data that reflected at least 90 percent occupancy, including two months of data that preceded the July 1, 2019 Medicaid bed increase, May and June 2019. HHSC will deny the nursing facility's request because occupancy data from months prior to the last allocation increase cannot be used in calculations for future allocation increases. Only occupancy data from months following an allocation increase can be used in requests for subsequent allocation increases.

7.3 Non-Certified Nursing Facility Exemption

The rules for the non-certified nursing facilities exemption are found at 26 TAC §554.2322(f)(4). Licensed nursing facilities that do not have

Medicaid-certified beds may apply to HHSC for an initial allocation of Medicaid beds by submitting Form 3711 to Medicaid_Bed_Allocation@hhs.texas.gov. The application for Medicaid beds may be for no more than 10 percent, rounded to the nearest whole number, of the facility's licensed nursing facility beds (e.g., 10.4 would equal 10 and 10.5 would equal 11).

7.4 Spend-Down Medicaid Beds Exemption

The rules for the spend-down Medicaid bed exemption are found at 26 TAC §554.2322(f)(6). Medicaid-certified nursing facilities may apply to HHSC for temporary spend-down Medicaid beds for residents who have "spent down" their resources to become eligible for Medicaid, but for whom no Medicaid bed is available. HHSC approval of spend-down Medicaid beds allows a nursing facility to exceed temporarily its allocated Medicaid bed capacity. Medicaid-certified facilities must submit Form 3712 to Medicaid_Bed_Allocation@hhs.texas.gov to request a spend-down bed. To qualify for a spend-down Medicaid bed, a nursing facility must meet the following requirements.

- The applicant nursing facility must have a Medicaid contract with a Medicaid bed capacity of at least 10 percent of licensed capacity of the facility.
- All Medicaid- or dually-certified beds must be occupied by Medicaid or Medicare recipients at the time of application.
- The resident for whom the spend-down bed is requested:
  - must not have been eligible for Medicaid at the time of the resident's most recent admission to the nursing facility; and
  - must have been a resident of the nursing facility for at least the immediate three months before becoming eligible for Medicaid, excluding hospitalizations.

7.5 Transfer of Medicaid Beds

The rules for the transfer of Medicaid beds are found at 26 TAC §554.2322(f)(2). An applicant may request to transfer allocated Medicaid beds certified or previously certified to another physical plant within the same county.

The applicant must own the physical plant where the beds are allocated, or the applicant must provide:

- a valid Medicaid bed transfer agreement that specifies the number of additional Medicaid beds the applicant is requesting HHSC allocate to the receiving nursing facility; or
- a valid Medicaid bed assignment that specifies the number of additional Medicaid beds the applicant is requesting HHSC allocate to the receiving nursing facility.

If the Medicaid beds are allocated to a specific physical plant, the applicant must obtain and submit written approval from the property owner and, if the physical plant has a lien, written approval from all lien holders to transfer Medicaid beds to another facility. If the physical plant where the Medicaid beds are allocated does not have a lien, the applicant must submit a written attestation of that fact with the transfer request.

The receiving licensee must comply with level of acceptable care requirements.

Form 3711 needs to be submitted for each Medicaid-certified facility involved in the transaction.

If a facility relocates to a new physical plant and has written approval from the previous property owner to transfer the beds to the new physical plant, the applicant submits the request to transfer the beds once the new facility is licensed. The applicant may also request a 25% increase in accordance with 26 TAC §554.2322(f)(1) at that time.

In accordance with 26 TAC §554.2322(i)(1), transferred Medicaid beds must be certified at the receiving facility within six months after HHSC grants the exemption unless HHSC grants an extension. The waiver recipient may request an extension by taking the steps described in section 6.0 of this PL for requesting an extension of a construction benchmark.

8.0 General Policies for Exemptions

The guidance in this PL applies only to the exemptions described in section 7.0. The TAC also describes a low-capacity facility exemption. For more information concerning this exemption, please contact Medicaid_Bed_Allocation@hhs.texas.gov.

All applicants for exemptions, except for applicants for a spend-down Medicaid bed exemption, must comply with level of acceptable care requirements.

To apply for a replacement exemption, an applicant must submit a request via email to Medicaid_Bed_Allocation@hhs.texas.gov. The recipient of a replacement exemption must meet the construction benchmarks described in section 6.0 of this PL.

- To apply for a high-occupancy exemption or a non-certified nursing facility exemption, an applicant must submit Form 3711.
- To apply for a transfer exemption, each Medicaid-certified nursing facility involved in the transfer must submit a Form 3711.
- To apply for a spend-down Medicaid bed exemption, an applicant must submit Form 3712.
- The forms may be submitted to Licensing and Credentialing via email to Medicaid_Bed_Allocation@hhs.texas.gov .

9.0 Requests for Medicaid Bed Changes

CMS' authority to regulate bed size changes in a SNF or a NF is based on the authority to ensure compliance with the provider agreement. CMS has provided additional guidance regarding the designation of Medicaid distinct parts in Section 3202 of the State Operations Manual.

9.1 Definitions

In all cases, the facility must maintain up-to-date records specifying the location of all licensed beds with Medicare or Medicaid status. The facility must be able to immediately identify the location of all beds with Medicare or Medicaid status on request of HHSC staff or staff of any other authorized regulatory agency. The facility must also maintain these same records for Medicaid billing purposes.

Distinct Parts
The term distinct part refers to a portion of a facility that is certified to provide either Medicare or Medicaid services or both. A distinct part must be physically distinguishable from the larger institution and fiscally separate for cost-reporting purposes. The distinct part must consist of all beds within the designated area. The distinct part can be a wing, a separate building, a floor, a

hallway or one side of a corridor. Also, the distinct part does not have to be confined to a single location within the institution or institutional complex's physical plant. It may, for example, consist of several floors or wards in a single building, or floors or wards that are located throughout several different buildings within the same institutional complex. Even when a distinct part consists of several floors or wards in a single building, or floors or wards that are located throughout several different buildings within the same institutional complex, it is a single distinct part.

Fully Participating
An institution is fully participating when all beds within the institution or institutional complex are certified to participate in either the Medicare or Medicaid program, or both. For example, an institution has four wings that consist of 25 beds each for a total of 100 licensed beds. Three contiguous wings that contain 75 beds are dually participating (i.e., participating in Medicare and Medicaid). The fourth wing, which consists of 25 beds, is only certified to participate in Medicare. In this instance, the institution is fully participating for purposes of Medicare (i.e., all 100 beds) and a distinct part for purposes of Medicaid (i.e., 75 beds).

Dually Participating
A bed that is both Medicare (SNF) and Medicaid (NF) certified is a dually participating (SNF/NF) bed.

Medicare Distinct Parts
All facilities in Texas have the option to become fully participating in Medicare or establish a distinct part of the facility that is Medicare certified. Facilities that elect not to become fully participating in Medicare will be required to adhere to the all-distinct part requirements.

Medicaid Distinct Parts
Not all facilities in Texas have the option to become fully participating in Medicaid as they do for Medicare. The number of Medicaid-certified beds in each facility is limited or restricted, due to the Medicaid nursing facility bed certification and

decertification requirements mandated by state legislation in Texas. *See* Texas Human Resources Code §32.0213. The rules implementing these requirements are found at 26 TAC §554.2322. Because of the Medicaid bed allocation restrictions, many facilities have licensed nursing facility beds that cannot be Medicaid certified. Consequently, the facility cannot elect to fully participate in Medicaid. Medicaid distinct parts in Texas nursing facilities are frequently created based on mandated bed limitations and are not based on facility choice. Facilities that are not fully participating in Medicaid must comply with the requirements in section 9.1.5.1 of this PL.

9.1.5.1 Movement of Medicaid Bed Status

No current Medicaid resident will be required to relocate merely to adhere to the distinct part requirements. When it is to the resident's benefit to move the Medicaid status of an eligible bed to the resident's current location rather than move the Medicaid resident to the vacant Medicaid bed, the bed status should be moved to the resident. Facility residents that become Medicaid-eligible but are not residents within the prospective Medicaid distinct part should be allowed to continue residing in their current location.

Moving the Medicaid status of a bed to another licensed bed within the nursing facility is permissible and need not be reported to HHSC. However, at no time may the number of beds designated by the facility to have Medicaid status exceed the number of Medicaid beds certified.

Moving the Medicaid (NF) status into or out of a dually participating (SNF/NF) bed is also permissible and need not be reported to HHSC as long as the conditions of the previous paragraph are met. HHSC acknowledges that a by-product of the above procedures in facilities with Medicare and Medicaid distinct parts, is that the number of beds that are dually certified (SNF/NF) will periodically increase or decrease as the NF status of beds is moved into and out of beds in the Medicare distinct part of the facility. Additionally, in facilities that are fully participating in Medicare but also have a Medicaid distinct part,

the location of dually certified beds will change as the Medicaid status of beds is periodically moved throughout the Medicare facility. However, the facility must continue to comply with all distinct part requirements related to the Medicare (SNF) distinct part. This includes the prohibition of changing the size or location of the Medicare distinct part without prior approval from HHSC. These procedures are described in the following sections.

9.2 Requests for Changes in Bed Size

A change in bed size, for the purpose of this policy, constitutes an increase or decrease in the size of a facility's Medicare or Medicaid distinct part or both. A certified nursing facility may change the size of its distinct part up to two times per cost-reporting year. Facilities may submit only one request for a change in bed size at a time. Two decreases in bed size within the same cost-reporting year will not be permitted. Facilities that undergo a change of ownership or change their cost-reporting year are not exempt from the following bed change procedures:

- Requests for changes in bed allocation must be received in HHSC state office 45 calendar days before:
    - the first day of the facility's cost-reporting year, if the effective date will be on the first day of the cost reporting year; **or**
    - the first day of a single cost-reporting quarter within the same cost-reporting year, if the effective date will be on the first day of the designated cost-reporting quarter.

Note: For a facility to change the allocation of its distinct part up to two times per cost-reporting year, the first request must be received by HHSC 45 calendar days before the first day of the cost-reporting year; otherwise, only one change in bed size can be made for that year.

The request must be accompanied by current and proposed floor plans and lists that identify current and proposed bed configurations, in order to determine whether the proposed change conforms to rules for distinct part certification or full participation, whichever applies. Lists identifying bed configurations must include ALL beds in the facility, not just those being changed.

The request must also include a reference to the facility's cost-reporting year. If there has been a change in the cost-reporting year, submit a copy of the fiscal intermediary's letter approving the change.

HHSC cannot approve a request for a change in bed size on a retroactive basis; changes are made on a prospective basis only. HHSC will consider an exception to this on a case-by-case basis. Licensing and Credentialing is responsible for advising the Medicare Administrative Contractor (MAC) and updating ASPEN of any approved changes in bed allocation.

9.3 Exceptions

There are certain situations which warrant an exception to the policy. Even if a facility has been approved for changes in bed size in accordance with the policies above, the facility may be granted an additional change in bed size on the basis of one of the following situations:

- Life Safety Code (LSC) Requirements - An exception may be granted if the request is to reduce the total bed capacity to avoid being out of compliance with LSC requirements (e.g., a portion of the facility was damaged by severe weather). To meet LSC requirements, the proposed bed configuration must be separated from the rest of the facility by a two-hour fire wall, so that there is no danger of a fire spreading from other parts of the facility. In this case, the proposed reduction in size of the distinct part may be established with an effective date requested by the facility. However, the effective date may not be earlier than the date an LSC surveyor has verified that a two-hour fire wall exists. If the reason for the request is to avoid noncompliance with LSC requirements, then the LSC staff must perform a full survey.
- Elimination of Distinct Part - An exception may be granted if a facility wants to become fully participating. If this is the case, the facility cannot return to distinct part certification until, at the earliest, the beginning of its next cost reporting year.
- Enlargement Through Construction, Purchase, or Lease of Additional Space - An exception may be granted if the facility requests to increase the size of the distinct part to include space

acquired through new construction, purchase or lease (e.g., constructing a new wing, purchasing an adjacent building or leasing a floor in a hospital).

9.4 Requests for Changes in Designated Bed Locations

For the purpose of this policy, a change in designated bed locations refers to a change in the location of beds without a change in the number of beds in the facility's distinct parts.

A facility may request a change in designated bed locations if both of the following apply:

- there is no change in the number of beds certified to participate in the Medicare or Medicaid program; and
- HHSC receives the request at least 30 calendar days before the actual change to the bed location(s).

The facility must submit current and proposed floor plans and lists that identify current and proposed bed configurations. HHSC will review these documents to determine whether the proposed change conforms with rules. HHSC must approve the request before the facility makes the change. No changes may be made on a retroactive basis.

When requesting bed location changes, facilities must adhere to notification requirements in 42 CFR 483.10(g)(14)(iii)(A), and residents' rights requirements in 42 CFR 483.10(e)(7). Furthermore, facilities must also adhere to rules on Medicaid nursing facility bed allocation requirements in 26 TAC §554.2322 of the "Nursing Facility Requirements for Licensure and Medicaid Certification."

To request a bed location change, submit Form 3711, Request for Bed Changes and Bed Relocation, to Mediciad_Bed_Allocation@hhs.texas.gov . Please use this form to list and identify current and proposed bed configurations and submit it to HHSC with all accompanying information. For any bed location change request to be considered complete, HHSC must receive all accompanying information with the request. HHSC will not process incomplete requests.

10.0 Informal Review

The informal review rules are found at 26 TAC §554.2322(k). An applicant for a waiver or exemption, a Medicaid-certified nursing facility that has been denied an increase in its Medicaid bed allocation, or a Medicaid-certified nursing facility that was subject to a decertification or de-allocation of Medicaid beds may request an informal review of HHSC's actions regarding the bed allocations. A NF must request an informal review in writing within 30 days of the date referenced on the notification of HHSC's proposed action. The informal review request must include all information, documentation, or evidence that forms the basis of the informal review.

11.0 Withdrawal from Medicaid

A facility may voluntarily terminate from Medicaid participation in accordance with 26 TAC §554.2310.

11.1 Withdrawal from Medicaid Without Closing

If a facility decides to withdraw from Medicaid but continues to provide nursing facility services, the facility must notify HHSC of the withdrawal date and provide a list of all current residents as of the day before the date of withdrawal. As of the withdrawal date, the facility may no longer accept new Medicaid residents. However, the facility may not use the withdrawal as a reason to transfer or discharge a resident who was residing in the facility on the day before the effective date of the withdrawal. The facility can only move a resident from a Medicaid certified bed to a non-certified bed with the voluntary consent of the resident or the resident's representative. The facility cannot make a Medicaid resident or any other resident living in the facility the day before the facility withdraws from Medicaid waive his or her right to apply for Medicaid in the future. The withdrawal process is not complete until every resident at the nursing facility the day before the withdrawal effective date is no longer a resident of the nursing facility, regardless of their Medicaid status on that date. Until the withdrawal process is complete, the facility must maintain a minimum of five Medicaid beds.

A nursing facility that withdraws from Medicaid but continues to provide nursing facility services cannot place the Medicaid beds in

replacement status. The replacement exemption is for the construction of a new facility only. Medicaid beds can be transferred to another existing facility in the same county. The property owner must notify HHSC of its intended future use of the Medicaid beds within 90 days after ceasing to participate in Medicaid as required by 26 TAC §554.2322(j)(4). Medicaid beds in a facility that has initiated the Medicaid withdrawal process will not be subject to the annual decertification process.

11.2 Withdrawal from Medicaid due to Closure

The property owner of a nursing facility that closes must inform HHSC in writing of the intended future use of the Medicaid beds within 90 days after closure. Unless the Medicaid beds will be used for a replacement nursing facility under a replacement exemption, the allocated beds must be re-certified within 12 months of the date the Medicaid contract was terminated. HHSC may de-allocate Medicaid beds for failure to meet these requirements.

12.0 De-allocation

The de-allocation rules are found at 26 TAC §554.2322(j)(5). HHSC may review Medicaid bed occupancy rates annually to de-allocate and decertify unused Medicaid beds. Medicaid beds will be de-allocated and decertified in facilities that have an average occupancy rate below 70 percent. De-allocated beds cannot be placed in replacement or transferred to another facility.

HHSC decertifies and de-allocates Medicaid beds granted through a Alzheimer's waiver, state veterans home waiver, criminal justice waiver, teaching nursing facility waiver or small house waiver if HHSC determines the facility in which the beds are located does not continue to meet the waiver requirements under which the beds were awarded.

13.0 Monthly Occupancy Reporting

The monthly occupancy report rules can be found at 26 TAC §554.2322(l). Each month, HHSC requires nursing facilities who participate in the Medicaid program to report on occupied Medicaid bed days, census of the licensed beds, and children under the age 22 no later than the 5th day of the month

for the previous month's census. Monthly Medicaid occupancy reporting instructions can be found here. Previous occupancy reports are made available on the HHSC website. Failure to submit occupancy data by the 5th day of the month may result in a vendor hold.

13.1 Changes to Monthly Occupancy Data

If a NF needs to change submitted occupancy data, the NF must submit a request to HHSC via email to MedOccupancy@hhs.texas.gov and must include supporting documentation, such as the facility census report, in order for the change to be approved and the facility's occupancy data to be updated. If the submitted documentation supports the occupancy data change, HHSC will make the change.

13.2 Validation of Monthly Occupancy Data

HHSC is required to validate monthly occupancy data through risk-based sampling of the data submitted. If chosen as part of the sample, the facility is required to submit supporting documentation, such as the facility's census report, for both the current month and the previous month's occupancy data. Failure to submit the supporting documentation within five business days may result in a vendor hold.

14.0 Background/History

Based on recent feedback from external stakeholders, HHSC is issuing this guidance to clarify the process related to Medicaid bed allocation waiver applications.

15.0 Resources

26 TAC §554.2322

Form 3709: Medicaid Bed Waiver Application

Form 3711: Request for Bed Changes and Bed Relocation

Form 3712: Temporary Medicaid Spend-Down Bed Request

16.0 Contact Information

If you have any questions about this letter, please contact the Policy Section by email at Medicaid_Bed_Allocation@hhs.texas.gov or call 512-438-2630 Option 4.