MANAGING MEDICAID PENDING · STATE 1 OF 50

Texas.

Your Medicaid pending AR is not a paperwork problem.

It is a training problem, and the fix is already sitting in your building.

WHO DOES WHAT

Application filed · Form H1200 · 30-day stay required

MEDICAL NECESSITY · ALL YOURS

Form 3618 to portal, 72 hours
OBRA MDS transmitted
LTCMI submitted
TMHP nurse reviews

FINANCIAL · YOU COLLECT IT

Bank statements, deeds, notes
Policies, burial, annuities, trusts

HHSC caseworker decides

Medical necessity approved?

NO
DENIED. Financial never decides.

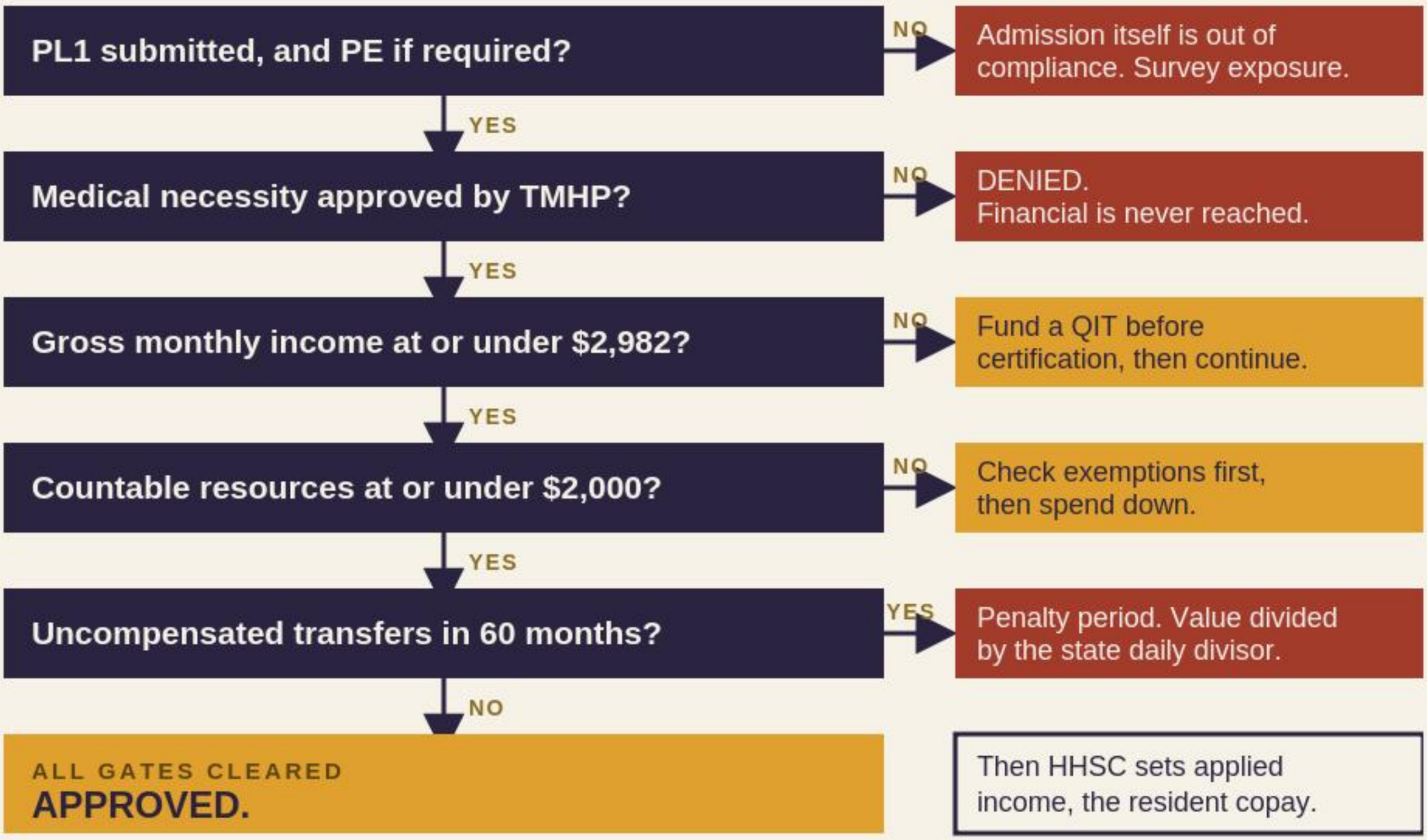
YES
HHSC reviews what you sent.

DOCS MISSING OR OVER LIMIT
DENIED.

VERIFIED AND WITHIN LIMITS
APPROVED.

Gold is your work. It is in both columns.

THE FULL DECISION PATH, GATE BY GATE



The 30-consecutive-day stay requirement runs underneath all of it before benefits can begin.

THE SCREENING THAT PRECEDES EVERYTHING

PASRR is not a Medicaid form. It is an admission requirement.

A PL1 Screening is completed for every person seeking admission to a Texas Medicaid-certified nursing facility, regardless of funding source. It is federally mandated. Private pay included.

01 A positive PL1 alerts the LIDDA, LMHA, or LBHA through the LTC Online Portal.

02 The local authority initiates face-to-face contact for the PE within 72 hours and submits it within seven calendar days.

03 Both the PL1 and the PE must be on the portal before admission, outside the seven expedited admission categories.

04 If the PE is positive, your facility certifies on PL1 Section D whether it is able to serve the person, before they arrive.

HHSC has stated that continued non-compliance carries sanction exposure at certification survey.

If medical necessity is not approved, the application is denied.

HHSC states it plainly. The caseworker is informed and the application is denied. It does not matter how clean the H1200 was.

THE SHORTCUT ALMOST NOBODY USES

For a PASRR-positive resident, TMHP determines medical necessity from the preadmission PE. The initial MDS inherits that determination if its effective date falls within thirty days either side of the PE assessment date.

A PASRR process run properly can hand you medical necessity before the MDS is even submitted.

THE MEDICAL SEQUENCE IS FIXED

01 Form 3618 goes to the TMHP LTC Online Portal within 72 hours of the transaction.

02 The OBRA MDS is completed and transmitted.

03 Only once both have landed on the portal can your staff submit the LTCMI.

04 Only then can a TMHP nurse begin the review.

WHO DOES ALL OF THIS

Your staff. Every step. No outside vendor can perform any of it on your behalf.

72

hours. Not a courtesy. A regulation.

40 TAC 19.2615 requires the facility to electronically submit the resident transaction notice within 72 hours of admission or discharge, signed by the administrator.

For a private pay resident applying, the transaction date is the first day of the month the application was filed. Physical admission is a separate field.

A last name that does not match.

If the Social Security number or last name on the MDS does not match Form 3618 or the Medicaid card, the portal cannot retrieve the assessment.

Now you are submitting an MDS modification to CMS while the clock runs.

This is a clerical mismatch. It costs weeks. A consultant will never catch it, because it happened before they saw the file.

THE HALF NOBODY WARNS YOU ABOUT

HHSC decides. Your office has to go get it.

Bank statements, deeds, notes, mortgages, insurance policies, prepaid burial contracts, annuities, trust instruments. HHSC lists all of it, and says plainly that gathering it takes time and that more may be requested.

AND YOU ARE ASKING

A daughter three states away. A son who is not speaking to his sister. A resident with dementia and no responsible party. Someone who stopped answering the phone in week three.

This is the hardest part of the process, and a vendor calling that same family has less standing than you do.

Over the limit is not the same as ineligible.

01 **IRAs and 401ks are exempt in Texas** if they are in payout status and the owner is taking the required minimum distribution.

02 **VA Aid and Attendance and Housebound allowances** above the basic pension do not count as income here.

03 **One vehicle is excluded** regardless of value. So are personal belongings and household furnishings.

04 **The homestead is exempt** if a spouse, minor child, or disabled child lives there, or with intent to return under the $752,000 equity limit.

05 **Irrevocable burial trusts** and life insurance with total face value of $1,500 or less are excluded.

THE CLOCK IS REAL

45 days	Standard processing window for applicants 65 and older.
90 days	For an applicant under 65 who has never had a disability determination.
H1215	Report of Delay in Certification. Extensions exist, but an application that cannot be certified inside the window plus the extension must be denied.

Every day spent chasing a document the business office could have requested in week one comes out of this.

THE 2026 NUMBERS, EFFECTIVE JANUARY 1

$2,982	Maximum gross monthly income, individual. $5,964 for a couple both applying.
$2,000	Countable resource limit for the applicant. $3,000 for a couple both applying.
$162,660	Community spouse keeps half the couple's countable assets up to this ceiling, with a floor of $32,532.
$4,066.50	Minimum monthly maintenance needs allowance for the community spouse.

Source: HHSC MEPD Handbook, Appendix XII.

$75

is all the resident keeps.

HHSC sets the personal needs allowance at $75 a month. After that, Medicare and health insurance premiums, and any income diverted to a community spouse, everything else becomes patient liability.

Your business office collects it. Every month. Medicaid pays only the gap between that liability and the facility rate.

FOUR ROLES. WHAT EACH ONE OWNS.

01 **Business office manager.** Owns the financial file end to end. Starts requesting documents in week one, not when the application is filed.

02 **Business office manager.** Knows the assigned MEPD specialist by name. HHSC tells you who it is.

03 **Business office manager.** Watches portal status daily for information requests. Those are answerable. Nobody answers them.

04 **MDS coordinator.** Treats the LTCMI as a payment document, not only a clinical one.

05 **Admissions.** Verifies the name and SSN on the paperwork match the Medicaid card at admission.

06 **Administrator.** Available to sign the 3618 or 3619. The 72-hour clock does not pause for a travel schedule.

INCOME OVER THE CAP IS A DEADLINE, NOT A DENIAL

The QIT is not a reason to wait. It is the reason to move today.

The day you learn income exceeds $2,982, tell the family or POA to open the trust account and fund it with that month's check. HHSC publishes a model instrument in MEPD Appendix XXXVI. You do not have to wait on a law office to start.

HHSC HANDBOOK F-6800

Income must be directed to the trust account during the calendar month in which it is received. Income not directed that month is countable income for that month.

Every month it sits unfunded is a month the resident is over the cap. That month is gone.

Two things get trusts rejected: it must be irrevocable, and it must name the state as residuary beneficiary. Whole income streams go in, not just the excess.

THE POINT

Collect on day one, or chase for ninety.

Both halves run through your building. The clinical half you own outright. The financial half depends on documents only your staff are positioned to ask for, early, while the relationship is new.

Two situations are genuinely attorney work: a look-back with real transfers in it, and a contested spousal resource allowance. Everything else on these fifteen pages is a workflow you can train.

Sources: HHSC MEPD Handbook Appendices XII, XVI, XXXIII, XXXVI, and sections F-6800, H-1500, R-3100; HHSC MDS Preparing for Medicaid Applicants; TMHP LTC User Guide for Forms 3618/3619; 40 TAC 19.2615. Figures effective January 1, 2026. Not legal advice.

Texas is state one. Forty-nine to go.