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State/Territory Name: Texas

State Plan Amendment (SPA) #: TX 25-0028

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

July 28, 2026

Emily Zalkovsky
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

RE: TN 25-0028

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Texas state plan amendment (SPA) to Attachment 4.19-D, TX 25-0028, which was submitted to CMS on September 24, 2025. This plan amendment implements the Patient Driven Payment Model for Long Term Care (PDPM LTC) rate methodology and payment rates for Nursing Facilities (NFs).

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of September 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Tom Caughey at 517-487-8598 or via email at Tom.caughey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **25-0028** **TX**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: **CENTER DIRECTOR**
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act § 1919
42 CFR §440.155

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ **$2,676,872**
b. FFY 2026 $ **$30,815,551**

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See attachment to blocks 7 & 8

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See attachment to blocks 7 & 8

9. SUBJECT OF AMENDMENT

The purpose of the amendment is to implement the Patient Driven Payment Model for Long Term Care (PDPM LTC) rate methodology and payment rates for Nursing Facilities (NFs). The Texas Health and Human Services Commission (HHSC) is making these changes in accordance with the 2024-25 General Appropriations Act (GAA), House Bill 1, 88th Texas Legislature, Regular Session, 2023 (Article II, HHSC, Rider 25), which provides appropriations for HHSC to develop and implement a Texas version of the federal PDPM reimbursement methodology to improve care in long-term stay NF services in the Medicaid program.

The proposal also implements the 2026-27 GAA, Senate Bill (S.B.) 1, 89th Legislature, Regular Session, 2025 (Article II, HHSC, Rider 25) and S.B. 457, 89th Legislature, Regular Session, 2025 to provide additional appropriations to fund dietary and administrative costs for NFs. The proposal modifies the reimbursement methodology to support the implementation of Rider 25 and S.B. 457. The proposal also discontinues the Direct Care Staff Enhancement Program and direct care spending requirements and implements the annual patient care expense ratio in accordance with S.B. 457. The proposed amendment also deletes information that is no longer applicable to the NF program from the state plan pages. The proposed amendment corrects inconsistencies in page numbering and improves the clarity of the NF section. The proposed amendment is effective September 1, 2025.

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Emily Zalkovsky

13. TITLE
State Medicaid Director

14. DATE SUBMITTED
September 24, 2025

15. RETURN TO
Emily Zalkovsky
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR CMS USE ONLY

16. DATE RECEIVED
September 24, 2025

17. DATE APPROVED
07/28/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
September 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

Attachment to Blocks 7 & 8 of CMS Form 179

Transmittal Number 25-0028

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19-D	Attachment 4.19-D
NF	NF
Page 1	Page 1 (TN 22-0013)
Page 11a.1	Page 11a.1 (new page)
Page 11a.2	Page 11a.2 (new page)
Page 11a.3	Page 11a.3 (new page)
Page 11a.4	Page 11a.4 (new page)
Page 11a.5	Page 11a.5 (new page)
Page 11a.6	Page 11a.6 (new page)
Page 11a.7	Page 11a.7 (new page)
Page 11a.8	Page 11a.8 (new page)
Page 11a.9	Page 11a.9 (new page)
Page 11a.10	Page 11a.10 (new page)
Page 11a.11	Page 11a.11 (new page)
Page 11a.12	Page 11a.12 (new page)
Page 11a.13	Page 11a.13 (new page)
Page 11a.14	Page 11a.14 (new page)

REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES BEFORE SEPTEMBER 1, 2025

The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority over Medicaid rates. HHSC determines nursing facility (NF) Medicaid payment rates after considering financial and statistical information analysis and the effect of the reimbursement on achieving program objectives, including economic conditions and budgetary considerations.

The RUG-III (resource utilization group) rates for NFs are available on the agency website, as outlined in Attachment 4.19-D Page 1. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private NF providers. The agency's fee schedule rates were set as of September 1, 2023, and are effective for services provided on or after that due date. All rates are published on https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf.

(l) General

(A) Uniform Rates. Reimbursement rates are uniform statewide for the same class of service.

(B) Unit of Service. The unit of service reimbursed is a day of care provided to a Medicaid client by a Medicaid contracted NF. A day is defined as a 24-hour period extending from midnight to midnight.

(C) Frequency of Rate Determination. Rates are determined for a period of two years based upon cost reports.

REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES ON OR AFTER SEPTEMBER 1, 2025

The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority over Medicaid rates. HHSC determines nursing facility (NF) Medicaid payment rates after considering financial and statistical information analysis and the effect of the reimbursement on achieving program objectives, including economic conditions and budgetary considerations.

The Patient Driven Payment Model for Long-Term Care (PDPM LTC) rates for NFs are available on the agency website, as outlined in Attachment 4.19-D Page 11a. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private NF providers. The agency's fee schedule rates were set as of September 1, 2025, and are effective for services provided on or after that due date. All rates are published on https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf.

(I) General

(A) Uniform Rates. Reimbursement rates are uniform statewide for the same class of service.

(B) Unit of Service. The unit of service reimbursed is a day of care provided to a Medicaid client by a Medicaid contracted NF. A day is defined as a 24-hour period extending from midnight to midnight.

(C) Frequency of Rate Determination. Rates are determined every two years based on cost reports.

(II) Cost Reporting

(A) Cost Reports. To ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires that each contracted provider submit an annual cost report and, if necessary, a supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent HHSC cost reporting rules and cost report instructions, on the cost report and/or any supplemental reports required by HHSC.

(B) Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, reimbursements will be based on a pro-forma approach. This approach involves using historical costs of delivering similar services and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

(C) Desk Reviews and Field Audits. HHSC conducts desk reviews and field audits of provider cost reports to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.

(D) Informal Reviews and Appeals. A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance.

(III) Rate Setting Methodology. HHSC calculates methodological NF rates for each rate component as defined below.

(A) PDPM LTC Classification. HHSC reimbursement rates for nursing facilities vary according to the assessed characteristics of Medicaid recipients based on minimum data set (MDS) assessment data.

(1) In each of the PDPM LTC groups, nursing facility residents are classified according to one of six nursing case-mix classifiers, one of three non-therapy ancillary (NTA) case-mix classifiers, and a Brief Interview for Mental Status (BIMS) classification, which indicates if a resident has cognitive impairment. For the case-mix adjusted rate components, the case-mix index (CMI) is assigned based on relevant MDS assessment data. The nursing and NTA case-mix classifiers and the BIMS classification are described below.

(a) Nursing Case-Mix Classifiers. A resident is assigned based on their level of acuity and the level of nursing care needed to address their health conditions effectively.

(b) NTA Case-Mix Classifiers. A resident is assigned one of three NTA case-mix classifications based on the presence of certain conditions or the need for certain extensive services found to be correlated with increases in NTA costs.

(c) BIMS Classification. A resident is assigned as qualifying for additional BIMS reimbursement if MDS assessment data indicates a cognitive impairment.

(2) PDPM LTC default groups are assigned using the lowest CMI among nursing case-mix classifiers, the lowest CMI among NTA case-mix classifiers, and without a BIMS classification of severe cognitive impairment. Both default groups will be reimbursed at the same total rate. If MDS assessment data is unavailable or invalid, a resident is assigned to 1 of 2 default groups. A default group assigns a temporary classification when MDS assessment data is incomplete or when an MDS assessment is missing. PDPM LTC default groups are assigned using the lowest CMI among nursing case-mix classifiers, the lowest CMI among NTA case-mix classifiers, and without a BIMS classification of severe cognitive impairment. Both default groups will be reimbursed at the same total rate.

(B) Reimbursement Determination.

(1) Rate Components. Under the PDPM LTC methodology, rates are comprised of seven cost related components: nursing rate component, NTA rate component, BIMS rate component, dietary rate component, operations rate component, administration rate component, and fixed capital asset rate component.

(a) Calculation of CMI-Adjusted Rate Components. HHSC adjusts the nursing component and the NTA component by the most recent corresponding CMI established for PDPM Medicare available for the rate year, as determined by the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The CMI-adjusted rate components are calculated as follows:

(i) Calculation of the Nursing Rate Component. HHSC determines a per diem cost for the nursing component by calculating a median of the allowable nursing costs defined in subparagraph (IV)(F)(1) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1.07, a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(ii) Calculation of the NTA Rate Component. HHSC determines a per diem cost for the NTA rate component by calculating a median of allowable NTA costs as defined in subparagraph (IV)(F)(2) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1. 07, a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(b) Calculation of the BIMS Rate Component. This rate component is calculated at 5 percent of the nursing rate component established for a nursing case-mix classifier associated with the highest CMI.

(c) Calculation of the Dietary Rate Component. HHSC calculates a median of allowable dietary costs defined in subparagraph (IV)(F)(4) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1.07 a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(d) Calculation of the Operations Rate Component. HHSC calculates a median of the allowable operations costs defined in subparagraph (IV)(F)(5) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1.07 a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(e) Calculation of the Administration Rate Component. HHSC calculates a median of the allowable administration costs defined in subparagraph (IV)(F)(6) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1.07 a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(f) Calculation of the Fixed Capital Assets Rate Component. HHSC calculates a median of allowable fixed capital costs defined in subparagraph (IV)(F)(7) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period and multiplied by 1.07 a mark-up factor to ensure the methodological rate component is calculated above the weighted median.

(g) Total Per Diem Rate Determination. For each of the PDPM LTC groups and default groups, the recommended total per diem rate is determined as the sum of the following seven rate components:

(i) Nursing rate component;

(ii) NTA rate component;

(iii) BIMS rate component;

(iv) Dietary rate component;

(v) Operations rate component;

(vi) Administration rate component; and

(vii) Fixed capital asset rate component.

(h) HIV/AIDS Add-On. Diagnosis codes for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in the MDS assessment data. PDPM LTC methodology establishes a special per diem add-on intended to reimburse nursing facilities for enhanced nursing and NTA costs associated with providing care to a resident with an HIV/AIDS diagnosis. The total HIV/AIDS add-on is a sum of the amounts discussed as follows:

(i) The nursing rate component per PDPM LTC group assigned to a qualifying resident will receive an 18 percent add-on amount.

(ii) The NTA rate component amount will receive an add-on amount, which is calculated as the difference between the resident's NTA rate component amount based on their assigned NTA case-mix classifier, and the NTA rate component amount associated with the NTA case-mix classifier with the highest CMI.

(iii) The total enhanced HIV/AIDS add-on is equal to the sum of subsections (i) and (ii). To receive add-on under PDPM LTC for a resident with an HIV/AIDS diagnosis, NFs must ensure clinical documentation supports the diagnosis and submit a billing claim including the following information:

i. Appropriate bill code for PDPM LTC rate with HIV/AIDS add-on, and
ii. Appropriate ICD-10 code in the diagnosis field on a billing claim.

(IV) Cost Finding Methodology.

(A) Cost reports. A nursing facility provider must file a cost report unless:

(A) The cost report would represent costs accrued during a time period immediately preceding a period of decertification if the decertification period was greater than either 30 calendar days or one entire calendar month; or

(B) The provider meets one or more of the following conditions:

(a) If the provider performed no billable services during the provider's cost-reporting period;

(b) If the cost-reporting period would be less than or equal to 30 calendar days or one entire calendar month.

(c) If circumstances beyond the provider's control, such as the loss of records due to natural disasters or removal of records from the provider's custody by a regulatory agency, make cost-report completion impossible;

(d) If all the contracts that the provider is required to include in the cost report have been terminated before the cost-report due date;

(e) If the total number of days that the provider performed service for recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period.

(B) Communication. When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for one of the reasons stated in paragraph (A) of this subsection.

(C) Exclusion of and adjustments to certain reported expenses. Providers are responsible for eliminating unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable costs from the cost report and to exclude entire cost reports from the reimbursement determination database if there is reason to doubt the accuracy or allowability of a significant part of the information reported.

(A) Cost reports included in the database used for reimbursement determination.

(i) Individual cost reports will not be included in the database used for reimbursement determination if:

1. there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

2. an HHSC examiner determines that reported costs are not verifiable.

(ii) If all cost reports submitted for a specific facility are disqualified through the application of subparagraph (1)(a)(i) or (ii) of this paragraph, the facility will not be represented in the reimbursement database for the cost report year in question.

(B) Occupancy adjustments. HHSC adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. HHSC adjusts the target occupancy rate to the lower of:

(i) 85 percent; or

(ii) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the base.

(D) Cost projections. HHSC projects certain expenses in the reimbursement base to normalize or standardize the reporting period and to account for cost inflation between reporting periods and the period to which the prospective reimbursement applies.

(E) The following apply to costs for nursing facilities:

(A) Medical costs. The following costs for medical services and items are allowable:

(a) nursing care;

(b) social services;

(c) regular, special, and supplemental diets, including tube feedings;

(d) non-legend drugs, with the exception of insulin, and alcoholic beverages unless prescribed for medicinal purposes. Alcoholic beverages:

(i) prescribed for medicinal purposes must include the dosage and frequency of the alcohol; and

(ii) not prescribed for medicinal purposes are at the expense of the recipient or family;

(e) for a recipient who is not eligible for Medicare Part D benefits, legend drugs that are not covered by the Medicaid Vendor Drug Program;

(f) for a recipient who is eligible for Medicare Part D benefits, legend drugs in a category that is not covered by Medicare Part D and that are not covered by the Medicaid Vendor Drug Program;

(g) regular laundry services, except dry cleaning;

(h) medical accessories, such as cannulas, tubes, masks, catheters, ostomy bags and supplies, IV fluids, IV equipment, and equipment that can be used by more than one person, such as wheelchairs, adjustable chairs, crutches, canes, mattresses, hospital-type beds, enteral pumps, trapeze bars, walkers, and oxygen equipment, such as tanks, concentrators, tubing, masks, valves, and regulators.

(i) Facilities are required to maintain, in good repair, equipment necessary to meet the needs of the recipient.

(ii) If a recipient desires equipment for exclusive use, its purchase is the responsibility of the recipient:

1. Only the recipient can use the equipment, and it must be identified as the personal property of the recipient.

2. Upon discharge from the facility, the recipient retains the equipment he purchased. If the recipient dies, the purchased equipment must be transferred to the estate. If it is donated or sold to the facility by the recipient or the estate, the transaction must be documented.

(iii) If a recipient owns a piece of equipment that is medically necessary, the facility must maintain and repair the equipment.

(iv) When Part B Medicare benefits are accessed to pay for equipment and accessories, the recipient or family may not be charged by the facility or supply company for any portion of these items;

(i) medical supplies, including, but not limited to tongue depressors, swabs, band aids, cotton balls, and alcohol; and

(j) basic personal hygiene items and services to meet the needs of the residents. The specific type or brand of personal hygiene items used by the facility must be disclosed to the recipient; then, if a recipient prefers to use a specific type or brand of a personal hygiene item(s) rather than the item(s) furnished by the facility, he may use his personal funds to purchase the item(s).

(i) Before purchasing or charging for the preferred item(s), the facility must secure written authorization from the recipient or family indicating his desired preference, the date, and signature of the person requesting the preferred item(s). The signature may not be that of an employee of the facility.

(ii) If the recipient's personal funds are used to purchase an item(s), the item(s) is for his sole use.

(iii) When the facility purchases personal hygiene item(s) with the recipient's personal funds, the facility must ensure that the item(s) is in an individual container or package that is labeled with the recipient's name. The facility is not held responsible for labeling personal hygiene items brought into the facility and not reported to the management.

(B) Chaplaincy or pastoral services. Expenses for chaplaincy or pastoral services are allowable costs.

(C) Voucherable costs. Any expenses directly reimbursable to the provider through a voucher payment and any expenses in excess of the limit for a voucher payment system are unallowable costs.

(D) Preferred items. Costs for preferred items that are billed to the recipient, responsible party, or the recipient's family are not allowable costs.

(E) Preadmission Screening and Annual Resident Review (PASARR) expenses. Any expenses related to the direct delivery of specialized services and treatment required by PASARR for residents are unallowable costs.

(F) Advanced Clinical Practitioner (ACP) or Licensed Professional Counselor (LPC) services. Expenses for services provided by an ACP or LPC are unallowable costs.

(G) Limits on contracted management fees. To ensure that the results of HHSC's cost analyses accurately reflect the costs that an economical and efficient provider must incur, HHSC may place upper limits on contracted management fees and expenses included in the administration rate component. HHSC sets upper limits at the 90th percentile of all costs per unit of service as reported by all contracted facilities using the cost report database immediately preceding the database used to establish reimbursements in paragraph (III)(B).

(F) Cost Determination by Rate Component. HHSC combines adjusted expenses from the rate base to determine seven rate-related components.

(1) Nursing Rate Component. The nursing rate component includes compensation costs for employee and contract labor Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs) and Minimum Data Set (MDS) coordinators; Licensed Vocational Nurses (LVNs), including DONs, ADONs, and MDS coordinators; medication aides; restorative aides; nurse aides performing nursing related duties for Medicaid contracted beds; and certified social worker and social service assistant wages. For facilities providing care for qualifying ventilator-dependent residents, Registered Respiratory Therapists and Certified Respiratory Therapy Technicians are included in the nursing rate component.

(2) Non-Therapy Ancillary (NTA) Rate Component. The NTA rate component includes the cost of providing care to residents with certain comorbidities or the use of certain extensive services. This rate component includes central supply costs, including central supply staff compensation and benefits; and other direct care non-professional staff wages, including medical records staff compensation and benefits; ancillary costs, including ancillary staff compensation and benefits; diagnostic laboratory and radiology costs; durable medical equipment purchase, rent, or lease costs; oxygen costs; and pharmaceuticals; therapy consultant costs; and other ancillary supplies and services purchased by a nursing facility.

(3) Brief Interview for Mental Status (BIMS) Rate Component. The BIMS rate component includes additional staff costs associated with providing care to residents with a BIMS score between 0 and 7 or a determination of severe or moderate impairment based on the calculation of the PDPM cognitive level for residents without a BIMS score on the MDS.

(4) Dietary Rate Component. The dietary rate component includes compensation, payroll taxes, benefits, and workers' compensation claims for the following staff types: food service supervisory and professional staff, other food service staff, and dietitian/nutritionist staff. This rate component also includes the following non-staff costs: dietary supplies and contracted dietary services costs.

(5) Operations Rate Component. The operations component includes the following expenses: compensation, payroll taxes, benefits, and worker's compensation claims for activity director, activity services assistants, laundry and housekeeping staff, and other facility and operations staff, not including transportation and maintenance staff expenses. This rate component also includes the following non-staff costs; including, non-durable equipment and supplies, operations supplies, and other contracted services.

(6) Administration Rate Component. The administration rate component includes the following expenses: compensation, payroll taxes, benefits, and workers' compensation claims for executive administrator, assistant administrator, administrative assistants, owner, other administrative staff, transportation and maintenance staff, and central office staff. This rate component also reflects the following non-staff costs: utilities; telecommunications; other interest; insurance, excluding liability insurance expenses reimbursed under subsection (VIII) of this section; staff training and seminars; staff travel costs including personal mileage reimbursement; management contract fees; contracted administrative, professional, consulting and training services; licenses and permits; other taxes excluding non-administrative staff payroll taxes; advertising, allowable dues and membership; transportation costs.

(7) Fixed Capital Asset Rate Component. The fixed capital asset rate component includes building and building equipment depreciation and lease expense, mortgage interest, land improvement depreciation, and leasehold improvement amortization.

(G) Exclusion of Certain Reported Expenses. Providers are responsible for eliminating unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable costs from the cost report and to exclude entire cost reports from the reimbursement determination database if there is a reason to doubt the accuracy or allowability of a significant part of the information reported.

(H) Projected Costs. HHSC projects NF providers' costs by accounting for changes in cost-related conditions anticipated to occur between the base period and the prospective rate period. Such changes include, but are not limited to, wage and price inflation or deflation, changes in program utilization, modifications of federal or state regulations and statutes, and implementation of federal court orders and settlement agreements. The base period is a single state fiscal year spanning from September 1 through August 31, and the prospective rate period is two state fiscal years beginning with the first day of a state fiscal year, which is at least one fiscal year after the base period year. Inflation factors and multipliers that HHSC uses to project costs from the base period to the prospective rate period are determined per subsections (H)(1) through (H)(4):

(A) General Inflation Index. For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.

(B) Item-Specific and Program-Specific Inflation Indices. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

(C) For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic review of the chosen inflation index will be performed on cumulative cost report data on nursing wages and salaries.

(D) Adjustment of Tax Rates. HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages.

(V) HHSC establishes an annual patient care expense ratio for nursing facilities on or after September 1, 2025. The patient care expense ratio is calculated as described in the following subsections of this section.

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

(a) Annual patient expense ratio--The ratio of patient care expenses as defined in paragraph (2) of this subsection to the NF's patient care revenue as defined in paragraph (3) of this subsection for a rate year as defined in paragraph (4) of this subsection.

(b) Patient care expenses—

(i) Include allowable expenses incurred by an NF in a rate year for the following cost areas:

1. Compensation and benefits for direct care staff and direct care contracted labor for the following staff: licensed registered nurse; licensed vocational nurse; medication aide; restorative aide; nurse aide who provides nursing-related care to residents occupying medical assistance beds; licensed social worker; social services assistant; additional staff associated with providing care to facility residents with a severe cognitive impairment; nonprofessional administrative staff, including medical records staff and accounting or bookkeeping staff; central supply staff and ancillary facility staff; laundry staff; housekeeping staff; and food service staff.

2. Central supply costs and ancillary costs for facility services and supplies, including diagnostic laboratory and radiology costs; durable medical equipment costs, including costs to purchase, rent, or lease the equipment; costs for oxygen used to provide oxygen treatment; prescription and nonprescription drug costs; therapy consultant costs.

3. Costs for dietary and nutrition services, including costs for food services and related supplies, and nutritionist services; and

(ii) Exclude the following:

1. Administrative or operational costs, other than administrative or operational costs described in (a) of this subsection, and fixed capital assets costs.

(c) Patient care revenue--In a rate year, the medical assistance revenue paid to an NF where the revenue is associated with the following rate components as described in (III)(B)(1) of this section:

(i) Nursing rate component;

(ii) NTA rate component;

(iii) BIMS rate component;

(iv) Dietary rate component; and

(v) Operations rate component.

(d) Rate year--The rate year begins on the first day of September and ends on the last day of August of the following year and aligns with the NF's annual cost reporting period.

(B) Reporting requirements. An NF must submit an annual cost report in accordance with subsection (II) and subsection (IV) of this section. HHSC will examine the cost report in accordance with subsection (II) of this section.

(C) Determining the annual patient expense ratio and spending requirement. HHSC will calculate an NF's annual patient expense ratio to ensure the NF's patient expense ratio is at least 80 percent.

(D) Recoupment. An NF that fails to meet the annual patient expense ratio is subject to a spending requirement and recoupment calculated as follows.

(a) HHSC will calculate a spending requirement for the rate year by multiplying the patient care revenues as defined in subsection (A)(3) of this section by 0.80.

(b) HHSC will calculate a total patient care expense amount by summing the allowable patient care expenses as defined in (A)(2) of this subsection accrued during the rate year.

(c) The estimated recoupment will be calculated by subtracting paragraph (2) of this subsection from paragraph (1) of this subsection. HHSC or its designee will recoup the difference from an NF whose patient care expenses are less than its spending requirement.

(E) Recoupment exclusions. HHSC may not recoup a medical assistance reimbursement amount under this section if the NF meets one of the following conditions during the rate year.

(a) The NF held at least a four-star rating under the Centers for Medicare and Medicaid Services (CMS) five-star quality rating system for nursing facilities in three or more of the following categories:

(i) Overall, health inspections, staffing, and long-stay quality measures.

(b) The NF:

(i) Maintained an average daily occupancy rate of 75 percent or less; and spent at least 70 percent of the patient care revenue as defined in subsection (A)(3) of this section on patient care expenses as defined in subsection (A)(2)(a) of this section.

(c) The NF incurred expenses related to a disaster for which the governor issued a disaster declaration under Texas Government Code Chapter 418.

(F) Notification of recoupment based on annual cost reports. HHSC will notify an NF that failed to meet the annual patient care expense ratio of the associated spending requirement and recoupment.

(G) State-owned facilities. This section does not apply to state-owned facilities.

(VI) Medicaid Liability Insurance Add-On. On or after September 1, 2025, HHSC determines the payment rate for purchased liability insurance as follows:

(A) HHSC determines the total portion of Medicaid's liability insurance costs using the most recently examined NF cost report data.

(B) HHSC divides Medicaid's total liability insurance costs by the number of days of service in the reporting period used for paragraph (A) of this subsection to calculate the average daily liability insurance Medicaid add-on payment rate.

(C) HHSC adjusts the payment rate for purchased Medicaid liability insurance.

(D) HHSC pays the same Medicaid add-on rate for providers who purchase general liability insurance without professional liability insurance, providers who purchase professional liability insurance without general liability insurance, and providers who purchase both general and professional liability insurance.