

## **Table of Contents**

**State/Territory Name: Texas**

**State Plan Amendment (SPA) #: TX 25-0037**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S3-14-28  
Baltimore, Maryland 21244-1850



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**Financial Management Group**

June 2, 2026

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

RE: TN 25-0037

Dear Director Zalkovsky:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Texas state plan amendment (SPA) to Attachment 4.19-A, TX 25-0037, which was submitted to CMS on September 29, 2025. This plan amendment updates reimbursement methodologies for hospitals inpatient services to include an obstetrics-gynecology (OBGYN) add-on to eligible rural hospitals standard dollar amount (SDA) rates and makes other non-substantive clarifications.

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](mailto:tom.caughey@cms.hhs.gov).

Sincerely,



Rory Howe  
Director  
Financial Management Group

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER  
2 5 0 0 3 7

2. STATE  
T X

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 § 1902(a)(30)  
42 CFR §440.10 and 42 CFR §440.20

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
FFY 2025 \$ 351,623  
FFY 2026 \$ 4,207,523

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
  
Attachment 4.19-A  
Page 3  
Page 3a  
Page 3a.1  
Page 8h  
Page 8h.1

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
  
Attachment 4.19-A  
Page 3 (TN 21-0032)  
Page 3a (TN 23-0038)  
Page 3a.1 (TN 21-0032)  
Page 8h (TN 23-0038)  
Page 8h.1 (new page)

9. SUBJECT OF AMENDMENT

This amendment updates reimbursement methodologies for hospitals inpatient services to include an obstetrics-gynecology (OB-GYN) add-on to eligible rural hospitals standard dollar amount (SDA) rates and makes other non-substantive clarifications.

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 Signature]

12. TYPED NAME  
Emily Zalkovsky

13. TITLE  
State Medicaid Director

14. DATE SUBMITTED  
September 29, 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 29, 2025

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL  
September 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

[Redacted Signature]

20. TYPED NAME OF APPROVING OFFICIAL  
Rory Howe

21. TITLE OF APPROVING OFFICIAL  
Director, FMG

22. REMARKS

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT  
HOSPITAL SERVICES (continued)**

- (21) Interim rate—The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.
- (22) Mean length of stay (MLOS)—One factor used in determining the payment amount calculated for each DRG, the average number of inpatient days.
- (23) Medical education add-on—An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.
- (24) Military hospital—A hospital operated by the armed forces of the United States.
- (25) New Hospital—A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.
- (26) Obstetrics and Gynecology (OB-GYN) add-on—An adjustment to the base SDA for a rural hospital that operates an obstetrics and gynecology department.
- (27) Obstetrics and Gynecology Department- A department that provides services as outlined in 42 CFR § 482.59
- (28) Out-of-state children's hospital—A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.
- (29) Realignment- Recalculation of the base SDA and add-ons using current RCCs, inflation factors, and base year claims as specified by HHSC, or its designee, for one or more hospital types. Realignment will occur based on legislative direction.
- (30) Rebasing—Calculation of SDAs and add-ons, DRG relative weights, MLOS, and day outlier thresholds for all hospitals using a base period as specified by HHSC, or its designee. Rebasing will occur based on legislative direction.
- (31) Relative weight—The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.
- (32) Rural base year stays- An individual set of base year stays is compiled for rural hospitals for the purposes of rate setting and realignment. All inpatient FFS claims and inpatient Managed Care encounters for reimbursement filed by a rural hospital that:
  - (A) had a date of admission occurring within a base year;
  - (B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such stays that had zero inpatient days;
  - (C) were not stays for patients who are covered by Medicare; and
  - (D) were not Medicaid spend-down stays; and were not stays associated with military hospitals out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT  
HOSPITAL SERVICES (continued)**

(33) Rural hospital—A hospital that:

(A) is located in a county with 68,750 or fewer persons based on the 2020 decennial census;  
or

(B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or

(C) meets all of the following criteria:

(i) has 100 or fewer beds;

(ii) is designated by Medicare as a CAH, SCH, or RRC; and

(iii) is located in an MSA.

(34) Safety-Net add-on—An adjustment to the base SDA for a safety-net hospital to reflect the higher costs of providing Medicaid inpatient services in a hospital that provides a significant percentage of its services to Medicaid and/or uninsured patients.

(35) Safety-Net hospital—An urban or children's hospital that meets the eligibility and qualification requirements described in Appendix 1 to Attachment 4.19-A (relating to Disproportionate Share Hospital Reimbursement Methodology) in the Texas State Medicaid Plan for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

(36) Standard Dollar Amount (SDA)—A standardized payment amount calculated by HHSC, as described for the costs incurred by prospectively paid hospitals in Texas for furnishing covered inpatient hospital services.

(37) State-owned teaching hospital—Acute Care Hospital owned and operated by the state of Texas.

(38) Teaching hospital—A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(39) Teaching medical education add-on—An adjustment to the base SDA for children's teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children's hospitals.

(40) TEFRA target-cap—A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to the hospital's cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT**

**HOSPITAL SERVICES (continued)**

- (41) Tentative settlement—Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.
- (42) Texas provider identifier (TPI)—A unique number assigned to a provider of Medicaid services in Texas.
- (43) Trauma add-on—An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations. To be eligible for the trauma add-on, a hospital must be eligible to receive an allocation from the trauma facilities and emergency medical services account under Texas Health and Safety Code Chapter 780.
- (44) Trauma hospital—An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation.
- (45) Universal mean—Average base year cost per claim for all urban hospitals.
- (46) Urban hospital—Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT  
HOSPITAL SERVICES (continued)**

- (B) Full-cost SDA. Calculate a hospital-specific full-cost SDA by dividing each hospital's base year cost, calculated as described in subparagraph (A) of this paragraph, by the sum of the relative weights for the rural base year stays.
- (C) Calculating the SDA floor and ceiling.
- (i) Calculate the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.
  - (ii) Calculate the standard deviation of the hospital-specific SDAs identified in subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.
  - (iii) Calculate an SDA floor as clause (i) minus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.
  - (iv) Calculate an SDA ceiling as clause (i) plus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.
- (D) Assigning a final hospital-specific SDA.
- (i) If the adjusted hospital-specific SDA from subparagraph (B) is less than the SDA floor in subparagraph (C)(iii) of this paragraph, the hospital is assigned the SDA floor amount as the final SDA.
  - (ii) If the adjusted hospital-specific SDA from subparagraph (B) is more than the SDA ceiling in subparagraph (C)(iv), the hospital is assigned the SDA ceiling amount as the final SDA.
  - (iii) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in clauses (i) and (ii) of this subparagraph.
- (E) A rural hospital may receive increases to the base SDA for any of the following.
- (i) Eligibility. Rural hospitals must operate both obstetrics and gynecology departments to be eligible for the OB-GYN add-on.
  - (ii) Add-On Amount. HHSC calculates the OB-GYN add-on amounts annually or at the time of realignment as follows.
    - I. The add-on will be applied to the calculation described in section C to determine a fixed add-on amount.
    - II. The fixed amount will be added to the hospital-specific SDA rate.
- (F) Add-on status verification.
- (i) Notification. HHSC will determine a hospital's initial add-on status by reference to the attestation forms submitted by rural hospitals annually in combination with the response to survey(s) implemented by HHSC. HHSC may post the information on its website, send it through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send it through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.
  - (ii) During realignment, HHSC will calculate a hospital's final SDA using the add-on status

## METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT

### HOSPITAL SERVICES (continued)

initially determined by HHSC unless, within 14 calendar days after the date of the notification, the HHSC Provider Finance Department receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect; and

(iii) The hospital provides documentation of its eligibility for an OB-GYN add-on.

(G) Annually, HHSC will calculate a hospital's final SDA using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(i) The hospital provides documentation of the new OB-GYN departments.

(ii) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(2) Alternate SDA for labor and delivery. For labor and delivery services provided by rural hospitals on or after September 1, 2023, the final SDA is the alternate SDA for labor and delivery stays, which is equal to the final SDA determined in paragraph (1)(D) of this subsection plus an SDA add-on sufficient to increase paid claims by no less than \$1,500.

(3) HHSC calculates a new rural hospital's final SDA as follows.

(A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA in paragraph (1)(C)(i) of this subsection.

(B) The mean rural SDA assigned in subparagraph (A) of this paragraph remains in effect until the next realignment.

(4) Biennial review of rural rates. Every two years, HHSC will calculate new rural SDAs using the methodology in this subsection to the extent allowed by federal law.