The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §355.304, concerning Direct Care Staff Spending Requirement on or after September 1, 2023; §355.306, concerning Cost Finding Methodology; §355.307, concerning Reimbursement Setting Methodology; and §355.308, concerning Direct Care Staff Rate Component; the repeal of §355.309, concerning Performance-based Add-on Payment Methodology; and §355.314, concerning Supplemental Payments to Non-State Government-Owned Nursing Facilities; and new §355.318, concerning Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025; and §355.320, concerning Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement the 2024-25 General Appropriations Act (GAA), House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 25). Rider 25 provides appropriations for HHSC to "develop and implement a Texas version of the Patient Driven Payment Model (PDPM) methodology for the reimbursement of long-term stay nursing facility services in the Medicaid program to achieve improved care for long-term stay nursing facility services, excluding services provided by a pediatric care facility or any state-owned facilities."

The proposal amends §355.304, concerning Direct Care Staff Spending Requirement on or after September 1, 2023, to specify how the spending requirement will operate under PDPM Long-Term Care (LTC). The proposal amends the title of §355.306 to "Cost Finding Methodology before September 1, 2025," and revises the rule text to replace "Rate Analysis Department" with "Provider Finance Department." The title of §355.307 is amended to "Reimbursement Setting Methodology before September 1, 2025" and the title of §355.308 is amended to "Direct Care Staff Rate Component before September 1, 2025." The revised titles clarify that the rules are in effect until September 1, 2025, when the PDPM LTC methodology is implemented. The proposal repeals §355.309, concerning Performance-based Add-on Payment Methodology and §355.314, concerning Supplemental Payments to Non-State Government-Owned Nursing Facilities, as these rules are no longer applicable to nursing facility reimbursement. Finally, the proposal adds new rules §355.318, concerning Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025, and §355.320, concerning Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025. The new rules operationalize the rider requirements, enabling HHSC to implement PDPM LTC.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.304 updates references and adds new definition "nursing care staff base rate" to subsection (b). The proposed amendment also adds new subsection (k), which outlines how the spending requirements for

September 1, 2023, will operate under PDPM LTC once it is implemented. Formatting edits are made to account for the addition of a definition.

The proposed amendment to §355.306 changes the title to "Cost Finding Methodology before September 1, 2025," and revises the rule text to replace "Rate Analysis Department" with "Provider Finance Department." Other edits are made to hyphenate terms and correct punctuation.

The proposed amendment to §355.307 changes the title to "Reimbursement Setting Methodology before September 1, 2025."

The proposed amendment to §355.308 changes the title to "Direct Care Staff Rate Component before September 1, 2025."

The proposal repeals §355.309 and §355.314, because these rules no longer apply to nursing facility reimbursement.

Proposed new §355.318(a) introduces the new PDPM LTC methodology. Subsection (b) defines terms used in the rule. Subsection (c) outlines the PDPM LTC classification system. Subsection (d) defines the PDPM LTC rate components and specifies cost categories included in each of the rate components. Subsection (e) outlines reimbursement determination for total per diem rates, including base rate calculation, calculation of all rate components, and the HIV/AIDS rate add-on. Subsection (f) defines reimbursement for hospice care in a nursing facility. Subsection (g) revises the cost finding methodology currently described under §355.306 and outlines how it will operate under PDPM LTC. The proposal also limits the costs associated with contracted management fees to ensure that they are reasonable. Subsection (h) defines the reimbursement methodology for special reimbursement classes of nursing facilities (without change according to §355.307). Subsection (i) incorporates and updates language outlining reimbursement for nurse aide training and competency evaluation costs. Subsection (j) specifies that adopted rates are limited to available levels of appropriated state and federal funds.

Proposed new §355.320 changes the name of the Direct Care Staff Enhancement Program specified in §355.308 to the Nursing Care Staff Enhancement Program to align with rate components under PDPM LTC. The amendment incorporates revisions to the program. Subsection (a) introduces the Nursing Care Staff Rate Enhancement Program for nursing facilities on or after September 1, 2025. Subsection (b) defines terms used in the rule. Subsection (c) outlines the enrollment process for new facilities willing to participate in the Nursing Care Staff Rate Enhancement Program. Subsection (d) outlines reporting requirements for participants in the rate enhancement program. Subsection (e) outlines vendor hold payments for participating facilities. Subsection (f) defines requirements for completion of staffing and compensation reports for the rate enhancement program. Subsection (g) outlines rate enhancement program enrollment limitations. Subsection (h) determines the nursing care staff component enhancements. Subsection (i) outlines the process for granting nursing care staff rate enhancement. Subsection (j) outlines how the total nursing rate component is

determined for each participating facility. Subsection (k) establishes nursing care staff spending requirements for participating facilities and describes how recoupment is calculated. The proposal sets new requirements that no longer include staffing requirements associated with Licensed Vocational Nurse (LVN) equivalent minutes, as outlined in §355.308(j). Subsection (l) explains the process for mitigating recoupment of funds described in §355.320(k). Subsection (m) discusses adjustments to spending requirements. Subsection (n) outlines the process for voluntary withdrawal from the rate enhancement program. Subsection (o) outlines how HHSC notifies participating facilities about recoupments based on Annual Staffing and Compensation Reports. Subsection (p) outlines the reporting process for facilities required to submit a Staffing and Compensation Report due to a change of ownership or contract termination. The proposal also establishes responsibility for the reporting requirement for a new owner. Subsection (q) defines undocumented nursing care staff and contract labor compensation costs as unallowed in case a facility fails to document staff spending. Subsection (r) outlines the process of informal reviews and formal appeals for participating facilities. Subsection (s) outlines participation in the Nursing Care Staff Rate Enhancement Program if a facility's contract is canceled. Subsection (t) outlines how HHSC determines a facility's compliance with spending requirements in the aggregate for entities that control more than one participating nursing facility contract. Subsection (u) outlines the Medicaid Swing Bed Program for Rural Hospitals. Subsection (v) outlines how HHSC will notify providers about a lack of available funds for participation in the rate enhancement program.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, there will be an estimated additional cost to state government as a result of enforcing and administering the rules as proposed. Enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of local government.

The effect on state government for each year of the first five years the proposed rules are in effect is an estimated cost of $39,468,477 GR ($99,920,196 AF) in FY 2026, $39,468,477 GR ($99,920,196 AF) in FY 2027, $39,468,477 GR ($99,920,196 AF) in FY 2028, $39,468,477 GR ($99,920,196 AF) in FY 2029, $39,468,477 GR ($99,920,196 AF) in FY 2028, $39,468,477 GR ($99,920,196 AF) in FY 2030.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:

(1) the proposed rules will not create or eliminate a government program;

(2) implementation of the proposed rules will not affect the number of HHSC employee positions;

(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;

(4) the proposed rules will not affect fees paid to HHSC;

(5) the proposed rules will create a new regulation;

(6) the proposed rules will not expand, limit, or repeal existing regulations;

(7) the proposed rules will not change the number of individuals subject to the rules; and

(8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. HHSC does not anticipate additional costs as a result of the proposed rules. Rider 25 of the 2024-2025 GAA provides additional appropriations for nursing facility reimbursements under the proposed methodology. The proposed methodology does not include specific changes to direct care staffing ratios, training, or assumed compensation. The proposed methodology will use a new classification system for assigning residents to certain care groups. The assessment requirements are the same for both the current and the proposed methodologies and use the Minimum Data Set Resident Assessment Instrument.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of the Provider Finance Department, has determined that for each year of the first five years the rules are in effect, the public benefit will be to improve care for long-term stay nursing facility services and incentivize client care and quality of services.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with

the proposed rules because rate increases are anticipated to offset any economic costs to comply with the rules.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing to receive comments on the proposal will be held on May 21, 2024, at 9:00 AM at the HHSC's Public Hearing Room 125W in the John H. Winters Building located at 701 W. 51st Street, Austin, TX 78751.

Please contact the HHSC Provider Finance Department Long-Term Services and Supports at PFD-LTSS@hhs.texas.gov or (512) 730-7401, if you have questions.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030, or street address 4601 W. Guadalupe Street, Austin, Texas 78751; or by email to PFD-LTSS@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R019" in the subject line.

STATUTORY AUTHORITY

The amendments and new sections are authorized by Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

The amendments and new sections affect Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

<rule>

§355.304. Direct Care Staff Spending Requirement on or after September 1, 2023.

(a) (No change.)

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

(1) Direct care staff base rate--The direct care staff base rate is calculated in accordance with §355.308(k) of this subchapter [~~chapter~~] (relating to Direct Care Staff Rate Component before September 1, 2025).

(2) Direct care staff cost center--This cost center will include compensation for employee and contract labor Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs); Licensed Vocational Nurses (LVNs), including DONs and ADONs; medication aides; and nurse aides performing nursing-related duties for Medicaid contracted beds.

(3) Nursing care staff base rate--The nursing care staff base rate is calculated in accordance with §355.318(d) of this subchapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025).

(4)[~~(3)~~] Rate year--The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(5)[~~(4)~~] Responsible entity--The contracted provider, owner, or legal entity that received the revenue to be recouped is responsible for the repayment of any recoupment amount.

(c) - (j) (No change).

(k) Transition to Patient Driven Payment Model (PDPM) for Long-Term Care (LTC). Effective September 1, 2025, HHSC will utilize the PDPM LTC reimbursement methodology for nursing facilities as described in §355.318 of this subchapter. HHSC will adopt new rates for PDPM LTC with the intent of supporting the new classification system and maintaining the September 1, 2023, direct care rate increases as part of the nursing rate component. HHSC will hold providers accountable to nursing care staff spending requirements under the PDPM LTC as follows.

(1) HHSC will transition direct care rates to the nursing component under PDPM LTC as follows.

(A) HHSC will calculate a nursing component base rate as specified in §355.318 of this subchapter. The nursing component base rate will be proportional to the direct care rate component revenue effective August 31, 2023 and any additional revenue appropriated for direct care.

(B) HHSC will reallocate the portion of the direct care component of the RUG-III rates associated with increases effective September 1, 2023, described in subsection (d) of this section, to the nursing rate component of the PDPM LTC rates. Reallocation will be proportional based on the case-mix indices (CMI) applicable to the nursing case-mix classifiers.

(2) Nursing care staff base rate spending floor under PDPM LTC will be calculated as follows.

(A) HHSC will calculate a nursing care staff base rate spending floor by multiplying accrued Medicaid fee-for-service and managed care nursing care staff revenues proportional to the nursing staff base rate specified in paragraph (1)(A) of this subsection by 0.70 for each provider.

(B) Accrued allowable Medicaid nursing care staff expenses for the rate year will be compared to the base rate spending floor from subparagraph (A) of this paragraph. If the base rate spending floor is less than the accrued allowable Medicaid nursing care staff expenses, HHSC or its designee will notify the provider as specified in subsection (g) of this section. There will be no recoupment associated with a provider's failure to meet the nursing care base rate spending floor specified in this paragraph.

(3) Total Nursing Care Spending Floor will be calculated as follows.

(A) At the end of the rate year, HHSC will calculate the nursing care spending floor by multiplying accrued Medicaid fee-for-service and managed care nursing care staff revenues proportional to the nursing care staff rate increases specified in paragraph (1)(B) of this subsection by 0.90 and the nursing care staff base rate spending floor as specified in paragraph (2)(A) of this subsection.

(B) Accrued allowable Medicaid nursing care staff expenses for the rate year will be compared to the total nursing care staff spending floor from subparagraph (A) of this paragraph. If the nursing care spending floor is less than the accrued allowable Medicaid nursing care staff expenses, HHSC or its designee will recoup the difference between the nursing care spending floor and the accrued allowable Medicaid nursing care staff expenses from providers whose Medicaid nursing care staff spending is less than their nursing care spending floor.

(4) At no time will a provider's nursing care rates after recoupment be less than the nursing care base rates as defined in paragraph (1)(A) of this subsection.

(5) For participants in the nursing care staff enhancement program, HHSC will calculate spending requirements as specified under §355.320(k) of this subchapter

(relating to Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025).

§355.306. Cost Finding Methodology before September 1, 2025.

(a) – (f) (No change.)

(g) Allowable appraised property values. Allowable appraised property values are determined as follows:

(1) Proprietary facilities. The allowable appraised values of proprietary facilities to be reported on Texas Medicaid cost reports are determined from local property taxing authority appraisals. The year of the property appraisal must be the calendar year within which the provider's cost report fiscal year ends, or the prior calendar year.

(2) Tax-exempt [~~Tax-exempt~~] facilities. The allowable appraised property values for tax-exempt [~~tax-exempt~~] facilities are determined as follows.

(A) Tax-exempt [~~Tax-exempt~~] facilities provided an appraisal from their local property taxing authority. Tax-exempt [~~Tax-exempt~~] facilities provided an appraisal from their local property taxing authority must report this appraised value on their Texas Medicaid cost report. The year of the property appraisal must be the calendar year within which the provider's cost report fiscal year ends, or the prior calendar year.

(B) Tax-exempt [~~Tax-exempt~~] facilities not provided an appraisal from their local property taxing authority. Tax-exempt [~~Tax-exempt~~] facilities not provided an appraisal from their local property taxing authority because of an "exempt" status must provide documentation received from the local taxing authority certifying exemption for the current reporting period and must contract with an independent appraiser to appraise the facility land and improvements. These independent appraisals must meet the following criteria.

(i) The appraisal must value land and improvements using the same basis used by the local taxing authority under Texas laws regarding appraisal methods and procedures.

(ii) The appraisal must be updated every five years, with the initial appraisal setting the five-year interval.

(I) Facilities achieving exempt status during their fiscal year ending in calendar year 1997 or a subsequent year must submit an initial appraisal to HHSC's Provider Finance [~~Rate Analysis~~] Department as part of their cost report for the fiscal year during which the exempt status was achieved. This appraisal must be reflective of the facility's appraised value during that fiscal year.

(II) If a facility is reappraised due to improvements or reconstruction as defined in clause (iii) of this subparagraph, a new five-year interval will be set.

(iii) Facilities making capital improvements[~~,~~] or requiring reconstruction due to fire, flood, or other natural disaster, when the improvements or reconstruction cost more than $2,000 per licensed bed, may contract with an independent appraiser to have land and improvements reappraised within the cost reporting period in which the improvements are [~~improvement(s) is~~] placed into service.

(iv) If for any reason an appraisal becomes available from the local taxing authority for a provider who previously lacked such an appraisal, the provider must report, on the next Texas Medicaid cost report submitted, the local taxing authority's appraised values instead of the independent appraisal values.

(3) Governmental facilities. Governmental facilities are exempt from the requirement to report an appraised property value.

(h) (No change.)

§355.307. Reimbursement Setting Methodology before September 1, 2025.

(a) - (f) (No Change.)

§355.308. Direct Care Staff Rate Component before September 1, 2025.

(a)-(dd) (No Change.)

§355.318. Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) establishes the Patient Driven Payment Model (PDPM) for Long-Term Care (LTC) described in this section to reimburse nursing facilities on or after September 1, 2025. The PDPM LTC methodology will be implemented pending necessary system modifications.

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

(1) Brief interview for mental status (BIMS)--BIMS is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a nursing facility. BIMS is a part of minimum data set (MDS) assessment data. It is used to determine if a resident has a severe cognitive impairment, which necessitates additional reimbursement under the PDPM LTC classification system.

(2) Case-mix classifiers--These classifiers are codes based on MDS assessment data used to differentiate between case-mix index (CMI)-adjusted groups for the nursing and non-therapy ancillary (NTA) rate components.

(3) Case-mix index (CMI)--CMI is a relative value based on assessment data used to assign nursing facility residents to a diagnosis-related group for CMI-adjusted rate components.

(4) Minimum data set (MDS) assessment data--MDS is clinical assessment data collected by Medicare and Medicaid-certified nursing facilities as a part of a federally mandated process. MDS assessment data provide a comprehensive evaluation of each resident's functional capabilities, comorbidities, and health conditions and are used to determine case-mix classifiers and PDPM LTC groups.

(5) Patient Driven Payment Model (PDPM) Long-Term Care (LTC) classification system--This classification system is used to classify Medicaid recipients who reside in a nursing facility into 1 of 36 PDPM LTC groups based on MDS assessment data. If MDS assessment data is unavailable or invalid, a resident is assigned to 1 of 2 default groups.

(6) Patient Driven Payment Model (PDPM) Long-Term Care (LTC) default group--A default group assigns a temporary classification when MDS assessment data is incomplete or in error or when an MDS assessment is missing.

(7) Patient Driven Payment Model (PDPM) Long-Term Care (LTC) group--Each group represents a unique combination, including a nursing case-mix classifier, an NTA case-mix classifier, and a BIMS classification. PDPM LTC groups are used to calculate total per diem rates under the PDPM LTC classification system.

(c) PDPM LTC classification. HHSC reimbursement rates for nursing facilities vary according to the assessed characteristics of Medicaid recipients based on 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 NTA case-mix classifiers; and a BIMS classification, which indicates if a resident has severe cognitive impairment. For the case-mix adjusted rate components, the 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 to one of six nursing case-mix classifications 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 severe 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.

(d) PDPM LTC rate components. Total per diem PDPM LTC rates consist of the following four rate components. Costs used in HHSC's determination of the following rate components are subject to the cost-finding methodology as specified in subsection (g) of this section.

(1) Nursing rate component. This rate component includes compensation costs for employee and contract labor Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs); Licensed Vocational Nurses (LVNs), including DONs and ADONs; medication aides; restorative aides; nurse aides performing nursing-related duties for Medicaid contracted beds; certified social worker and social service assistant wages; and other direct care non-professional staff wages, including medical records staff compensation and benefits.

(A) Compensation to be included for these employee staff types is the allowable compensation defined in §355.103(b)(1) of this chapter (relating to Specifications for Allowable and Unallowable Costs) that is reported as either wages (including payroll taxes and workers' compensation) or employee benefits. Benefits required by §355.103(b)(1)(A)(iii) of this chapter to be reported as costs applicable to specific cost report line items are not to be included in this cost center.

(B) Nursing staff who also have administrative duties not related to nursing must properly direct charge their compensation to each type of function performed based on daily time sheets maintained throughout the entire reporting period.

(C) Nurse aides must meet the qualifications specified under 26 TAC §556.3 (relating to Nurse Aide Training and Competency Evaluation Program (NATCEP) Requirements) to be included in this rate component. Nurse aides include certified nurse aides and nurse aides in training.

(D) Contract labor refers to personnel for whom the contracted provider is not responsible for the payment of payroll taxes (such as federal payroll tax, Medicare, and federal and state unemployment insurance) and who perform tasks routinely performed by employees. Allowable contract labor costs are defined in §355.103(b)(3) of this chapter.

(E) For facilities providing care to children with tracheostomies requiring daily care as described in §355.307(b)(3)(G) of this chapter (relating to Reimbursement Setting Methodology before September 1, 2025), staff required by 26 TAC

§554.901(15)(C)(iii) (relating to Quality of Care) performing nursing-related duties for Medicaid contracted beds are included in the nursing rate component.

(F) For facilities providing care for qualifying ventilator-dependent residents as described in §355.307(b)(3)(F) of this chapter, Registered Respiratory Therapists and Certified Respiratory Therapy Technicians are included in the nursing rate component.

(G) Nursing facility administrators and assistant administrators are not included in the nursing rate component.

(H) Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, restorative aide, or certified nurse aide, the staff member is not to be included in the nursing rate component but rather in the rate component where staff members with that licensure or certification status are typically reported.

(I) Paid feeding assistants are not included in the nursing rate component. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff.

(2) NTA rate component. This rate component includes costs 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; ancillary costs, including ancillary staff compensation and benefits; diagnostic laboratory and radiology costs; durable medical equipment purchase, rent, or lease costs; oxygen costs; drugs and pharmaceuticals; therapy consultant costs; and other ancillary supplies and services purchased by a nursing facility.

(3) BIMS rate component. This rate component includes additional staff costs associated with providing care to residents with severe cognitive impairment.

(4) Non-Case-Mix rate component. The Non-Case-Mix rate component includes the following cost areas.

(A) Dietary costs, including food service and nutritionist staff expenses and supplies.

(B) The administration and operations cost includes compensation and benefits for the following staff: laundry and housekeeping staff, maintenance and transportation staff, administrator and assistant, other administrative personnel, activity director and assistant, and central office staff. Administration and operations also include operations supply costs; building repair and maintenance costs; laundry and housekeeping supply costs; transportation and vehicle depreciation costs; utilities, telecommunications, and technology costs; contracted management costs;

insurance costs, excluding liability insurance reimbursed under §355.312 of this subchapter (relating to Reimbursement Setting Methodology--Liability Insurance Costs).

(C) The fixed capital asset costs, including the cost categories listed below:

(i) building and building equipment depreciation and lease expense;

(ii) mortgage interest;

(iii) land improvement depreciation; and

(iv) leasehold improvement amortization.

(e) Reimbursement determination. HHSC calculates methodological PDPM LTC rates for each rate component as defined below.

(1) 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 subsection (d)(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 as specified in §355.108 of this chapter (relating to Determination of Inflation Indices) and multiplied by 1.07.

(2) Calculation of the NTA rate component. HHSC determines a per diem cost for the NTA component by calculating a median of allowable NTA costs as defined in subsection (d)(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 as specified in §355.108 of this chapter and multiplied by 1.07.

(3) 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.

(A) Calculation of the total nursing rate component. HHSC will calculate CMI-adjusted nursing rate components for each nursing case-mix classifier by multiplying the result from paragraph (1) of this subsection by a CMI specific to each nursing case-mix classifier. There is one CMI per each nursing case-mix classifier.

(B) Calculation of the total NTA rate component. HHSC will calculate CMI-adjusted NTA rate components for each NTA case-mix classifier by multiplying the result

from paragraph (2) of this subsection by a CMI specific to each NTA case-mix classifier. There is one CMI per each NTA case-mix classifier.

(4) 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.

(5) Calculation of the non-case mix rate component. HHSC determines a per diem cost for the non-case mix rate component by the following.

(A) HHSC calculates a median of allowable dietary costs defined in subsection (d)(4)(A) 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 as specified in §355.108 of this chapter and multiplied by 1.07.

(B) HHSC calculates a median of the allowable administration and operations costs defined in subsection (d)(4)(B) 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 as specified in §355.108 of this chapter and multiplied by 1.07.

(C) HHSC calculates a median of allowable fixed capital costs defined in subsection (d)(4)(C) 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 as specified in §355.108 of this chapter and multiplied by 1.07.

(D) HHSC sums the results from subparagraphs (A) – (C) of this paragraph for the total non-case mix rate component.

(6) 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 four rate components:

(A) Nursing rate component;

(B) NTA rate component;

(C) BIMS rate component; and

(D) Non-Case Mix rate component.

(7) HIV/AIDS Add-on. According to the Texas Health and Safety Code (THSC) §81.103, it is prohibited to input selected International Classification of Diseases, Tenth Revision (ICD-10) 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.

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

(B) 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.

(f) Reimbursement for Hospice care in a nursing facility. Following 26 TAC §266.305 (relating to General Contracting Requirements), the Medicaid Hospice Program pays the Medicaid hospice provider a hospice-nursing facility rate that is no less than 95 percent of the Medicaid nursing facility rate for each individual in a nursing facility to take into account the room and board furnished by the facility.

(g) Cost finding methodology.

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

(A) the provider meets one or more of the conditions in §355.105(b)(4)(D) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures); or

(B) 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.

(2) 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 (1) of this subsection.

(3) 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:

(I) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(II) 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 (A)(i)(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.

(4) 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 as specified in §355.108 of this chapter.

(5) In addition to the requirements of §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs) and §355.103 of this chapter (relating to Specifications for Allowable and Unallowable costs), the following apply to costs for nursing facilities.

(A) Medical costs. The costs for medical services and items delineated in 26 TAC §554.2601 (relating to Vendor Payment (Items and Services Included)) are allowable. These costs must also comply with the general definition of allowable costs as stated in §355.102 of this chapter.

(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 non-case mix 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 subsection (e) of this section.

(h) Special Reimbursement Class. HHSC may define special reimbursement classes, including experimental reimbursement classes of service to be used in research and demonstration projects on new reimbursement methods and reimbursement classes of service, to address the cost differences of a select group of recipients. Special classes may be implemented on a statewide basis, may be limited to a specific region of the state, or may be limited to a selected group of providers. Reimbursement for the Pediatric Care Facility Class is calculated as specified in §355.316 of this chapter (relating to Reimbursement Methodology for Pediatric Care Facilities).

(i) Nurse aide training and competency evaluation costs.

(1) HHSC reimburses nursing facilities for the actual costs of training and testing nurse aides. Payments are based on cost reimbursement vouchers that are to be submitted quarterly. Allowable costs are limited to those costs incurred for training for:

(A) actual training course expenses up to a set amount determined by HHSC per nurse aide;

(B) competency evaluation; or

(C) supplies and materials used in the nurse aide training not already covered by the training course fee.

(2) Nurse aide salaries while in training are factored into the vendor rate and are not to be included in the reimbursement voucher.

(3) Training program costs that exceed the HHSC cost ceiling must have prior approval from HHSC before costs can be reimbursed. A written request to HHSC must include:

(A) name and vendor number of the facility;

(B) description of the training program for which the facility is seeking reimbursement approval, including:

(i) name, telephone number, and address of the NATCEP;

(ii) whether the NATCEP is facility or non-facility-based; and

(iii) name of the NATCEP director;

(C) an explanation of why the cost for the NATCEP exceeds the reimbursement ceiling and the explanation must include:

(i) a completed nurse aide unit cost calculation form for a facility-based NATCEP; or

(ii) a breakdown of the nurse aide unit cost by the instructor fees and training materials for a non-facility-based NATCEP; and

(D) an explanation of why the nursing facility cannot use a training program at or below the reimbursement ceiling and what steps the facility has taken to explore more cost-efficient training courses and the explanation must include:

(i) the availability of NATCEPs, such as the location or the frequency of training offered, in the geographic region of the facility;

(ii) the name and address of each NATCEP that the facility has explored as a provider of nurse aide training; and

(iii) the cost per nurse aide for each NATCEP identified in subparagraph (C)(i) or (ii) of this paragraph.

(4) All prior approval requests, as outlined in paragraph (3) of this subsection, must be submitted to HHSC and HHSC:

(A) may request additional information to evaluate a reimbursement request; and

(B) will make the final decision on a reimbursement request.

(5) All nurse aide training courses must be approved by HHSC before costs associated with them can be reimbursed.

(6) Nursing facilities are responsible for tracking and documenting nurse aide training costs for each nurse aide trained. All documentation is subject to HHSC audits. If substantiating documentation for amounts billed to HHSC cannot be verified, HHSC will immediately recoup funds paid to the facility.

(7) Individuals who have completed a NATCEP may be directly reimbursed for costs incurred in completing a NATCEP. The individual must meet all of the conditions specified in subparagraphs (A) - (E) of this paragraph.

(A) The individual must not have been employed at the time of completing the NATCEP.

(B) The individual must have been employed by or received an offer of employment from a nursing facility no later than 12 months after successfully completing the NATCEP.

(C) The individual must have been employed by the facility for no less than 6 months.

(D) The nursing facility must not have claimed reimbursement for training expenses for the individual.

(E) The individual must be listed on the current Nurse Aide Registry.

(8) Individuals must submit cost reimbursement vouchers to HHSC with proof that the individual has been employed by a facility for no less than 6 months.

(9) Individuals who leave nursing facility employment before accruing the required 6 months of employment, as specified in paragraph (7)(C) of this subsection, may receive 50 percent reimbursement as long as the individual was employed for no less than 3 months.

(10) Reimbursement to individuals may not exceed the HHSC reimbursement limit described in paragraph (1)(A) of this subsection.

(j) Adopted rates are limited to available levels of appropriated state and federal funds.

§355.320. Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) establishes the Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025. The Nursing Care Staff Rate Enhancement Program for Nursing Facilities established under this section will be implemented pending implementation of Patient Driven Payment Model (PDPM) for Long-Term Care (LTC), as specified in §355.318 of this subchapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025).

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

(1) Combined entity--Combined entities consist of one or more commonly owned corporation and one or more limited partnership, where the general partner is controlled by the same person as the commonly owned corporation.

(2) Commonly owned corporations--Commonly owned corporations are two or more corporations where five or fewer identical persons who are individuals, estates, or trusts control greater than 50 percent of the total voting power in each corporation.

(3) Control--The entity has greater than 50 percent ownership.

(4) Enrollment contract amendment--An acceptable enrollment contract amendment is defined as a legible document requesting a change in enrollment status that has been completed according to instructions, signed by an authorized representative per the HHSC signature authority designation form applicable to the provider's contract or ownership type, and received by HHSC within 30 days of HHSC's notification to the facility that an enrollment contract amendment must be submitted.

(A) An initial enrollment contract amendment is required from each facility choosing to participate in the Nursing Care Staff Rate Enhancement Program.

(B) Participating and nonparticipating facilities may request to modify their enrollment status (i.e., a nonparticipant can request to become a participant, a participant can request to become a nonparticipant, or a participant can request to change its enhancement level) during any open enrollment period.

(C) Nonparticipants and participants requesting to increase their enrollment levels will be limited to increases of three or fewer enhancement levels during any single open enrollment period unless HHSC waives such limits.

(D) Requests to modify a facility's enrollment status during an open enrollment period must be received by HHSC by the last day of the open enrollment period as per paragraph (8) of this subsection.

(i) If the last day of the open enrollment period falls on a weekend, national holiday, or state holiday, then the first business day following the last day of the open enrollment period is the final day the enrollment contract amendment will be accepted.

(ii) An enrollment contract amendment that is not received by the stated deadline will not be accepted.

(iii) A facility from which HHSC has not received an acceptable request to modify their enrollment by the last day of the open enrollment period will continue at the level of participation in effect during the open enrollment period, within available funds. The facility will continue at that level of enrollment until the facility notifies

HHSC following subsection (n) of this section that it no longer wishes to participate, or until the facility's enrollment is limited according to subsection (g) of this section.

(E) If HHSC determines that funds are not available to continue participation at the level in effect during the open enrollment period, facilities will be notified as per subsection (v) of this section.

(5) Entity--An entity is a parent company, sole member, individual, limited partnership, or group of limited partnerships controlled by the same general partner.

(6) Nursing care staff base rate--The nursing care staff base rate is equal to the adopted nursing rate component as specified in §355.318 of this subchapter.

(7) Nursing care staff cost center--The nursing care staff cost center is equal to the PDPM LTC nursing rate component as specified in §355.318 of this subchapter.

(8) Open enrollment--Open enrollment begins on the first day of July and ends on the thirty-first day of July, preceding the rate year for which payments are being determined. HHSC notifies providers of open enrollment via email sent to an authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. Requests to modify a provider's enrollment status during an open enrollment period must be received by HHSC by the last day of the open enrollment period through HHSC's enrollment portal or another method designated by HHSC. If the last day of open enrollment is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted. If open enrollment has been postponed or canceled, HHSC will notify providers by email before the first day of July. Should conditions warrant, HHSC may conduct additional enrollment periods during a rate year.

(9) Rate year--The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(10) Responsible entity--The contracted provider, owner, or legal entity that received the recouped revenue is responsible for the repayment of any recoupment amount.

(11) Staffing and compensation report--A staffing and compensation report is a report reflecting the provider's activities while delivering contracted services from the first day through the last day of the rate year or provider's cost report year while participating in the Nursing Care Staff Rate Enhancement Program. Staffing and compensation reports and cost reports functioning as staffing and compensation reports will include any information required by HHSC to implement the Nursing Care Staff Rate Enhancement Program. Staffing and compensation reports must be submitted annually or as specified in subsection (d) of this section. Cost and accountability reports requested by HHSC are considered staffing and compensation reports, and preparers must complete mandatory training

requirements per §355.102(d) of this subchapter (relating to General Principles of Allowable and Unallowable Costs). Staffing and compensation reports will be used as the basis for determining compliance with the spending requirements and recoupment amounts as described in subsection (k) of this section. Participating facilities failing to submit an acceptable annual staffing and compensation report within 60 days of the end of the rate year will be placed on vendor hold until an acceptable report is received and processed by HHSC.

(c) Enrollment for new facilities. For purposes of this section, for each rate year, a new facility is defined as a facility delivering its first day of service to a Medicaid recipient after the first day of the open enrollment period as defined in subsection (b)(8) of this section. Facilities that underwent an ownership change are not considered new facilities. New facilities will receive the nursing rate component as determined in §355.318 of this subchapter with no enhancements. For new facilities specifying their desire to participate in an acceptable enrollment contract amendment, the nursing rate component is adjusted as specified in subsection (j) of this section, effective on the first day of the month following receipt by HHSC of the acceptable enrollment contract amendment. If the granting of newly requested enhancements was limited as per subsection (g) of this section during the most recent enrollment, enrollment for new facilities will be subject to that same limitation.

(d) Reporting requirements.

(1) All participating facilities will provide HHSC, in a method specified by HHSC, an annual staffing and compensation report reflecting the activities of the facility while delivering contracted services from the first day through the last day of the rate year.

(2) When a participating facility changes ownership, the prior owner must submit a staffing and compensation report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the ownership-change effective date. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section. The new owner will be required to submit a staffing and compensation report covering the period from the day after the date recognized by HHSC or its designee as the ownership change effective date to the end of the rate year.

(3) Participating facilities whose contracts are terminated either voluntarily or involuntarily must submit a staffing and compensation report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the contract termination date. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section.

(4) Participating facilities who voluntarily withdraw from participation as per subsection (n) of this section must submit a staffing and compensation report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the rate year to the date of withdrawal as determined

by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section.

(5) When a participating facility changes ownership, the prior owner must submit a staffing and compensation report covering the period from the beginning of the facility's cost reporting period to the date recognized by HHSC or its designee as the ownership-change effective date. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section. The new owner will be required to submit a cost report covering the period from the day after the date recognized by HHSC or its designee as the ownership change effective date to the end of the facility's fiscal year.

(6) Participating facilities whose contracts are terminated either voluntarily or involuntarily must submit a staffing and compensation report covering the period from the beginning of the facility's cost reporting period to the date recognized by HHSC or its designee as the contract termination date. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section.

(7) Participating facilities who voluntarily withdraw from participation as per subsection (n) of this section must submit a staffing and compensation report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the facility's cost reporting period to the date of withdrawal as determined by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section. These facilities must still submit a cost report covering the entire cost reporting period. The cost report will not be used for determining any recoupment amounts.

(8) For new facilities, as defined in subsection (c) of this section, the reporting period will begin with the effective date of participation in enhancement.

(9) Existing facilities that become participants in the enhancement as a result of the open enrollment process described in subsection (b)(8) of this section on any day other than the first day of their fiscal year are required to submit a staffing and compensation report with a reporting period that begins on their first day of participation in the enhancement and ends on the last day of the facility's fiscal year. This report will be used as the basis for determining any recoupment amounts as described in subsection (k) of this section.

(10) A participating provider that is required to submit a staffing and compensation report under this paragraph will be excused from the requirement to submit a report if the provider did not provide any billable services to Medicaid recipients during the reporting period.

(11) Reports must be received before the date the provider is notified of compliance with spending requirements for the report in question as per subsection (k) of this section.

(12) HHSC may require other staffing and compensation reports from all facilities as needed.

(e) Vendor hold. HHSC or its designee will place on hold the vendor payments for any participating facility that does not submit a timely report as described in subsection (d) of this section. This vendor hold will remain in effect until HHSC receives an acceptable report.

(1) Participating facilities that do not submit an acceptable report completed in compliance with all applicable rules and instructions within 60 days of the due dates described in this subsection or, for cost reports, the due dates described in §355.105(b) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures), will become nonparticipants retroactive to the first day of the reporting period in question and will be subject to immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipants, and recouped funds will not be restored until they submit an acceptable report and repay to HHSC or its designee funds identified for recoupment from subsection (k) of this section. If an acceptable report is not received within 365 days of the due date, the recoupment will become permanent, and if all funds associated with participation during the reporting period in question have been recouped by HHSC or its designee, the vendor hold associated with the report will be released.

(2) Participating facilities with an ownership change or contract termination that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the change in ownership or contract termination will become nonparticipants retroactive to the first day of the reporting period in question. These facilities will be subject to an immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipants, and recouped funds will not be restored until they submit an acceptable report and repay to HHSC or its designee funds identified for recoupment from subsection (k) of this section. If an acceptable report is not received within 365 days of the change of ownership or contract termination date, the recoupment will become permanent, and if all funds associated with participation during the reporting period in question have been recouped by HHSC or its designee, the vendor hold associated with the report will be released.

(f) Completion of Reports. All staffing and compensation reports must be completed in compliance with the provisions of §§355.102 - 355.105 of this chapter (relating to General Principles of Allowable and Unallowable Costs; Specifications for Allowable and Unallowable Costs; Revenues; and General Reporting and Documentation Requirements, Methods, and Procedures, respectively) and may be reviewed or audited in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). All staffing and compensation reports must be completed by preparers who have attended the required nursing facility cost report training as per §355.102(d) of this chapter.

(g) Enrollment limitations. A facility will not be enrolled in the Nursing Care Staff Rate Enhancement Program at a level higher than the level it achieved on its most recently available audited staffing and compensation report. HHSC will notify a facility of its enrollment limitations (if any) before the first day of the open enrollment period.

(1) Notification of enrollment limitations. The enrollment limitation level is indicated in the State of Texas Automated Information Reporting System (STAIRS), the online application for submitting cost and accountability reports. STAIRS will generate an email to the entity contact, indicating that the facility's enrollment limitation level is available for review. The entity contact is the provider's authorized representative per the signature authority designation form applicable to the provider's contract or ownership type.

(2) Enrollment after a limitation. At no time will a facility be allowed to enroll in the enhancement program at a level higher than its current level of enrollment plus three additional levels unless otherwise instructed by HHSC.

(3) New owners after a change of ownership. Enhancement levels for a new owner after a change of ownership will be determined according to subsection (s) of this section. A new owner will not be subject to enrollment limitations based on the prior owner's performance. This exemption from enrollment limitations does not apply in cases where HHSC or its designee has approved a successor-liability-agreement that transfers responsibility from the former owner to the new owner.

(4) New facilities. A new facility's enrollment will be determined according to subsection (c) of this section.

(h) Determination of nursing care staff component enhancements. HHSC will determine a per diem add-on payment for each nursing rate component enhancement level using data from sources such as cost reports, surveys, or other relevant sources and considering the quality of care, labor market conditions, economic factors, and budget constraints. The nursing rate component enhancement add-ons will be determined on a per-unit-of-service basis. Add-on payments may vary by enhancement level.

(i) Granting of nursing staff rate enhancements. HHSC divides all requested enhancements, after applying any enrollment limitations from subsection (g) of this section, into two groups: pre-existing enhancements that facilities request to carry over from the prior year and newly requested enhancements. Newly requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year, desiring to be granted additional enhancements. Using the process described herein, HHSC first determines the distribution of carry-over enhancements. If HHSC determines that funds are not available to carry over some or all pre-existing enhancements, facilities will be notified as per subsection (v) of this section. If funds are available after the distribution of carry-over enhancements, HHSC then determines the distribution of newly requested enhancements. HHSC may not

distribute newly requested enhancements to facilities owing funds identified for recoupment from subsection (k) of this section.

(1) HHSC determines projected Medicaid units of service for facilities requesting each enhancement option and multiplies this number by the rate add-on associated with that enhancement option as determined in subsection (h) of this section.

(2) HHSC compares the sum of the products from paragraph (1) of this subsection to available funds:

(A) if the product is less than or equal to available funds, all requested enhancements are granted; or

(B) if the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds. Based on an examination of existing staffing levels and staffing needs, HHSC may grant certain enhancement options priority for distribution.

(3) Notification of granting of enhancements. Participating facilities are notified of the status of their request for rate enhancements in a manner determined by HHSC.

(4) In cases where more than one enhanced rate level is in effect during the reporting period, the spending requirement will be based on the weighted average enhanced rate level in effect during the reporting period calculated as follows.

(A) Multiply the first enhanced rate level in effect during the reporting period by the most recently available reliable Medicaid days of service utilization data for the time period the first enhanced rate level was in effect.

(B) Multiply the second enhanced rate level in effect during the reporting period by the most recently available reliable Medicaid days of service utilization data for the time period the second enhanced rate level was in effect.

(C) Sum the products from subparagraphs (A) and (B) of this paragraph.

(D) Divide the sum from subparagraph (C) of this paragraph by the sum of the most recently available reliable Medicaid days of service utilization data for the entire reporting period used in subparagraphs (A) and (B) of this paragraph.

(j) Determine each participating facility's total nursing rate component. Each participating facility's total nursing rate component will be equal to the nursing care staff base rate as defined in subsection (b)(6) of this section, plus any add-on payments associated with staffing enhancements selected by and awarded to the facility during open enrollment. HHSC will determine a per diem add-on payment for each enhanced staffing level informed by analysis of the most recently available

reliable data relating to staff compensation levels and available appropriations for the program as specified in subsection (h) of this section.

(k) Spending requirements for participants. Participating facilities are subject to a nursing care staff spending requirement with recoupment calculated as follows.

(1) Effective September 1, 2023, HHSC will complete calculations associated with nursing care rate increases and spending requirements in compliance with §355.304 of this subchapter (relating to Direct Care Staff Spending Requirement on or after September 1, 2023).

(2) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service and managed care nursing care staff revenues by 0.70.

(3) Accrued allowable Medicaid nursing care staff fee-for-service expenses for the rate year will be compared to the spending floor from paragraph (2) of this subsection. HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid nursing care staff fee-for-service expenses from facilities whose Medicaid nursing care staff spending is less than their spending floor.

(4) At no time will a participating facility's nursing care rates after spending recoupment be less than the nursing care staff base rates.

(l) Dietary and Fixed Capital Mitigation. Recoupment of funds described in subsection (k) of this section may be mitigated by high dietary and fixed capital expenses as follows.

(1) Calculate dietary cost deficit. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If costs are greater than revenues, the dietary per diem cost deficit will be equal to the difference between accrued, allowable Medicaid dietary per diem costs and accrued Medicaid dietary per diem revenues. If costs are less than revenues, the dietary cost deficit will be equal to zero.

(2) Calculate dietary revenue surplus. At the end of the facility's rate, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If revenues are greater than costs, the dietary per diem revenue surplus will be equal to the difference between accrued Medicaid dietary per diem revenues and accrued, allowable Medicaid dietary per diem costs. If revenues are less than costs, the dietary revenue surplus will be equal to zero.

(3) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital asset per diem revenues will be compared to accrued, allowable Medicaid fixed capital asset per diem costs. Allowable fixed capital asset costs are defined in §355.318(d)(4)(C) of this subchapter. If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference

between accrued, allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85 percent are adjusted to the cost per diem the facility would have accrued had it maintained an 85 percent occupancy rate throughout the rate year.

(4) Calculate fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital asset per diem revenues will be compared to accrued, allowable Medicaid fixed capital asset per diem costs. Allowable fixed capital asset costs are defined in §355.318(d)(4)(C) of this subchapter. If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85 percent are adjusted to the cost per diem the facility would have accrued had it maintained an 85 percent occupancy rate throughout the rate year.

(5) Mitigation of a dietary per diem cost deficit. Facilities with a dietary per diem cost deficit will have their dietary per diem cost deficit reduced by their fixed capital per diem revenue surplus, if any. Any remaining dietary per diem cost deficit will be capped at $2.00 per diem.

(6) Mitigation of a fixed capital cost per diem deficit. Facilities with a fixed capital cost per diem deficit will have their fixed capital cost per diem deficit reduced by their dietary revenue per diem surplus, if any. Any remaining fixed capital per diem cost deficit will be capped at $2.00 per diem.

(7) Recoupment calculation. Each facility's recoupment, as calculated in subsection (k) of this section, will be reduced by the sum of that facility's dietary per diem cost deficit as calculated in paragraph (5) of this subsection and its fixed capital per diem cost deficit as calculated in paragraph (6) of this subsection.

(m) Adjusting spending requirements. Facilities that determine that they will not be able to meet their spending requirements from subsection (k) of this section may request a reduction in their spending requirements and associated rate add-on. These requests will be effective on the first day of the month following approval of the request.

(n) Voluntary withdrawal. Facilities wishing to withdraw from participation must notify HHSC in writing by certified mail and the request must be signed by an authorized representative as designated per the HHSC signature authority designation form applicable to the provider's contract or ownership type. Facilities voluntarily withdrawing must remain nonparticipants for the remainder of the rate year. The participation end date for facilities voluntarily withdrawing from the program will be effective on the date of the withdrawal, as determined by HHSC.

(o) Notification of recoupment based on annual staffing and compensation report or cost report. The estimated amount to be recouped is indicated in STAIRS. STAIRS will generate an email to the entity contact, indicating that the facility's estimated recoupment is available for review. If HHSC's subsequent review of the staffing and compensation report results in report adjustments that change the amount to be repaid to HHSC or its designee, the facility's entity contact will be notified by email that the adjustments and the adjusted amount to be repaid are available in STAIRS for review. HHSC or its designee will recoup any amount owed from a facility's vendor payments following the date of the initial or subsequent notification.

(p) Change of ownership and contract terminations.

(1) Facilities required to submit a staffing and compensation report due to a change of ownership or contract termination as described in subsection (d) of this section will have funds held as per 26 TAC §554.210 (relating to Change of Ownership and Notice of Changes) until HHSC receives an acceptable staffing and compensation report and funds identified for recoupment from subsection (k) of this section are repaid to HHSC or its designee. Informal reviews and formal appeals relating to these reports are governed by §355.110 of this chapter(relating to Informal Reviews and Formal Appeals). HHSC or its designee will recoup any amount owed from the facility's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity, as defined in subsection (b)(10) of this section, will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other Medicaid contracts controlled by the responsible entity, placement of a vendor hold on all Medicaid contracts controlled by the responsible entity and will bar the responsible entity from receiving any new contracts with HHSC or its designees until repayment is made in full. The responsible entity for these contracts will be notified as described in subsection (o) of this section before the recoupment of owed funds, placement of vendor hold, and barring of new contracts.

(2) Participation in the Nursing Care Staff Rate Enhancement Program transfers to the new owner as defined in 26 TAC §554.210 when there is a change of ownership. The new owner is responsible for the reporting requirements in subsection (d) of this section for any reporting period days occurring after the change. If the change of ownership occurs during an open enrollment period as defined in subsection (b)(8) of this section, then the owner recognized by HHSC or its designee on the last day of the enrollment period may request to modify the enrollment status of the facility.

(q) Failure to document staff spending. Undocumented nursing care staff and contract labor compensation costs will be disallowed and will not be used in the determination of nursing care staff costs per unit of service.

(r) Appeals. The subject matter of informal reviews and formal appeals is limited as per §355.110(a)(3) of this chapter.

(s) Contract cancellations. If a facility's Medicaid contract is canceled before the first day of an open enrollment period as defined in subsection (b)(8) of this section, and the facility is not granted a new contract until after the last day of the open enrollment period, participation in the Nursing Care Staff Rate Enhancement Program as it existed before the cancellation date of the facility's contract will be reinstated when the facility is granted a new contract. The contract must be under the same ownership, and reinstatement is subject to the availability of funding. Any enrollment limitations from subsection (g) of this section that would have applied to the canceled contract will apply to the new contract.

(t) Determination of compliance with spending requirements in the aggregate.

(1) Aggregation. For an entity, commonly owned corporation, or combined entity that controls more than one participating nursing facility contract, compliance with the spending requirements detailed in subsection (k) of this section can be determined in the aggregate for all participating nursing facility contracts controlled by the entity, commonly owned corporations, or combined entity at the end of the rate year, the effective date of the change of ownership of its last participating contract, or the effective date of the termination of its last participating contract rather than requiring each contract to meet its spending requirement individually. Corporations that do not meet the definitions under subsection (b) of this section are not eligible for aggregation to meet spending requirements.

(2) Aggregation Request. To exercise aggregation, the entity, combined entity, or commonly owned corporations must submit an aggregation request in a manner prescribed by HHSC when each staffing and compensation report is submitted. In limited partnerships in which the same single general partner controls all the limited partnerships, the single general partner must make this request. Other such aggregation requests will be reviewed on a case-by-case basis.

(3) Frequency of Aggregation Requests. The entity, combined entity, or commonly owned corporation must submit a separate request for aggregation for each reporting period.

(4) Ownership changes or terminations. Nursing facility contracts that change ownership or terminate, effective after the end of the applicable reporting period but before the determination of compliance with spending requirements as per subsection (k) of this section, are excluded from all aggregate spending calculations. These contracts' compliance with spending requirements will be determined on an individual basis and the costs and revenues will not be included in the aggregate spending calculation.

(u) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes nursing care to a Medicaid recipient under 26 TAC §554.2326 (relating to Medicaid Swing Bed Program for Rural Hospitals), HHSC or its designee pays the hospital using the same procedures, the same case-mix methodology, and the same PDPM LTC rates that HHSC authorizes for reimbursing nursing facilities receiving the nursing rate

component with no enhancement levels. These hospitals are not subject to the staffing and spending requirements detailed in this section.

(v) Notification of lack of available funds. If HHSC determines that funds are not available to continue participation for facilities from which it has not received an acceptable request to modify their enrollment by the last day of an enrollment period as per subsection (b)(8) of this section or to fund carry-over enhancements as per subsection (i) of this section, HHSC will notify providers in a manner determined by HHSC that such funds are not available.

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STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

The repeals affect Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

<rule>

§355.309. Performance-based Add-on Payment Methodology.

§355.314. Supplemental Payments to Non-State Government-Owned Nursing Facilities.