ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to Texas Administrative Code Title 1, Chapter 355, Subchapter A, concerning Cost Determination Process, §355.102 and §355.105; Subchapter C, concerning Reimbursement Methodology for Nursing Facilities, §355.318; Subchapter D, concerning Reimbursement Methodology for Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), §355.456; Subchapter E, concerning Community Care for Aged and Disabled, §§355.503, 355.505, 355.507, 355.509, and 355.513; Subchapter F, concerning Reimbursement Methodology for Programs Serving Persons with an Intellectual or Developmental Disability, §355.723; Subchapter G, concerning Advanced Telecommunications Services and Other Community-Based Services, §355.5902 and §355.6907; Subchapter H, concerning Attendant Cost Determination, §355.7051; Subchapter M, concerning Miscellaneous Programs, §355.9090; new rules in Subchapter C, concerning Reimbursement Methodology for Nursing Facilities, §355.305; and Subchapter H, concerning Attendant Cost Determination, §355.7052; and the repeals in Subchapter A, concerning Cost Determination Process, §355.112; Subchapter C, concerning Reimbursement Methodology for Nursing Facilities, §§355.304; 355.306; 355.307; 355.308; and 355.320; Subchapter D, concerning Reimbursement Methodology for Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), §355.457; and Subchapter F, concerning Reimbursement Methodology for Programs Serving Persons with an Intellectual or Developmental Disability, §355.722.

Sections 355.102, 355.305, 355.318, 355.456, 355.503, 355.505, 355.513, 355.723, 355.5902, and 355.7052 are adopted with changes to the proposed text as published in the July 11, 2025, issue of the *Texas Register* (50 TexReg 3953). These rules will be republished.

Sections 355.105, 355.507, 355.509, 355.6907, 355.7051, and 355.9090 and the repeal of §§355.112, 355.304, 355.306, 355.307, 355.308, 355.320, 355.457, and 355.722 are adopted without changes to the proposed text as published in the July 11, 2025, issue of the *Texas Register* (50 TexReg 3953). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The amendments, repeals, and new rules are necessary to implement the 2026-27 General Appropriations Act, Senate Bill (S.B.) 1, 89th Legislature, Regular Session, 2025 (Article II, Health and Human Services Commission, Riders 23 and 25, respectively) and Senate Bill 457 (S.B. 457), 89th Legislature, Regular Session, 2025. The adoption amends and repeals existing rules, and creates new rules that address the following.

1. The adoption revises the personal attendant wage, creates a new rate methodology for the attendant cost component, and repeals the Attendant Compensation Rate Enhancement Program.

The 2026-27 General Appropriations Act, S.B. 1, 89th Legislature, Regular Session, 2025 (Article II, Health and Human Services Commission, Rider 23) (Rider 23) provides appropriations for HHSC to increase the wage for personal attendants assumed in the adopted rates for attendant and attendant-like services to $13.00 per hour and to increase the associated payroll costs, taxes, and benefits percentage to 14 percent for community services and 15 percent for residential services. Rider 23 also discontinues the Attendant Compensation Rate Enhancement program.

2. The adoption revises the rate methodology for nursing facilities, implements a new annual patient expense ratio, repeals the Direct Care Staff Enhancement program and direct care spending requirements.

The 2026-27 General Appropriations Act, S.B. 1, 89th Legislature, Regular Session, 2025 (Article II, Health and Human Services Commission, Rider 25) (Rider 25) and S.B. 457 provide additional appropriations to fund dietary and administrative costs for nursing facilities. The amendment modifies reimbursement methodology to support the implementation of Rider 25 and S.B. 457.

3. The proposal revises cost report training requirements.

COMMENTS

The 21-day comment period ended on August 1, 2025.

During this period, HHSC received comments regarding the proposal from a total of 20 commenters.

For rules regarding attendant services and associated rules, HHSC received comments from 20 commenters representing the following organizations: Ambassadors Group, Cantex Continuing Care Network, The Coalition of Independent Nursing Homes, Creative Solutions Healthcare, Focused Post Acute Care Partners LLC, Fundamental Administrative, Gulf Coast Partners, Keystone Care, Mission Road Ministries, Nexion Health Management, Priority Management, Providers Alliance for Community Services of Texas (PACSTX), Regency Integrated Health Services, ResCare, Senior Living Properties, StoneGate Senior Living, Summit LTC Management, and Texas Association for Home Care & Hospice.

A summary of comments relating to §§355.102, 355.112, 355.456, 355.503, 355.505, 355.507, 355.513, 355.723, 355.5902, and 355.7052 and HHSC's responses follow.

Comment: One commenter suggested there were inconsistencies in the references to "accountability reports" in the proposed amendments to §355.102. The commentor also requested clarification on cost reporting requirements for providers contracted with managed care organizations and designated cost reporting periods for providers.

Response: HHSC agrees and revises the rule to remove references to accountability report from §355.102(d), §355.102(d)(2), §355.102(d)(2)(A) and 355.102(d)(2)(C). HHSC will continue to collect biennial cost reports from providers to comply with Rider 23 requirements. HHSC will publish an Information Letter related to cost reporting requirements for providers who are subject to Rider 23 reporting once the adopted amendment becomes effective.

Comment: Multiple commenters expressed concerns regarding HHSC's requirement in §355.102 that the primary entity contact and financial contact complete a mandatory cost report training as the commenters found this administratively burdensome and duplicative of the mandatory cost training completed by cost report preparers.

Response: HHSC disagrees and declines to revise the rule. Accurate cost reporting is the responsibility of the contracted provider. As such, individuals designated as primary entity contacts or financial contacts have responsibilties outside the scope of the cost report preparer's role during the cost reporting process. Accordingly, it is important that individuals who are legally responsible for a contracted provider complete a training to understand the cost reporting process, their responsibilities, and any financial implications that may impact the contracted provider through the process.

Comment: One commenter requested clarification on whether the 90th percentile limit on related party attendant compensation in §355.105(i)(4) is applied to all forms of compensation or base wage only, and whether this limitation applied universally to all related parties, regardless of their role or relationship to the contracted provider agency or client. The commenter requested guidance on how this limitation will be operationalized in HHSC's cost reports.

Response: To determine allowable costs for HHSC's cost reports, HHSC defines related parties in §355.102(i) in terms of common ownership or control between the contracted provider and a supplying organization and not in reference to the client receiving services unless the client is either the owner, has control over, or shares a familial relationship with the owner of the contracted provider. A family caregiver who serves as an employee of a contracted provider but has no common ownership or control of that provider would not be considered a related party for the purpose of HHSC's cost report.

The limitation on related party compensation would apply to all related parties with a contracted provider regardless of whether the related party shares common ownership, control, or has a familial relationship with the owner of the contracted provider. The limit on related party attendant compensation only applies to the base wage and does not encompass overtime or other non-hourly compensation. HHSC will provide more information on how the limitation of related party attendant compensation will be operationalized in HHSC's cost report instructions for each program that has attendant services.

Comment: Multiple commenters expressed concern that the repeal of §355.112 would discontinue the Attendant Compensation Rate Enhancement (ACRE) program and end payment of enhanced rates prior to the Federal approval and implementation of the rate increases appropriated through Rider 23.

Response: HHSC disagrees and declines to withdraw the repeal. Rider 23(b) directs HHSC to "utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase…and [to] discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services."

Comment: One commenter proposed modification of the repeal of §355.112 concerning the Attendant Compensation Rate Enhancement program to revise subsection (n) to create a transition period for the program. The recommendation would maintain the state fiscal year 2025 enhanced rates and delay the termination of the program until HHSC receives federal approvals for the base rates supported by appropriations from Rider 23. The comment also recommends a process to reconcile the payments made under the ACRE transition and the final rates proposed to be effective on September 1, 2025.

Response: HHSC disagrees and declines to withdraw the repeal. Rider 23(b) directs HHSC to "utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase…and [to] discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services." The Rider language does not allow for a transition period or a delay in discontinuing the program.

Comment: One commenter requested clarification on whether attendant supervisor wages who conduct direct care worker training in the field can be applied as direct care trainers. Specifically, the commenter asks whether a supervisor's hours and compensation may be classified as "direct care trainer" time and expenses under new §355.7052 structure when the supervisor is actively providing direct care training to attendants, and therefore count toward the 90 percent threshold for spending in the attendant cost area under Rider 23.

Response: HHSC agrees and revises the rules. HHSC is removing references to field, direct care or attendant supervisor's salaries, wages, and benefits from the administrative, other direct care cost area, or service support components, and costs excluded from the definition of an attendant respectively in §355.503(c)(1)(F)(ii), §355.723(c)(2), §355.5902(c)(1)(A), and §355.7052(b)(2) and adding these costs to the attendant cost area in §355.7052(b)(1)(C). HHSC is revising §355.723(c)(1) to include attendant and direct care supervisors. It is HHSC's intention to align the definition of the attendant cost component with Centers for Medicare & Medicaid Services (CMS) Final Rule, relating to Ensuring Access to Medicaid Services. CMS revised 42 Code of Federal Regulation (CFR) §441.302(k)(1)(ii) and noted that clinical supervisors including "nurses or other staff who provide clinical oversight and training for direct care workers participate in activities directly related to beneficiary care (such as completing or reviewing documentation of care), are qualified to provide services directly to beneficiaries, and periodically interact with beneficiaries should be included in the definition of direct care workers." 89 *Federal Register* 40542, 40628 (May 10, 2024). CMS also modified their definition of

direct care worker at 42 CFR §441.302(k)(1)(ii)(F) to clarify that it includes nurses and other staff providing clinical supervision.

As such HHSC is revising the amendment to better align with CMS' definition that compensation for attendant supervisors, field supervisors or other staff providing clinical supervision are included in the attendant cost component. For Rider 23 requirements, this means costs related to attendant or field supervisors can be considered for the 90 percent spending threshold; however, revenue for these costs is not included in the attendant cost component in the rates proposed to be effective September 1, 2025. HHSC will need to ensure that revenue for clinical supervision is shifted to the attendant component from the other direct care component or support services component as applicable before HHSC is required to comply with reporting for the CMS Medicaid Access rule. HHSC is affirming that staff who provide administrative supervision are excluded from the attendant cost component. HHSC will publish an information letter regarding Rider 23 requirements after this adoption is effective.

Comment: One commenter requested clarification on whether attendant services contracted through staffing agencies are allowable for the purposes of HHSC's cost report, considered part of the attendant cost component, and count toward the 90 percent threshold for spending in the attendant cost area under Rider 23. The commenter requested that HHSC segregate labor costs contracted through staffing agencies on the cost report, require providers to identify services delivered through contract labor arrangements, identify providers that heavily rely on these arrangements as a compliance concern, and modify the rule amendment to limit the use of contract labor so that the use of these arrangements do not exceed 10 percent of total attendant service hours.

Response: HHSC disagrees and declines to revise the rule. HHSC's cost report currently separates compensation between employees and contracted staff. Contract labor is defined in the cost report instructions as labor provided by non-staff individuals. Non-staff refers to personnel who provide services to the contracted provider intermittently, whose remuneration (i.e., fee or compensation) is not subject to employer payroll tax contributions (e.g., Federal Insurance Contributions Act /Medicare, Federal Unemployment Tax Act, or State Unemployment Tax Act), and who perform tasks routinely performed by employees. HHSC will evaluate if modifications of the cost report instructions need to occur to define how costs incurred for staffing agency contracts needs to be reported. HHSC will publish an information letter related to Rider 23 requirements after this adoption is effective. Regarding the request to limit the proportion of a provider's use of staffing agency contracted labor to provide attendant services, regulation of an agency's use of staffing agency contracts is outside the scope of this rule adoption.

Comment: One commenter suggested HHSC was inconsistent in removing mileage reimbursement for personal attendant staff from the attendant cost component. The commenter requested clarification on how HHSC intends for providers to treat mileage reimbursement within cost reporting, particularly with respect to wage calculations, overtime, and compliance with federal labor standards including the Department of Labor wage and hour regulations and the Federal Medicaid Access rule. The commenter asked HHSC to consider allowing the mileage reimbursement for the purposes of the 90 percent threshold for spending in the attendant cost area under Rider 23.

Response: HHSC agrees in part and revises the rules to be consistent that mileage reimbursement is not part of the attendant cost component. HHSC is removing mileage reimbursement expenses from §355.456(d)(4) and (5) and is adding new paragraphs (6)-(9) to specify indirect service cost areas including dietary costs, transportation, facilities and operations costs, and administration costs to be consistent with language in HHSC's state plan on page 7 of Attachment 4.19-D Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Mileage reimbursement is included in the administrative cost component with other travel costs. Current §355.456(d)(6) is relabeled as new paragraph (10). HHSC is removing mileage reimbursement from the attendant or direct care cost areas in §355.503(c)(1)(F)(i), §355.505(c)(4)(A)(viii)(I), §355.513(c)(7)(A), and §355.5902(c)(1)(B) and (C) and clarifying that mileage reimbursement for attendants and supervisory staff is included in the administrative cost component in §355.503(c)(1)(F)(ii), the administration and operations component in §355.723(c)(3)(B)(ii), and the service support cost area in §355.5902(c)(1)(A).

It is HHSC's intention to align our definition of the attendant cost component with CMS' Medicaid Access rule. CMS excluded travel costs "for direct care workers (such as mileage reimbursement or public transportation subsidies)" at 42 CFR §441.302(k)(1)(iii)(B). CMS added new 42 CFR §441.302(k)(1)(iii)(B), noting that the new language "specifies that travel costs (such as reimbursement for mileage or public transportation) may be considered an excluded cost for the purposes of the minimum performance requirement at §441.302(k)(3)." 89 *Federal Register* at 40624. For the purposes of the minimum performance requirement, CMS states "providers can deduct the total travel expenses for direct care workers that providers incur from the total Medicaid payments they receive before the compensation percentage is determined." 89 *Federal Register* at 40624. HHSC's proposal asks providers to follow similar logic. HHSC is not directing providers to change their internal business practices nor to engage in practices that conflict with Department of Labor regulations. For the purposes of cost reporting, HHSC is asking providers to separate mileage reimbursement from their total attendant compensation expenses and report these costs as administrative and operations costs on the cost report. HHSC will publish additional guidance in the cost report instructions regarding mileage reimbursement and an information letter regarding Rider 23 requirements after this adoption is effective.

Comment: One commenter requested that HHSC amend the methodology for calculating the attendant cost component under §355.7052 using costs from either a blended wage based on the Bureau of Labor Statistics classifications reflecting the composite role of direct service professionals or the wage paid to direct support professionals in the State Supported Living Centers to better reflect the cost for the direct care workforce.

Response: HHSC disagrees and declines to revise the rule. HHSC has long relied on a cost report based methodology to establish the methodological cost for the attendant cost components which HHSC believes is more reflective from other sources that are nonspecific to Texas Medicaid providers.

For rules regarding nursing facilities, HHSC received comments from 15 commenters representing the following organizations: Ambassadors Group, Cantex Continuing Care Network, The Coalition of Independent Nursing Homes, Creative Solutions

Healthcare, Ensign Services, Focused Post Acute Care Partners LLC, Fundamental Administrative, Gulf Coast Partners, Keystone Care, Nexion Health Management, Priority Management, Regency Integrated Health Services, Senior Living Properties, StoneGate Senior Living, Summit LTC Management, and Texas Health Care Association.

A summary of comments relating to §355.305 and §355.318 and HHSC's responses follow.

Comment: Multiple commenters expressed concern with the requirement in §355.305 that nursing facility providers submit an annual cost report and requested modification of the rule to allow for the submission of a shortened report that just includes expenses and revenues needed to calculate the patient care expense ratio.

Response: HHSC disagrees and declines to revise the rule. HHSC believes that a full cost report allows for the availability of more recent and complete cost data to inform the next legislative session and aligns with annual enrollment requirements for providers that participate in the Quality Incentive Payment Program. Furthermore, the creation of a separate report for non-cost report submission years to meet the requirements pertaining to the patient care expense ratio would require cost reporting system changes that are not currently contemplated and would require additional funding to support.

Comment: Multiple commenters seek clarity on the measurement period for achieving a four-star rating exemption from any recoupment under the patient care expense ratio in §355.305 since the CMS quarterly four-star reporting periods do not align with the Texas state fiscal year quarters.

Response: HHSC declines to revise the rule. HHSC will rely on the five-star ratings published by CMS that reflect the most closely aligned measurement period to the cost reporting period. The measurement period will cover the federal fiscal year (i.e., for fiscal year 2026, October 2025 through September 2026) and the cost reporting period will align with the state fiscal year (i.e., for fiscal year 2026, September 2025 through August 2026). HHSC expects CMS to publish five-star ratings for this period in January 2027 through the *Provider Information* public use file available in the CMS Provider Data Catalog. HHSC will publish an information letter regarding the requirements associated with the patient care expense ratio and cost reporting requirements once this adoption is effective.

Comment: Multiple commenters seek clarification whether transportation and maintenance expenses included within the operations rate component in §355.318 are included in the "allowable" patient care expenses listed in §355.305(b)(2)(A).

Response: HHSC agrees and revises the rule so there is consistency between §355.305 and §355.318 by removing transportation and maintenance costs in §355.318 from the operations rate component in subsection (d)(5) and moving it to the administration rate component in subsection (d)(6). HHSC cannot include transportation and maintenance costs under the patient care expense ratio as these expenses were not enumerated in S.B. 457. The bill indicates that any expenses not listed under patient care expenses are considered an administrative expense.

Comment: Multiple commenters expressed concerns that the Brief Interview for Mental Status (BIMS) rate component should be paid for residents with a BIMS score range of 0 to 10 instead of a range of 0 to 7 as currently indicated in §355.318.

Response: HHSC disagrees and declines to revise the rule. Expanding the payment of the rate component for residents with BIMS scores up to 10 does not clearly align with how HHSC interprets the BIMS score ranges under PDPM methodology in Medicare for skilled nursing facilities. Under the Medicare PDPM methodology, a BIMS score of 0-7 represents severe impairment while 8-12 represents moderate impairment. The inclusion of BIMS scores 8-10 for payment of the rate component could be problematic due to the overlap of the moderate impairment range. Moreover, HHSC's current appropriations do not support this change.

Comment: One commenter expressed concern with the definition used for the BIMS in §355.318(d)(3). The proposed rule states "residents with a BIMS score between 0 and 7 or a determination of severe or moderate impairment based on the calculation of the PDPM cognitive level for residents without a BIMS score on the MDS." The commenter states a BIMS score of 0-7 indicates severe cognitive impairment, while a score of 8-12 indicates moderate cognitive impairment. They suggest HHSC remove "severe or" from the proposed text.

Response: HHSC agrees in part and revises the rule. As described above, HHSC is not changing the BIMS score range of 0 to 7 for the purposes of payment of the BIMS component. HHSC agrees that the language in §355.318(d)(3) is not sufficiently clear and revises paragraph (3) to state: "This rate component includes additional staff costs associated with providing care to residents with a BIMS score between 0 and 7 or a determination of severe or moderate impairment based on the calculation of the PDPM cognitive level for residents without a BIMS score on the MDS." Corresponding edits are also made in subsections (b)(1), (c)(1), and (c)(1)(C).

HHSC understands that for residents for which a BIMS score is calculated on the MDS a score ranging from 0 to 7 is considered moderate impairment. It is HHSC's intention that the BIMS rate component is paid for residents with moderate impairment (BIMS score of 0 to 7) and for residents with moderate or severe impairment who do not have a BIMS score calculated on the Minimum Data Set (MDS). HHSC will follow CMS' prescribed process for determining impairment for individuals who do not have a BIMS score reported on the MDS as defined in the MDS 3.0 Resident Assessment Instrument manual.

Comment: One commenter seeks clarification on how appropriations provided through the 2024-25 General Appropriations Act, H.B. 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Riders 24 and 25) and 2026-27 General Appropriations Act Rider 25 were allocated to the nursing facility rates proposed to be effective September 1, 2025.

Response: This comment is not within the scope of this rule proposal. Comments related to the proposed rates were addressed as a part of the rate adoption process. All appropriations from the 88th and 89th legislative Sessions were included in the rates proposed at the July 16, 2025, rate hearing.

Comment: One commenter expressed that HHSC should clearly identify any compensation and benefits that would not be allowable under the patient care expense ratio in §355.305.

Response: HHSC disagrees and declines to revise the rule. HHSC believes §355.305(b)(2)(A) references that compensation and benefits for the listed staff types would be subject to the patient care expense ratio. 1 TAC 355.102(f) defines allowable costs as "expenses...that are reasonable and necessary…." Un-

der SB 457, the annual patient care expense ratio must require "that at least 80% of the portion of the of the medical assistant reimbursement amount paid to a nursing facility that is attributable to patient care expenses is spent on reasonable and necessary patient care expenses." This definition is consistent with HHSC's understanding of allowable costs.

Comment: One commenter expressed concern with the lack of an appeals process for meeting the annual patient care expense ratio and the associated spending requirement and recoupment described in §355.305. The commenter recommends a clear appeal process for providers to have their determinations reviewed.

Response: HHSC agrees and revises §355.305 by adding subsection (h) to address appeals process in this subsection. The current subsection §355.305(h) is relabeled as new subsection (i).

Comment: One commenter expressed concern with excluding MDS coordinators from the staff within the nursing rate component listed in §355.318(d)(1). The commenter recommends changing "including DONs and ADONs" to read "including DONs, ADONs, and MDS coordinators."

Response: HHSC agrees and revises §355.318(d)(1) to include "MDS coordinators."

Comment: One commenter expressed concern with worker's compensation claims being recognized as an operations component cost in §355.318(d)(5). Nursing facilities providers who are non-subscribers in the worker's compensation system will have incurred expenses associated with establishing a non-subscriber plan that should be included on a cost report.

Response: HHSC disagrees and declines to revise the rule. Allowable insurance costs based on type of plan are outlined in §355.103(b)(13).

HHSC made a minor edit to add the closing parenthesis in §355.503(b).

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §355.102, §355.105

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.102. General Principles of Allowable and Unallowable Costs.

(a) Allowable and unallowable costs. Allowable and unallowable costs, both direct and indirect, are defined to identify expenses that are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations. When a particular type of expense is classified as unallowable, the classification means only that the expense will not be included in the database for reimbursement determination purposes because the expense is not considered reasonable and/or necessary. The classification does not mean that individual contracted providers may not make the expenditure. The description of allowable and unallowable costs is designed to be a general guide and to clarify certain key expense areas. This description is not comprehensive, and the failure to identify a particular cost does not necessarily mean that the cost is an allowable or unallowable cost.

(b) Cost-reporting process. The primary objective of the cost-reporting process is to provide a basis for determining appropriate reimbursement to contracted providers. To achieve this objective, the reimbursement determination process uses allowable cost information reported on cost reports or other surveys. The cost report collects actual allowable costs and other financial and statistical information, as required. Costs may not be imputed and reported on the cost report when no costs were actually incurred (except as stated in §355.103(b)(19)(A)(i) of this title (relating to Specifications for Allowable and Unallowable Costs) or when documentation does not exist for costs even if they were actually incurred during the reporting period).

(c) Accurate cost reporting. Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs incurred, based on an accrual method of accounting, which are reasonable and necessary, in accordance with allowable and unallowable cost guidelines in this section and in §355.103 of this title, revenue reporting guidelines in §355.104 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. The Texas Health and Human Services Commission (HHSC) is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(d) Cost report training. It is the responsibility of the provider to ensure that each cost report preparer has completed the required state-sponsored training. Preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of cost report preparation. Preparers must complete training for each program for which a cost report is submitted, as applicable. Contracted preparer's fees to complete training are considered allowable expenses for cost reporting purposes. Preparers that participate in training may be assessed a convenience fee, which will be determined by HHSC. Convenience fees assessed for training are allowable costs. Applicable federal and state accessibility standards apply to training. Reporting schedules per program are determined by HHSC and are published on the HHSC website.

(1) Training schedules. For all programs. Preparers must complete the state-sponsored training each year a cost report is requested by HHSC and for each program for which a cost report is submitted. Preparers who complete the required state-sponsored training during the year in which a cost report is submitted for a program will not have to complete the training for that program to prepare any other reports required by HHSC during the following calendar year. At HHSC's discretion, HHSC may require a provider's primary entity contact and financial contact of a contracted provider to complete a state-sponsored training to certify and submit a cost or other report re-

quired by HHSC. A provider's primary entity contract and financial contact who completes a state-sponsored training to certify and submit a cost report for a program will not have to complete the training for that program during the next calendar year to submit other reports for that program required by HHSC.

(2) Failure to complete the required cost report training.

(A) For nursing facilities, failure to file a completed cost report signed by preparers who have completed the required cost report training may result in vendor hold as specified in §355.403 of this title (relating to Vendor Hold).

(B) For School Health and Related Services (SHARS) providers, failure to complete the required cost report training may result in an administrative contract violation as specified in §355.8443 of this title (relating to Reimbursement Methodology for School Health and Related Services (SHARS)).

(C) For all other programs, failure to file a completed cost report signed by preparers who have completed the required cost report training constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title (relating to Administrative Contract Violations).

(e) Generally accepted accounting principles. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost reporting rules differ from GAAP, IRS, or other authorities, HHSC rules take precedence for provider cost-reporting purposes.

(f) Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary, as defined in paragraphs (1) and (2) of this subsection, and which meet the requirements as specified in subsections (i), (j), and (k) of this section, in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(1) "Reasonable" refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service. In determining the reasonableness of a given cost, the following are considered:

(A) the restraints or requirements imposed by arm's-length bargaining, i.e., transactions with nonowners or other unrelated parties, federal and state laws and regulations, and contract terms and specifications; and

(B) the action that a prudent person would take in similar circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, and members, and the fulfillment of the purpose for which the business was organized.

(2) "Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted client care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing client care in accordance with the contract and state and federal regulations. In addition, to qualify as a necessary expense, a direct or indirect cost must meet all of the following requirements:

(A) the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;

(B) the cost does not appear as a specific unallowable cost in §355.103 of this title;

(C) if a direct cost, it bears a significant relationship to contracted client care. To qualify as significant, the elimination of the expenditure would have an adverse impact on client health, safety, or general well-being;

(D) the direct or indirect expense was incurred in the purchase of materials, supplies, or services provided to clients or staff in the normal conduct of operations to provide contracted client care;

(E) the direct or indirect costs are not allocable to or included as a cost of any other program in either the current, a prior, or a future cost-reporting period;

(F) the costs are net of all applicable credits;

(G) allocated costs of each program are adequately substantiated; and

(H) the costs are not prohibited under other pertinent federal, state, or local laws or regulations.

(3) Direct costs are those costs incurred by a provider that are definitely attributable to the operation of providing contracted client services. Direct costs include, but are not limited to, salaries and nonlabor costs necessary for the provision of contracted client care. Whether or not a cost is considered a direct cost depends upon the specific contracted client services covered by the program. In programs in which client meals are covered program services, the salaries of cooks and other food service personnel are direct costs, as are food, nonfood supplies, and other such dietary costs. In programs in which client transportation is a covered program service, the salaries of drivers are direct costs, as are vehicle repairs and maintenance, vehicle insurance and depreciation, and other such client transportation costs.

(4) Indirect costs are those costs that benefit, or contribute to, the operation of providing contracted services, other business components, or the overall contracted entity. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office or home office administrative expenses are considered indirect costs. As specified in §355.8443 of this title, SHARS providers use an unrestricted indirect cost rate to determine indirect costs.

(g) Unallowable costs. Unallowable costs are expenses that are not reasonable or necessary, according to the criteria specified in subsection (f)(1) - (2) of this section and which do not meet the requirements as specified in subsections (i), (j), and (k) of this section or which are specifically enumerated in §355.103 of this title or program-specific reimbursement methodology. Providers must not report as an allowable cost on a cost report a cost that has been determined to be unallowable. Such reporting may constitute fraud. (Refer to §355.106(a) of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports)).

(1) For nursing facilities, placement as an allowable cost on a cost report of a cost which has been determined to be unallowable may result in vendor hold as specified in §355.403 of this title.

(2) For Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), Home and Community-based Services (HCS), Service Coordination/Targeted Case Management, Rehabilitative Services, and Texas Home Living (TxHmL) programs, placement as an allowable cost on a cost report

a cost, which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS providers, submission of a cost that has been determined to be unallowable may result in an administrative contract violation as specified in §355.8443 of this title.

(4) For all other programs, submission of a cost, which has been determined to be unallowable, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(h) Other financial and statistical data. The primary purpose of the cost report is to collect allowable costs to be used as a basis for reimbursement determination. In addition, providers may be required on cost reports to provide information in addition to allowable costs to support allowable costs, such as wage surveys, workers' compensation surveys, or other statistical and financial information. Additional data requested may include, when specified and in the appropriate section or line number specified, costs incurred by the provider which are unallowable costs. All information, including other financial and statistical data, shown on a cost report is subject to the documentation and verification procedures required for an audit desk review and/or field audit.

(1) For nursing facilities, inaccuracy in providing, or failure to provide, required financial and statistical data may result in vendor hold as specified in §355.403 of this title.

(2) For ICF/IID, HCS, Service Coordination/Targeted Case Management, Rehabilitative Services, and TxHmL programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(3) For SHARS, inaccuracy in providing, or failure to provide, required financial and statistical data may result in an administrative contract violation as specified in §355.8443 of this title.

(4) For all other programs, inaccuracy in providing, or failure to provide, required financial and statistical data constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(i) Related party transactions.

(1) In determining whether a contracted provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. Related to a contracted provider means that the contracted provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnishing the services, equipment, facilities, leases, or supplies. Common ownership exists if an individual or individuals possess any ownership or equity in the contracted provider and the institution or organization serving the contracted provider. Control exists if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. If the elements of common ownership or control are not present in both organizations, then the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for cost-reporting purposes:

(A) husband and wife;

(B) natural parent, child, and sibling;

(C) adopted child and adoptive parent;

(D) stepparent, stepchild, stepsister, and stepbrother;

(E) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law;

(F) grandparent and grandchild;

(G) uncles and aunts by blood or marriage;

(H) nephews and nieces by blood or marriage; and

(I) first cousins.

(2) A determination as to whether an individual (or individuals) or organization possesses ownership or equity in the contracted provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the contracted provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization, e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation.

(3) The term control includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise. The facts and circumstances in each case must be examined to ascertain whether legal or effective control exists. Since a determination made in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same. Organizations, whether proprietary or nonprofit, are considered to be related through control to their directors in common.

(4) Costs applicable to services, equipment, facilities, leases, or supplies furnished to the contracted provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, the cost must not exceed the price of comparable services, equipment, facilities, leases, or supplies that could be purchased or leased elsewhere. The purpose of this principle is twofold: to avoid the payment of a profit factor to the contracted provider through the related organization (whether related by common ownership or control), and to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. The related organization's costs include all actual reasonable costs, direct and indirect, incurred in the furnishing of services, equipment, facilities, leases, or supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the contracted provider itself. Therefore, if a cost would be unallowable if incurred by the contracted provider itself, it would be similarly unallowable to the related organization. The principles of reimbursement of contracted provider costs described throughout this title will generally be followed in determining the reasonableness and allowability of the related organization's costs, where application of a principle in a nonprovider entity would be clearly inappropriate.

(5) An exception is provided to the general rule applicable to related organizations. The exception applies if the contracted provider demonstrates by convincing evidence to the satisfaction of

HHSC that certain criteria have been met. If all of the conditions of this exception are met, then the charges by the supplier to the contracted provider for such services, equipment, facilities, leases, or supplies are allowable costs. If Medicare has made a determination that a related party situation does not exist or that an exception to the related party definition was granted, HHSC will review the determination made by Medicare to determine if it is applicable to the current situation of the contracted provider and in compliance with this subsection (relating to related party transactions). In order to have the Medicare determination considered for approval by HHSC, a copy of the applicable Medicare determination must accompany each written exception request submitted to HHSC, along with evidence supporting the Medicare determination for the current cost-reporting period. If the exception granted by Medicare no longer is applicable due to changes in circumstances of the contracted provider or because the circumstances do not apply to the contracted provider, HHSC may choose not to consider the Medicare determination. Written requests for an exception to the general rule applicable to related organizations must be submitted for approval to the HHSC Provider Finance Department no later than 45 days prior to the due date of the cost report in order to be considered for that year's cost report. Each request must include documentation supporting that the contracted provider meets each of the four criteria listed in subparagraphs (A) - (D) of this paragraph. Requests that do not include the required documentation for each criteria will not be considered for that year's cost report.

(A) The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the contracted provider organization.

(B) A majority of the supplying organization's business activity of the type carried on with the contracted provider is transacted with other organizations not related to the contracted provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, equipment, facilities, leases, or supplies furnished by the organization. In determining whether the activities are of similar type, it is important also to consider the scope of the activity. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arm's-length bargaining by well-informed buyers and sellers.

(C) The services, equipment, facilities, leases, or supplies are those which commonly are obtained by entities such as the contracted provider from other organizations and are not a basic element of contracted client care ordinarily furnished directly to clients by such entities. This requirement means that entities such as the contracted provider typically obtain the services, equipment, facilities, leases, or supplies from outside sources, rather than producing them internally.

(D) The charge to the contracted provider is in line with the charge of such services, equipment, facilities, leases, or supplies in the open, competitive market and no more than the charge made under comparable circumstances to others by the organization for such services, equipment, facilities, leases, or supplies.

(6) Disclosure of all related-party information on the cost report is required for all costs reported by the contracted provider, including related-party transactions occurring at any level in the provider's organization, (e.g., the central office level, and the individual contracted provider level). The contracted provider must make available, upon request, adequate documentation to support the costs incurred by the related party. Such documentation must include an identification of the related person's or organization's total costs, the basis of allocation of direct and indirect costs to the contracted provider, and other business entities served. If a contracted provider fails to provide adequate documentation to substantiate the cost to the related person or organization, then the reported cost is unallowable. For further guidelines regarding adequate documentation, refer to §355.105(b)(2) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(7) When calculating the cost to the related organization, the cost-determination guidelines specified in this section and in §355.103 of this title apply.

(j) Cost allocation. Direct costing must be used whenever reasonably possible. Direct costing means that allowable costs, direct or indirect, (as defined in subsection (f)(3) - (4) of this section) incurred for the benefit of, or directly attributable to, a specific business component must be directly charged to that particular business component. For example, the payroll costs of a direct care employee who works across cost areas within one contracted program would be directly charged to each cost area of that program based upon that employee's continuous daily time sheets and the costs of a direct care employee who works across more than one service delivery area would also be directly charged to each service delivery area based upon that employee's continuous daily time sheets. Health insurance premiums, life insurance premiums, and other employee benefits must be direct costed.

(1) If cost allocation is necessary for cost-reporting purposes, contracted providers must use reasonable methods of allocation and must be consistent in their use of allocation methods for cost-reporting purposes across all program areas and business entities.

(A) The allocation method should be a reasonable reflection of the actual business operations. Allocation methods that do not reasonably reflect the actual business operations and resources expended toward each unique business entity are not acceptable. Allocated costs are adjusted if HHSC considers the allocation method to be unreasonable. An indirect allocation method approved by some other department, program, or governmental entity is not automatically approved by HHSC for cost-reporting purposes.

(B) HHSC reviews each cost-reporting allocation method on a case-by-case basis in order to ensure that the reported costs fairly and reasonably represent the operations of the contracted provider. If in the course of an audit it is determined that an existing or approved allocation method does not fairly and reasonably represent the operations of the contracted provider, then an adjustment to the allocation method will be made consistent with subsection (f)(3) - (4) of this section. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title (relating to Informal Reviews and Formal Appeals).

(C) Any allocation method used for cost-reporting purposes must be consistently applied across all contracted programs and business entities in which the contracted provider has an interest.

(D) Providers must use an allocation method approved or required by HHSC. Any change in cost-reporting allocation methods from one year to the next must be fully disclosed by the contracted provider on its cost report and must be accompanied by a written explanation of the reasons and justification for such change. If the provider wishes to use an allocation method that is not in compliance with the cost-reporting allocation methods in paragraphs (3) - (4) of this subsection, the contracted provider must obtain written prior approval from HHSC's Provider Finance Department.

(i) Requests for approval to use an allocation method other than those identified in paragraphs (3) - (4) of this

subsection or for approval of a provider's change in cost-reporting allocation method other than those identified in paragraphs (3) - (4) of this subsection must be received by HHSC's Provider Finance Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(ii) The HHSC Provider Finance Department will forward its written decision to the contracted provider within 45 days of its receipt of the provider's original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, then HHSC may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title.

(iii) Failure to use an allocation method approved or required by HHSC or to disclose a change in an allocation to HHSC will result in the following.

(I) For nursing facilities, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC may result in vendor hold as specified in §355.403 of this title.

(II) For ICF/IID, HCS, Service Coordination/Targeted Case Management, Rehabilitative Services, and TxHmL programs, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(III) For SHARS, failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this title.

(IV) For all other programs, failure to disclose a change in an allocation method or failure to use the allocation method approved or required by HHSC constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this title.

(E) For small and large state-operated ICF/IID, designated as Bond Homes and State Supported Living Centers for cost reporting purposes, these facility types may use an allocation method other than those identified in paragraphs (3) - (4) of this subsection in order to represent indirect costs that are a reasonable reflection of the actual business operations. If an allocation method other than those identified in paragraphs (3) - (4) of this subsection is used for indirect costs, the allocation method must adhere to Generally Accepted Accounting Principles.

(2) Cost-reporting methods for allocating costs must be clearly and completely documented in the contracted provider's workpapers, with details as to how pooled costs are allocated to each segment of the business entity, for both contracted and noncontracted programs.

(A) If a contracted provider has questions regarding the reasonableness of an allocation method, that contracted provider should request written approval from the HHSC Provider Finance Department prior to submitting a cost report utilizing the allocation method in question. Requests for approval must be received by the HHSC Provider Finance Department prior to the end of the contracted provider's fiscal year. Requests for approval of allocation methods will not be acceptable as a basis for the extension of the cost report due date.

(B) The HHSC Provider Finance Department will forward its written decision to the contracted provider within 45 days of its receipt of the original written request. If sufficient documentation is not provided by the provider to verify the acceptability of the allocation method, HHSC may extend the decision time frame. However, an extension of the due date of the cost report will not be granted. Written decisions made on or after the due date of the cost report will apply to the next year's cost report. A contracted provider may request an informal review, and subsequently an appeal, of a decision concerning its allocation methods in accordance with §355.110 of this title.

(3) When a building is shared and the building usage is separate and distinct for each entity using the building, the building costs, identified as building and facility cost categories on the cost report, should be allocated based upon square footage and may not be allocated with other indirect costs as a pool of costs. When the same building space is shared by various entities, the shared building costs, identified as building and facility cost categories on the cost report, should be allocated using a reasonable method which reflects the actual usage, such as an allocation based on time in shared activity areas or a functional study of shared dietary costs related to shared dining and kitchen areas.

(4) Where costs are shared, are not directly chargeable and are allocated as a pool of costs, the following allocation methods are acceptable for cost-reporting purposes.

(A) If all the business components of a contracted provider have equivalent units of equivalent service, indirect costs must be allocated based upon each business component's units of service. For example, if a provider had two nursing facilities, indirect costs requiring allocation as a pool of costs must be allocated based upon each nursing facility's units of service, since the units of service are equivalent units and the services are equivalent services. If a provider had a nursing facility and a residential care program, indirect costs requiring allocation as a pool of costs could not be allocated based upon units of service because even though the units of service for a nursing facility and a residential care facility are equivalent units, the services are not equivalent services. If a home health agency has indirect costs requiring allocation as a pool of costs across its Medicare home health services and its Medicaid primary home care services, it could not use units of service to allocate those costs, since neither the units of service nor the services are equivalent.

(B) If all of a contracted provider's business components are labor-intensive without programmatic residential facility or residential building costs, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs based either on each business component's pro rata share of salaries or labor costs or on a cost-to-cost basis.

(i) For cost-reporting cost allocation purposes, the term "salaries" includes wages paid to employees directly charged to the specific business component. The term "salaries" also includes fees paid to contracted individuals, excluding consultants, who perform services routinely performed by employees, which are directly charged to the specific business component. The term "salaries" does not include payroll taxes and employee benefits associated with the wages of employees.

(ii) For cost-reporting cost-allocation purposes, the term "labor costs" includes salaries as defined in clause (i) of this sub-

paragraph, plus the payroll taxes and employee benefits associated with the wages of the employees.

(iii) The cost-to-cost method allocates costs based upon the percentage of each business component's directly-charged costs to the total directly-charged costs of all business components.

(C) If a contracted provider's business components are mixed, with some being labor-intensive and others having a programmatic residential or institutional component, the contracted provider must allocate its indirect costs requiring allocation as a pool of costs either:

(i) based upon the ratio of each business component's total costs less that business component's facility or building costs, as related to the contracted provider's total business component costs less facility or building costs for all the contracted provider's business components, with "facility or building costs" referring to those cost categories as identified on the cost report; or

(ii) based upon the labor costs method stated in subparagraph (B)(ii) of this paragraph.

(D) In order to achieve a more accurate and representative reporting of costs than results from allocating shared indirect costs as a pool of costs, a provider may choose to allocate its indirect shared expenses on an appropriate and reasonable functional basis. If allocating shared direct client care costs, a provider may use an appropriate and reasonable functional method. For example, costs of a central payroll operation could be allocated to all business components based on the number of checks issued; the costs of a central purchasing function could be allocated based on the number of purchases made or requisitions handled; payroll costs for an administrative employee working across business components could be directly charged based upon that employee's time sheets and/or allocated based upon a documented time study; food costs could be allocated based upon a functional study of shared dietary costs; transportation equipment costs could be allocated based upon mileage logs; and shared laundry costs could be allocated based upon a functional study of the number of pounds/loads of laundry processed. Providers choosing to allocate allowable employee-related self-insurance paid claims in accordance with §355.103(b)(13)(B)(ii) of this title should base the allocation on percentage of salaries of employees benefiting from the coverage for fully self-insured situations or on percentage of premiums of covered employees for partially self-insured situations since purchased premiums must be directly charged.

(E) Because the determination of reimbursement is based on cost data, allocation methods based upon revenue streams are inappropriate and unallowable.

(k) Net expenses. Net expenses are gross expenses less any purchase discounts or returns and allowances. Purchase discounts are cash discounts reducing the purchase price as a result of prompt payment, quantity purchases, or for other reasons. Purchase returns and allowances are reductions in expenses resulting from returned merchandise or merchandise which is damaged, lost, or incorrectly billed. Only net expenses may be reported on the cost report. Expenses reported on the cost report must be adjusted for all such purchase discounts or returns and allowances.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 867-7817

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1 TAC §355.112

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025

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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §§355.304, 355.306 - 355.308, 355.320

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025

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1 TAC §355.305, §355.318

STATUTORY AUTHORITY

The amendment and new rules are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.305. Annual Patient Care Expense Ratio for Nursing Facilities.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) establishes the annual patient care expense ratio for nursing facilities (NF) 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) Annual patient expense ratio--The ratio of patient care expenses as defined in paragraph (2) of this subsection to the NF's patient care revenue as defined in paragraph (3) of this subsection for a rate year as defined in paragraph (4) of this subsection.

(2) Patient care expenses--

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

(i) compensation and benefits for direct care staff and direct care contracted labor for the following staff:

(I) licensed registered nurse;

(II) licensed vocational nurse;

(III) medication aide;

(IV) restorative aide;

(V) nurse aide who provides nursing-related care to residents occupying medical assistance beds;

(VI) licensed social worker;

(VII) social services assistant;

(VIII) additional staff associated with providing care to facility residents with a severe cognitive impairment;

(IX) nonprofessional administrative staff, including medical records staff and accounting or bookkeeping staff;

(X) central supply staff and ancillary facility staff;

(XI) laundry staff;

(XII) housekeeping staff; and

(XIII) food service staff; and

(ii) central supply costs and ancillary costs for facility services and supplies, including:

(I) diagnostic laboratory and radiology costs;

(II) durable medical equipment costs, including costs to purchase, rent, or lease the equipment;

(III) costs for oxygen used to provide oxygen treatment;

(IV) prescription and nonprescription drug costs;

(V) therapy consultant costs; and

(iii) costs for dietary and nutrition services, including costs for food services and related supplies, and nutritionist services; and

(B) exclude the following:

(i) administrative or operational costs, other than administrative or operational costs described in subparagraph (A) of this paragraph; and

(ii) fixed capital assets costs.

(3) Patient care revenue--In a rate year, the medical assistance revenue paid to an NF where the revenue is associated with the following rate components as described in §355.318 of this subchapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025):

(A) nursing rate component;

(B) non-therapy ancillary (NTA) rate component;

(C) brief interview for mental status (BIMS) rate component;

(D) dietary rate component; and

(E) operations rate component.

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

(c) Reporting requirements. An NF must submit an annual cost report in accordance with §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). HHSC will examine the cost report in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

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

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

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

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

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

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

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

(A) overall;

(B) health inspections;

(C) staffing; and

(D) long-stay quality measures.

(2) The NF:

(A) maintained an average daily occupancy rate of 75 percent or less; and

(B) spent at least 70 percent of the patient care revenue as defined in subsection (b)(3) of this section on patient care expenses as defined in subsection (b)(2)(A) of this section.

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

(g) Notification of recoupment based on annual cost reports. HHSC will notify an NF that failed to meet the annual patient care expense ratio of the associated spending requirement and recoupment as specified under §355.107 (relating to Notification of Exclusions and Adjustments).

(h) Appeals. Informal reviews and formal appeals relating to these reporting requirements in subsection (c) of this section are governed by §355.110 of this chapter (relating to Informal Reviews and Formal Appeals).

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

§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 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 a 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 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), Assistant Directors of Nursing (ADONs), and Minimum Data Set (MDS) coordinators; Licensed Vocational Nurses (LVNs), including DONs, ADONs, and MDS coordinators; medication aides; restorative aides; nurse aides performing nursing-related duties for Medicaid contracted beds; and certified social worker and social service assistant wages.

(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 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, 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, 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, and other direct care non-professional staff wages, including medical records staff compensation and benefits; ancillary costs, including ancillary staff compensation and benefits; diagnostic laboratory and radiology costs; durable medical equipment purchase, rent, or lease costs; oxygen costs; 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 a BIMS score between 0 and 7 or a determination of severe or moderate impairment based on the calculation of the PDPM cognitive level for residents without a BIMS score on the MDS.

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

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

(6) Administration rate component. The administration rate component includes the following expenses: compensation, payroll taxes, benefits, and worker's compensation claims for executive administrator, assistant administrator, administrative assistants, owner, other administrative staff, transportation and maintenance staff, and central office staff. This rate component also reflects the following non-staff costs: utilities; telecommunications; other interest; insurance, excluding liability insurance expenses reimbursed under §355.312 of this subchapter (relating to Reimbursement Setting Methodology--Liability Insurance Costs); staff training and seminars; staff travel costs including personal mileage reimbursement; management contract fees; contracted administrative, professional, consulting and training services; licenses and permits; other taxes excluding non-administrative staff payroll taxes; advertising, allowable dues and membership; transportation costs; and other allowable costs not included in the other rate components.

(7) Fixed capital asset rate component. This rate component includes building and building equipment depreciation and lease expense, mortgage interest, land improvement depreciation, and 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 dietary rate component. HHSC calculates a median of allowable dietary costs defined in subsection (d)(4) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

(6) Calculation of the operations rate component. HHSC calculates a median of the allowable operations costs defined in subsection (d)(5) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

(7) Calculation of the administration rate component. HHSC calculates a median of the allowable administration costs defined in subsection (d)(6) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

(8) Calculation of the fixed capital assets rate component. HHSC calculates a median of allowable fixed capital costs defined in subsection (d)(7) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

(9) Total per diem rate determination. For each of the PDPM LTC groups and default groups, the recommended total per diem rate is determined as the sum of the following seven rate components:

(A) Nursing rate component;

(B) NTA rate component;

(C) BIMS rate component;

(D) Dietary rate component;

(E) Operations rate component;

(F) Administration rate component; and

(G) Fixed capital asset rate component.

(10) 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 administration rate component. HHSC sets upper limits at the 90th percentile of all costs per unit of service as reported by all contracted facilities using the cost report database immediately preceding the database used to establish reimbursements in 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) and §355.321 of this chapter (relating to Reimbursement Methodology for Intellectual and Developmental Disabilities Nursing Facilities Special Reimbursement Class).

(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.

(k) 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 under this section.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. REIMBURSEMENT METHODOLOGY FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH AN INTELLECTUAL DISABILITY OR RELATED CONDITIONS (ICF/IID)

1 TAC §355.456

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.456. Reimbursement Methodology.

(a) Types of facilities. There are two types of facilities for purposes of rate setting: state-operated and non-state operated. Facilities are further divided into classes that are determined by the size of the facility.

(b) Classes of non-state operated facilities. There is a separate set of reimbursement rates for each class of non-state operated facilities, which are as follows.

(1) Large facility--A facility with a Medicaid certified capacity of 14 or more as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(2) Medium facility--A facility with a Medicaid certified capacity of nine through 13 as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(3) Small facility--A facility with a Medicaid certified capacity of eight or fewer as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(c) Classes of state-operated facilities. There is a separate interim rate for each class of state-operated facilities, which are as follows:

(1) Large facility--A facility with a Medicaid certified capacity of 17 or more as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(2) Small facility--A facility with a Medicaid certified capacity of 16 or less as of the first day of the full month immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(d) Reimbursement rate determination for non-state operated facilities. The Texas Health and Human Services Commission (HHSC) will adopt the reimbursement rates for non-state operated facilities in accordance with §355.101 of this title (relating to Introduction) and this subchapter.

(1) Covered services. Reimbursement rates combine residential and day program services, i.e., payment for the full 24 hours of daily service.

(2) Level of need (LON) differentiation. Reimbursement rates are differentiated based on the level of need (LON) of the individual receiving the service. The levels of need are intermittent, limited, extensive, pervasive, and pervasive plus.

(3) Cost components determination. The recommended modeled rates are based on cost components deemed appropriate for economically and efficiently operated services. The determination of these components is based on cost reports submitted by Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) providers.

(4) Direct service workers cost area. This cost area includes direct service workers' salaries, wages, and benefits expenses. The reimbursement rate for this cost area is calculated as specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(5) Direct care trainers and job coaches cost area. This cost area includes direct care trainers' and job coaches' salaries, wages, and benefits expenses. The reimbursement rate for this cost area is calculated as specified in §355.7052 of this chapter.

(6) Other resident care cost area. This cost area includes compensation costs for laundry and housekeeping personnel, social workers, medical records personnel, resident care training personnel, therapists, psychologists, and other direct care consultants, as well as costs for medical equipment and supplies, and laundry and housekeeping equipment and supplies.

(7) Dietary costs. This cost area includes compensation costs for dietary personnel as well as costs for food and dietary supplements.

(8) Transportation, facilities and operations costs area. This cost area includes compensation costs for maintenance personnel and drivers, maintenance supplies, departmental equipment and transportation equipment rentals and leases and depreciation, land and leasehold improvement, depreciation and amortization, mortgage interest, property taxes and vehicle insurance, and utilities and telecommunications.

(9) Administration costs. This cost area includes compensation costs for administration personnel such as facility administrator, clerical support and central office staff, administrative staff, general liability insurance, interest expense on working capital, allowable advertising, travel (including mileage reimbursement) and seminars, dues and subscriptions, office supplies, central office costs, and other similar office expenses.

(10) High Medical Needs Add-on reimbursement rate on or after September 1, 2025. This add-on methodology will be implemented pending implementation of the Patient Driven Payment Model (PDPM) for Long-Term Care (LTC), as specified in §355.318 of this chapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025).

(A) The add-on is based on the PDPM LTC classification system as described in §355.318 of this chapter.

(B) There are three add-on groupings based on PDPM LTC classification and nursing case-mix classifiers, associated with the assessed nursing score.

(i) Group 1 includes nursing case-mix classifier "E" relating to the Extensive Services category.

(ii) Group 2 includes nursing case-mix classifiers "H" and "L" relating to the Special Care High and Special Care Low categories.

(iii) Group 3 includes nursing case-mix "C" relating to the Clinically Complex category.

(C) An individual must meet the following criteria to be eligible to receive the add-on rate:

(i) be assigned a PDPM LTC nursing case-mix classifier in Group 1, Group 2, or Group 3;

(ii) be a resident of a large state-operated facility for at least six months immediately prior to referral or a resident of a Medicaid-certified nursing facility immediately prior to referral; and

(iii) for residents of a large state-operated facility only, have a LON which includes a medical LON increase as described in 26 TAC §261.241 (relating to Level of Need Criteria), but not be assessed a LON of pervasive plus.

(D) The add-on for each Group is determined based on data and costs from the most recent nursing facility cost reports accepted by HHSC.

(i) Calculate the average number of nursing hours per daily unit of service by dividing total nursing hours by total days of service.

(ii) Calculate the average licensed vocational nurse (LVN) cost per day by multiplying estimated LVN hourly wages by the average number of nursing hours per daily unit of service.

(iii) For each Group, compute the median per diem amount of the nursing care base case-mix adjusted rate component for all facilities as specified in §355.318 of this chapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025); and

(iv) Subtract the average nursing daily cost as specified in clause (ii) of this subparagraph from the median per diem amount of the nursing care rate component as specified in clause (iii) of this subparagraph current recommended modeled rates as specified in subsection (d)(3) of this section.

(e) Reimbursement determination for state-operated facilities. Except as provided in paragraph (2) of this subsection and subsection (f) of this section, state-operated facilities are reimbursed an interim rate with a settlement conducted in accordance with paragraph (1)(B) of this subsection. HHSC will adopt the interim reimbursement rates for state-operated facilities in accordance with §355.101 of this title and this subchapter.

(1) State-operated facilities certified prior to January 1, 2001, will be reimbursed using an interim reimbursement rate and settlement process.

(A) Interim reimbursement rates for state-operated facilities are based on the most recent cost report accepted by HHSC.

(B) Settlement is conducted each state fiscal year by class of facility. If there is a difference between allowable costs and the reimbursement paid under the interim rate, including applied income, for a state fiscal year, federal funds to the state will be adjusted based on that difference.

(2) A state-operated facility certified on or after January 1, 2001, will be reimbursed using a pro forma rate determined in accordance with §355.101(c)(2)(B) and §355.105(h) of this title (relating to Introduction and General Reporting and Documentation Requirements, Methods and Procedures). A facility will be reimbursed under the pro forma rate methodology until HHSC receives an acceptable cost report which includes at least 12 months of the facility's cost data and is available to be included in the annual interim rate determination process.

(f) HHSC may define experimental classes of service to be used in research and demonstration projects on new reimbursement methods. Demonstration or pilot projects based on experimental classes may be implemented on a statewide basis or may be limited to a specific region of the state or to a selected group of providers. Reimbursement for an experimental class is not implemented, however, unless HHSC and the Centers for Medicare and Medicaid Services (CMS) approve the experimental methodology.

(g) Cost Reporting.

(1) Providers must follow the cost-reporting guidelines as specified in §355.105 of this title.

(2) Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs).

(3) Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

(h) Adjusting costs. Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices). HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs, according to §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(i) Field Audit and Desk Review. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: September 11, 2025
Proposal publication date: July 11, 2025
For further information, please call: (512) 867-7817

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1 TAC §355.457

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

1 TAC §§355.503, 355.505, 355.507, 355.509, 355.513

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code

Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.503. Reimbursement Methodology for Long-Term Services and Supports State Plan and Home and Community-Based Services Waiver Program Services Delivered through the STAR+PLUS Managed Care Program.

(a) General requirements. The Texas Health and Human Services Commission (HHSC) establishes the rate methodology for long-term services and supports (LTSS) state plan and Home and Community-Based Services (HCBS) waiver program services delivered through STAR+PLUS managed care.

(1) HHSC applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction).

(2) For HCBS waiver program services, providers are reimbursed for services provided to individuals who meet the criteria for alternatives to nursing facility care. Additionally, providers are reimbursed a one-time administrative expense fee for a pre-enrollment assessment of potential waiver participants. The pre-enrollment assessment covers care planning for the participant.

(3) If HHSC has determined that there is not sufficient reliable cost report data from which to determine reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using data from surveys, cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services, and other sources.

(b) State plan services reimbursement determination. For LTSS state plan services delivered through STAR+PLUS, Community First Choice (CFC) personal assistance services (PAS) and habilitation services are calculated as specified in §355.9090 of this title (relating to Reimbursement Methodology for Community First Choice); non-CFC PAS is calculated as specified in §355.5902 of this title (relating to Reimbursement Methodology for Primary Home Care); day activity and health services (DAHS) are calculated as specified in §355.6907 of this title (relating to Reimbursement Methodology for Day Activity and Health Services); emergency response services (ERS) are calculated as specified in §355.510 of this subchapter (relating to Reimbursement Methodology for Emergency Response Services (ERS)); financial management services agency (FMSA) fees are calculated as specified in §355.114 of this title (relating to Consumer Directed Services Payment Option).

(c) STAR+PLUS HCBS Waiver reimbursement determination. Recommended reimbursements are determined in the following manner.

(1) Unit of service reimbursement. Reimbursement for non-CFC PAS and in-home respite care services, and cost per unit of service for nursing services provided by a registered nurse (RN), nursing services provided by a licensed vocational nurse (LVN), physical therapy, occupational therapy, speech/language therapy, supported employment, employment assistance, and day activity and health services (DAHS) is determined in the following manner.

(A) Total allowable costs for each provider are determined by analyzing the allowable historical costs reported on the cost report.

(B) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this title (relating to Determination of Inflation Indices). The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect.

(C) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(D) Allowable administrative and facility costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's units of service to the amount of total waiver units of service.

(E) For in-home and out-of-home nursing services provided by an RN, in-home and out-of-home nursing services provided by an LVN, in-home and out-of-home physical therapy, in-home and out-of-home occupational therapy, speech/language therapy, supported employment, employment assistance, and in-home respite care services, an allowable cost per unit of service is calculated for each contracted provider cost report for each service. The allowable cost per unit of service for each contracted provider cost report is multiplied by 1.044. This adjusted allowable cost per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this subchapter (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(F) For non-CFC PAS, two cost areas are created.

(i) The attendant cost area includes salaries, wages, and benefits calculated as specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(ii) The administration and facility cost area includes attendants and field supervisors' mileage reimbursement expenses; building, building equipment, and operation and maintenance costs; administration costs; and other service costs. An allowable cost per unit of service is determined for each contracted provider cost report for the administration and facility cost area. The allowable cost per unit of service for each contracted provider cost report are arrayed. The units of service for each contracted provider cost report in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and multiplied by 1.044.

(iii) The attendant cost area and the administration and facility cost area are summed to determine the PAS cost per unit of service.

(G) CFC PAS and habilitation services are calculated as specified in §355.9090 of this title (relating to Reimbursement Methodology for Community First Choice).

(2) Per day reimbursement.

(A) The reimbursement for Adult Foster Care (AFC) and out-of-home respite care in an AFC home is determined as a per day reimbursement using a method based on modeled projected expenses, which are developed using data from surveys, cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services, and other sources. The room and board payments for AFC Services are not covered in these reimbursements and will be paid to providers from the client's Supplemental Security Income (SSI), less a personal needs allowance.

(B) The reimbursement for assisted living (AL) services is determined as a per day reimbursement in accordance with §355.509(c)(2) of this subchapter (relating to Reimbursement Methodology for Residential Care).

(i) The per day reimbursement for attendant care for each of the levels of care is determined based on client need for attendant care.

(ii) A total reimbursement amount is calculated and the proposed reimbursement is equal to the total reimbursement less the client's room and board payments.

(iii) The room and board payment is paid to the provider by the client from the client's SSI, less a personal needs allowance.

(iv) The reimbursement for out-of-home respite in an AL facility is determined using the same methodology as the reimbursement for AL except that the out-of-home respite rates:

(I) are set at the rate for providers who choose not to participate in the attendant compensation rate enhancement; and

(II) include room and board costs equal to the client's SSI, less a personal needs allowance.

(C) The reimbursement for out-of-home respite care provided in a Nursing Facility is based on the amount determined for the Nursing Facility case mix class into which the participant is classified.

(D) The reimbursement for Personal Care 3 is composed of two rate components, one for the direct care cost center and one for the non-direct care cost center.

(i) Direct care costs. The rate component for the direct care cost center is determined by modeling the cost of the minimum required staffing for the Personal Care 3 setting, as specified by HHSC, and using staff costs and other statistics from the most recently audited cost reports from providers delivering similar care.

(ii) Non-direct care costs. The rate component for the non-direct care cost center is equal to the non-attendant portion of the non-apartment assisted living rate per day for non-participants in the Attendant Compensation Rate Enhancement. Providers receiving the Personal Care 3 rate are not eligible to participate in the Attendant Compensation Rate Enhancement and receive direct care add-ons to the Personal Care 3 rates.

(3) ERS. The reimbursement for ERS is determined as a monthly reimbursement ceiling, based on the ceiling amount determined in accordance with §355.510 of this subchapter (relating to Reimbursement Methodology for Emergency Response Services (ERS)).

(4) Requisition fees. Requisition fees are reimbursements paid to home and community support services contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, and minor home modifications for participants. Reimbursement for requisition fees for adaptive aids, medical supplies, dental services, and minor home modifications will vary based on the actual cost of the adaptive aids, medical supplies, dental services, and minor home modifications. Reimbursements are determined using a method based on modeled projected expenses, which are developed by using data from surveys, cost report data from similar programs, consultation with other service providers and/or professionals experienced in delivering contracted services, and/or other sources.

(5) Pre-enrollment expense fee. Reimbursement for pre-enrollment assessment is determined using a method based on modeled projected expenses that are developed by using data from surveys, cost report data from other similar programs, consultation with other service providers and/or professionals experienced in delivering contracted services, and other sources.

(6) Home-Delivered Meals. The reimbursement for Home-Delivered Meals is determined on a per meal basis, based on the ceiling amount determined in accordance with §355.511 of this subchapter (relating to Reimbursement Methodology for Home-Delivered Meals).

(7) Exceptions to the reimbursement determination methodology. HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs, according to §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(d) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this title.

(e) Reporting of cost.

(1) Cost reporting guidelines. If HHSC requires a cost report for any LTSS program or service delivered through STAR+PLUS, providers must follow the cost-reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information that are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may 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 auditor determines that reported costs are not verifiable.

(4) Allowable and unallowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs), in addition to the following.

(A) Client room and board expenses are not allowable, except for those related to respite care.

(B) The actual cost of adaptive aids, medical supplies, dental services, and home modifications are not allowable for cost reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher

payment system is unallowable for cost reporting purposes. Refer to §355.103(b)(20)(K) of this title.

(f) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

(g) Reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

§355.505. Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program.

(a) General requirements. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this chapter (relating to Introduction). Providers are reimbursed for waiver services provided to Medicaid-enrolled persons with related conditions. Additionally, providers will be reimbursed a one-time administrative expense fee for a pre-enrollment assessment of potential waiver participants. The pre-enrollment assessment covers care planning for the participant.

(b) Reporting of cost.

(1) Reporting guidelines. Providers must follow the cost reporting guidelines as specified in §355.105 of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(2) Number of cost reports to be submitted. All legal entities must submit a cost report unless the number of days between the date the legal entity's first Texas Health and Human Services Commission (HHSC) client received services and the legal entity's fiscal year end is 30 days or fewer.

(3) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this chapter.

(c) Waiver reimbursement determination methodology.

(1) Unit of service reimbursement or reimbursement ceiling by unit of service. Reimbursement or reimbursement ceilings for related-conditions waiver services, habilitation, nursing services provided by a registered nurse (RN), nursing services provided by a licensed vocational nurse (LVN), physical therapy, occupational therapy, speech and language pathology, behavioral support, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, supported employment, day activity and health services, and in-home and out-of-home respite care services will be determined on a fee-for-service basis. These services are provided under §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(2) Monthly reimbursement. The reimbursement for case management waiver service will be determined as a monthly reimbursement. This service is provided under the §1915(c) of the Social Security Act Medicaid waiver for persons with related conditions.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers; the purpose is to ensure that the database reflects costs and other information that are necessary for the provision of services and are consistent with federal and state regulations.

(B) Individual cost reports may 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 auditor determines that reported costs are not verifiable.

(4) Reimbursement determination. Recommended unit of service reimbursements and reimbursement ceilings by unit of service are determined in the following manner.

(A) Unit of service reimbursement for habilitation, and cost per unit of service for in-home and out-of-home nursing services provided by an RN, in-home and out-of-home nursing services provided by an LVN, in-home and out-of-home physical therapy, in-home and out-of-home occupational therapy, speech and language pathology, behavioral support services, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, supported employment, and in-home and out-of-home respite care are determined in the following manner.

(i) The total allowable cost for each contracted provider cost report will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) The total allowable cost is reduced by the amount of the administrative expense fee and requisition fee revenues accrued for the reporting period.

(iii) Each provider's total allowable cost, excluding depreciation and mortgage interest, is projected from the historical cost reporting period to the prospective reimbursement period as described in §355.108 of this chapter (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Allowable administrative and facility costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's units of service to the amount of total waiver units of service.

(vi) Each provider's projected total allowable cost is divided by the number of units of service to determine the projected cost per unit of service.

(vii) For in-home and out-of-home nursing services provided by an RN, in-home and out-of-home nursing services provided by an LVN, in-home and out-of-home physical therapy, in-home and out-of-home occupational therapy, speech and language pathology, in-home respite care, behavioral support services, auditory integration training/auditory enhancement training (audiology services), nutritional services, employment assistance, and supported employment, the projected cost per unit of service, for each provider is multiplied by 1.044. This adjusted allowable cost per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this subchapter (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(viii) For habilitation services two cost areas are created.

(I) The attendant cost area includes salaries, wages, and benefits calculated as specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(II) Another attendant cost area is created which includes the other habilitation services costs not included in subclause (I) of this clause as determined in clauses (i) - (v) of this subparagraph to create another attendant cost area. An allowable cost per unit of service is calculated for the other habilitation cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed and weighted by the number of units of service, and the median cost per unit of service is calculated. The median cost per unit of service is multiplied by 1.044.

(III) The attendant cost area and the other attendant cost area are summed to determine the habilitation attendant cost per unit of service.

(ix) For out-of-home respite care, the allowable costs per unit of service are calculated as determined in clauses (i) - (vi) of this subparagraph. The allowable costs per unit of service for each contracted provider cost report are multiplied by 1.044. The costs per unit of service are then arrayed and weighted by the number of units of service, and the median cost per unit of service is calculated.

(B) The monthly reimbursement for case management services is determined in the following manner.

(i) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report and other pertinent cost survey information.

(ii) Total allowable costs are reduced by the amount of administrative expense fee revenues reported.

(iii) Each provider's total allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost reporting period to the prospective reimbursement period as described in §355.108 of this chapter (relating to Determination of Inflation Indices).

(iv) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or social security, Medicare contributions, Workers' compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(v) Each provider's projected total allowable costs are divided by the number of monthly units of service to determine the projected cost per client month of service.

(vi) Each provider's projected cost per client month of service is arrayed from low to high and weighted by the number of units of service and the median cost per client month of service is calculated.

(vii) The median projected cost per client month of service is multiplied by 1.044.

(C) The unit of service reimbursement for day activity and health services is determined in accordance with §355.6907 of this chapter (relating to Reimbursement Methodology for Day Activity and Health Services).

(D) HHSC also adjusts reimbursement according to §355.109 of this chapter (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) if new legislation, regulations, or economic factors affect costs.

(5) Reimbursement determination for support family services and continued family services. The reimbursement for support family services and continued family services will be determined as a per day rate using a method based on modeled costs which are developed by using data from surveys, cost report data from other similar programs, payment rates from other similar programs, consultation with other service providers and/or professionals experienced in delivering contracted services, or other sources as determined appropriate by HHSC. The per day rate will have two parts, one part for the child placing agency and one part for the support family.

(d) Administrative expense fee determination methodology.

(1) One-time administrative expense fee. Reimbursement for the pre-enrollment assessment and care planning process required to determine eligibility for the waiver program will be provided as a one-time administrative expense fee.

(2) Administrative expense fee determination process. The recommended administrative expense fee is determined using a method based on modeled projected expenses which are developed using data from surveys, cost report data from other similar programs or services, professionals' experience in delivering similar services, and other relevant sources.

(e) Requisition fees. Requisition fees are reimbursements paid to the CLASS direct service agency contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications for CLASS participants. Reimbursement for requisition fees for adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications will vary based on the actual cost of the adaptive aids, medical supplies, dental services, specialized therapies, and minor home modifications. Reimbursements are determined using a method based on modeled projected expenses which are developed by using data from surveys; cost report data from similar programs; consultation with other service providers and/or professionals experienced in delivering contracted services; and/or other sources.

(f) Allowable and unallowable costs.

(1) Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §355.102 and §355.103 of this chapter (relating to General Principles of Allowable and Unallowable Costs, and Specifications for Allowable and Unallowable Costs) as well as the following provisions.

(2) Participant room and board expenses are not allowable, except for those related to respite care.

(3) The actual cost of adaptive aids, medical supplies, dental services, and home modifications is not allowable for cost reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable. Refer to §355.103(b)(20)(K) of this chapter (relating to Specifications for Allowable and Unallowable Costs).

(g) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this chapter (relating to Introduction).

(h) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this chapter (relating to Revenues).

(i) Reviews and field audits of cost reports. Desk reviews or field audits are performed on all contracted providers' cost reports. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this chapter (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this chapter (relating to Informal Reviews and Formal Appeals).

(j) Reporting requirements. The program director's full salary is to be reported on the line item of the cost report designated for the director.

§355.513. Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program.

(a) General information. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this chapter (relating to Introduction). Providers are reimbursed for waiver services provided to individuals who are deaf-blind with multiple disabilities.

(b) Other sources of cost information. If HHSC has determined that there is not sufficient reliable cost report data from which to set reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using rates for similar services from other Medicaid programs; data from surveys; cost report data from other similar programs; consultation with other service providers or professionals experienced in delivering contracted services; and other sources.

(c) Waiver rate determination methodology. If HHSC deems it appropriate to require contracted providers to submit a cost report, recommended reimbursements for waiver services will be determined on a fee-for-service basis in the following manner for each of the services provided.

(1) Total allowable costs for each provider will be determined by analyzing the allowable historical costs reported on the cost report.

(2) Each provider's total reported allowable costs, excluding depreciation and mortgage interest, are projected from the historical cost-reporting period to the prospective reimbursement period as described in §355.108 of this chapter (relating to Determination of Inflation Indices). The prospective reimbursement period is the period of time that the reimbursement is expected to be in effect.

(3) Payroll taxes and employee benefits are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense for the appropriate group of staff. Employee benefits will be charged to a specific salary line item if the benefits are reported separately. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Medicare Contributions, Workers' Compensation Insurance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(4) Allowable administrative and overall facility/operations costs are allocated or spread to each waiver service cost component on a pro rata basis based on the portion of each waiver service's service units reported to the amount of total waiver service units reported. Service-specific facility and operations costs for out-of-home respite, and individualized skills and socialization services will be directly charged to the specific waiver service.

(5) For in-home and out-of-home nursing services provided by a registered nurse (RN), in-home and out-of-home nursing services provided by a licensed vocational nurse (LVN), in-home and out-of-home physical therapy, in-home and out-of-home occupational therapy, speech and language pathology, behavioral support services, audiology services, dietary services, employment assistance, and supported employment, an allowable cost per unit of service is calculated for each contracted provider cost report in accordance with paragraphs (1) - (4) of this subsection. The allowable costs per unit of service for each contracted provider cost report is multiplied by 1.044. This adjusted allowable costs per unit of service may be combined into an array with the allowable cost per unit of service of similar services provided by other programs in determining rates for these services in accordance with §355.502 of this subchapter (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(6) Requisition fees are reimbursements paid to the Deaf-Blind with Multiple Disabilities (DBMD) Waiver contracted providers for their efforts in acquiring adaptive aids, medical supplies, dental services, and minor home modifications for DBMD participants. Reimbursement for adaptive aids, medical supplies, dental services, and minor home modifications will vary based on the actual cost of the adaptive aid, medical supply, dental service, and minor home modification. Reimbursements are determined using a method based on modeled projected expenses which are developed by using data from surveys, cost report data from similar programs, consultation with other service providers or professionals experienced in delivering contracted services, or other sources.

(7) For residential habilitation transportation, chore, and intervener (excluding Interveners I, II, and III), services, two cost areas are created:

(A) The attendant cost area, which includes salaries, wages, and benefits calculated as specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(B) An administration and facility cost area, which includes costs for services not included in subparagraph (A) of this paragraph as determined in paragraphs (1) - (4) of this subsection. An allowable cost per unit of service is determined for each contracted provider cost report for the administration and facility cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed. The units of service for each contracted provider cost report in the array are summed until the median unit of service is

reached. The corresponding expense to the median unit of service is determined and is multiplied by 1.044.

(C) The attendant cost area, and the administration and facility cost area are summed to determine the cost per unit of service.

(8) For Interveners I, II, and III, payment rates are developed based on rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma approach in accordance with §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(9) Assisted living services payment rates are determined using a pro forma approach in accordance with §355.105(h) of this chapter. The rates are adjusted periodically for inflation. The room and board payments for waiver clients receiving assisted living services are covered in the reimbursement for these services and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

(10) Pre-enrollment assessment services and case management services payment rates are determined by modeling the salary for a Case Manager staff position. This rate is periodically updated for inflation.

(11) The orientation and mobility services payment rate is determined by modeling the salary for an Orientation and Mobility Specialist staff position. This rate is updated periodically for inflation.

(12) The employment readiness payment rates will initially be determined using a pro forma approach in accordance with §355.105(h) of this chapter. Once cost report data for this service are available, HHSC will calculate the methodological rate for employment readiness as a weighted median cost of the service from the most recently examined Medicaid cost report, adjusted for anticipated programmatic and staffing requirements, and inflated from the cost reporting year to the prospective rate year. The employment readiness rates will be rebased every biennium from the most recent projected cost report data. Adopted rates will be limited within available appropriations.

(13) HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs, according to §355.109 of this chapter (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(d) The individualized skills and socialization services payment rate is equal to the individualized skills and socialization services payment rate for an individual with a Level of Need 9 in the Home and Community-based Services waiver program as specified in §355.723 of this chapter (relating to Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs).

(e) Authority to determine reimbursement. The authority to determine reimbursement is specified in §355.101 of this chapter.

(f) Reporting of cost.

(1) Cost-reporting guidelines. If HHSC requires a cost report for any waiver service in this program, providers must follow the cost-reporting guidelines as specified in §355.105 of this chapter.

(2) Excused from submission of cost reports. If required by HHSC, a contracted provider must submit a cost report unless the provider meets one or more of the conditions in §355.105(b)(4)(D) of this chapter.

(3) Reporting and verification of allowable cost.

(A) Providers are responsible for reporting only allowable costs on the cost report, except where cost-report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursements. HHSC excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers to ensure the database reflects costs and other information necessary for the provision of services and is consistent with federal and state regulations.

(B) Individual cost reports may 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 auditor determines that reported costs are not verifiable.

(4) Allowable and unallowable costs. Providers must follow the guidelines specified in §355.102 and §355.103 of this chapter (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs) in determining whether a cost is allowable or unallowable. In addition, providers must adhere to the following principles:

(A) Client room and board expenses are not allowable, except for those related to respite care.

(B) The actual cost of adaptive aids, medical supplies, dental services, and minor home modifications is not allowable for cost-reporting purposes. Allowable labor costs associated with acquiring adaptive aids, medical supplies, dental services, and home modifications should be reported in the cost report. Any item purchased for participants in this program and reimbursed through a voucher payment system is unallowable. Refer to §355.103(b)(20)(K) of this chapter.

(g) Reporting revenue. Revenues must be reported on the cost report in accordance with §355.104 of this chapter (relating to Revenues).

(h) Reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of field audits are determined by HHSC staff to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this chapter (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this chapter (relating to Informal Reviews and Formal Appeals).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 867-7817

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SUBCHAPTER F. REIMBURSEMENT METHODOLOGY FOR PROGRAMS SERVING PERSONS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

1 TAC §355.722

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

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1 TAC §355.723

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.723. Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs.

(a) Prospective payment rates. The Texas Health and Human Services Commission (HHSC) sets payment rates to be paid prospectively to Home and Community-based Services (HCS) and Texas Home Living (TxHmL) providers.

(b) Levels of need.

(1) Variable rates. Rates vary by level of need (LON) for the following services:

(A) employment readiness;

(B) host home/companion care (HH/CC);

(C) individualized skills and socialization;

(D) residential support services (RSS); and

(E) supervised living (SL).

(2) Non-variable rates. Rates do not vary by LON for the following services:

(A) audiology;

(B) behavioral support;

(C) cognitive rehabilitative therapy (CRT);

(D) community first choice personal assistance services/habilitation (CFC PAS/HAB);

(E) community support services transportation (CSS);

(F) dietary;

(G) employment assistance (EA);

(H) in-home respite;

(I) in-home and out-of-home licensed vocational nurse (LVN);

(J) in-home and out-of-home occupational therapy (OT);

(K) out-of-home respite (OHR);

(L) in-home and out-of-home physical therapy (PT);

(M) in-home and out-of-home registered nurse (RN);

(N) social work;

(O) speech and language pathology;

(P) supported employment (SE); and

(Q) supported home living transportation (SHL).

(c) Recommended rates. The recommended payment rates are determined for each HCS and TxHmL service listed in subsections (b)(1) and (2) of this section by type and, for services listed in subsection (b)(1) of this section, by LON to include the following cost areas.

(1) Attendant compensation cost area. The determination of the attendant compensation cost area is calculated as specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). The attendant compensation cost area includes personal attendant staffing costs (wages, benefits, modeled staffing ratios for attendant staff, direct care trainers, job coaches, and attendant and direct care supervisors).

(2) Other direct care cost area. The other direct care cost area includes other direct service staffing costs not included under the attendant cost area. The other direct care cost area is determined by calculating a median from allowable other direct care costs for each service, weighed by units of service for the applicable service from the most recently examined HCS/TxHmL cost report adjusted for inflation from the cost reporting period to the prospective rate period as speci-

fied in §355.108 of this chapter (relating to Determination of Inflation Indices).

(A) For the following services, multiply the other direct care cost area as specified in this paragraph by 1.044:

(i) EA;

(ii) in-home respite;

(iii) OHR in a camp;

(iv) OHR in a respite facility;

(v) OHR in a setting where HH/CC is provided;

(vi) OHR in a setting that is not listed; and

(vii) SE.

(B) For the following services, multiply the other direct care cost area as specified in this paragraph by 1.07:

(i) employment readiness;

(ii) individualized skills and socialization;

(iii) in-home and out-of-home individualized skills and socialization;

(iv) OHR in an individualized skills and socialization facility;

(v) OHR in a setting with SL or RSS is provided;

(vi) RSS; and

(vii) SL.

(3) Administration and operations cost area. The administration and operation cost area includes:

(A) administration and operation costs; and

(B) professional consultation and program support costs, including:

(i) allowable costs for required case management and service coordination activities; and

(ii) service-specific transportation costs (including mileage reimbursement).

(4) Projected costs. Projected costs are determined by allowable administrative and operations costs from the most recently audited cost report adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter. The steps to determine projected costs are as follows.

(A) Step 1. Determine total projected administration and operation costs and projected units of service by service type using cost reports submitted by HCS and TxHmL providers in accordance with §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs).

(B) Step 2. Determine the HH/CC coordinator component of the HH/CC rate as follows: This component is determined by summing total reported HH/CC coordinator wages and allocated payroll taxes and benefits from the most recently available audited HCS cost report, inflating those costs to the rate period, and dividing the resulting product by the total number of host home units of service reported on that cost report.

(C) Step 3. Determine total HH/CC coordinator dollars as follows. Multiply the HH/CC coordinator component of the HH/CC rate from subparagraph (B) of this paragraph by the total number of HH/CC units of service reported on the most recently available, reliable audited HCS cost report database.

(D) Step 4. Determine total projected administration and operation costs after offsetting total HH/CC coordinator dollars as follows. Subtract the total HH/CC coordinator dollars from subparagraph (C) of this paragraph from the total projected administration and operation costs from subparagraph (A) of this paragraph.

(E) Step 5. Determine projected weighted units of service for each HCS and TxHmL service type as follows.

(i) SL and RSS in HCS. Projected weighted units of service for SL and RSS equal projected SL and RSS units of service times a weight of 1.00.

(ii) Individualized skills and socialization and employment readiness in HCS and TxHmL. Projected weighted units of service for individualized skills and socialization and employment readiness equal projected individualized skills and socialization and employment readiness units of service times a weight of 0.25.

(iii) HH/CC in HCS. Projected weighted units of service for HH/CC equal projected HH/CC units of service times a weight of 0.50.

(iv) SHL in HCS, high medical needs support in HCS, and CSS in TxHmL. For each service, projected weighted units of service equal projected units of service times a weight of 0.30.

(v) Respite in HCS and TxHmL. Projected weighted units of service for respite equal projected respite units of service times a weight of 0.20.

(vi) SE in HCS and TxHmL. Projected weighted units of service for SE equal projected units of service times a weight of 0.25.

(vii) Behavioral support in HCS and TxHmL. Projected weighted units of service for behavioral support equal projected behavioral support units of service times a weight of 0.18.

(viii) Audiology, CRT, OT, PT, and speech and language pathology in HCS and TxHmL. Projected weighted units of service for audiology, CRT, OT, PT, and speech and language pathology equal projected audiology, CRT, OT, PT, and speech and language pathology units of service times a weight of 0.18.

(ix) Social work in HCS. Projected weighted units of service for social work equal projected social work units of service times a weight of 0.18.

(x) In-home and out-of-home nursing in HCS and TxHmL and high medical needs nursing in HCS. Projected weighted units of service for nursing and high medical needs nursing equal projected nursing and high medical needs nursing units of service times a weight of 0.25.

(xi) EA in HCS and TxHmL. Projected weighted units of service for EA equal projected EA units of service times a weight of 0.25.

(xii) Dietary in HCS and TxHmL. Projected weighted units of service for dietary equal projected dietary units of service times a weight of 0.18.

(F) Step 6. Calculate the total projected weighted units of service by summing the projected weighted units of service from subparagraph (E) of this paragraph.

(G) Step 7. Calculate the percent of total administration and operation costs to be allocated to the service type by dividing the

projected weighted units for the service type from subparagraph (E) of this paragraph by the total projected weighted units of service from subparagraph (F) of this paragraph.

(H) Step 8. Calculate the total administration and operation cost to be allocated to the service type by multiplying the percent of total administration and operation costs allocated to the service type from subparagraph (G) of this paragraph by the total administration and operation costs after offsetting total HH/CC coordinator dollars from subparagraph (D) of this paragraph.

(I) Step 9. Calculate the administration and operation cost component per unit of service for each HCS and TxHmL service type by dividing the total administration and operation cost to be allocated to that service type from subparagraph (H) of this paragraph by the projected units of service for that service type from subparagraph (A) of this paragraph.

(J) Step 10. The final recommended administration and operation cost area per unit of service for each HCS and TxHmL service type is calculated as follows.

(i) For the following services, multiply the administration and operation cost area from this subparagraph by 1.044:

(I) CFC PAS/HAB;

(II) CSS;

(III) EA;

(IV) in-home individualized skills and socialization;

(V) in-home respite;

(VI) OHR in a camp;

(VII) OHR in a respite facility;

(VIII) OHR in a setting where HH/CC is provided;

(IX) OHR in a setting that is not listed;

(X) SE; and

(XI) SHL.

(ii) For the following services, multiply the administration and operation cost area from this subparagraph by 1.07:

(I) employment readiness;

(II) individualized skills and socialization;

(III) in-home and out-of-home individualized skills and socialization;

(IV) OHR in an individualized skills and socialization facility;

(V) RSS; and

(VI) SL.

(5) The facility cost area. The facility cost area includes the following:

(A) room and board costs, including rent, mortgage interest, depreciation expenses, property taxes, property insurance, and food costs as defined in §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs), unless excluded if unallowable under Federal Medicaid rules; and

(B) non-room and board costs not already reimbursed through the monthly amount collected from the individual receiving services as defined in 26 TAC §565.27(a) (relating to Finances and Rent).

(6) The facility cost area is determined by calculating a median cost for each service using allowable facility costs, weighted by units of service for the applicable service from the most recently audited cost report, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108.

(A) For the following services, multiply the facility cost component by 1.044:

(i) HH/CC;

(ii) OHR in a camp;

(iii) OHR in a respite facility; and

(iv) OHR in a setting where HH/CC is provided.

(B) For the following services, multiply the facility cost component by 1.07:

(i) employment readiness;

(ii) individualized skills and socialization;

(iii) in-home and out-of-home DH;

(iv) OHR in a DH or individualized skills and socialization facility;

(v) OHR in a setting where SL or RSS are provided;

(vi) RSS; and

(vii) SL.

(d) Recommended payment rates are determined for each service by the following.

(1) CFC PAS/HAB. The recommended payment rate is calculated by summing the attendant compensation cost area and the administration and operations cost area as defined in subsection (c) of this section. The recommended rate for CFC PAS/HAB does not include a cost component for other direct care staffing costs.

(2) CRT. The recommended payment rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(3) Employment readiness. The recommended rates will initially be determined using a pro forma approach in accordance with §355.105(h) of this chapter. Once cost report data for this service are available, the recommended rates will be calculated by summing the attendant compensation cost area, other direct care cost area, the administration and operations component, and the facility cost component as defined in subsection (c) of this section. Rates are adjusted for anticipated programmatic and staffing requirements for each level of need and inflated from the cost reporting year to the prospective rate year. Adopted rates will be limited within available appropriations.

(4) HH/CC. The recommended payment rate is determined by summing the direct care worker component, HH/CC coordinator cost area, administration and operations component, and facility cost area. The direct care worker component is calculated using the median of allowable direct care worker costs, weighted by HH/CC units of service from the most recently examined cost report database. The result is adjusted for each LON. The HH/CC coordinator cost area and administration and operations components are calculated as determined

in subsection (c) of this section. The facility cost area is calculated as determined in subsection (c) of this section but does not include room and board costs as defined in subsection (c)(5)(A) of this section. If HHSC lacks reliable cost report data, the rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(5) In-home respite. The recommended payment rate is calculated by summing the attendant compensation cost area and the administration and operations component as defined in subsection (c) of this section.

(6) Individualized skills and socialization. The recommended payment cost areas are adjusted using modeled staffing ratios to establish recommended rates for on-site and off-site rates by LON. The recommended rates are calculated by summing the attendant compensation cost area, other direct care cost area, the administration and operations component, and the facility cost component as defined in subsection (c) of this section. Transportation costs are calculated as a standalone component separate from the administration and operations component for off-site services. The enhanced staffing level one rate is equal to the LON 8 individualized skills and socialization off-site recommended rate. The enhanced staffing level two rate is modeled and assumes a one-staff-to-one-individual staffing ratio.

(7) In-home and out-of-home nursing services provided by an RN, in-home and out-of-home nursing services provided by an LVN, in-home and out-of-home physical therapy, in-home and out-of-home occupational therapy, speech and language pathology, behavioral support services, audiology services, dietary services, EA, SE, and transition assistance services are determined based on §355.725 of this subchapter (relating to Reimbursement Methodology for Common Waiver Services in Home and Community-based Services (HCS) and Texas Home Living (TxHmL)).

(8) OHR. The recommended payment cost areas may be adjusted using modeled direct care worker hour-per-unit ratios for similar services to calculate OHR rates that vary by setting where the service is provided. The recommended payment rates are calculated by summing the attendant compensation cost area, other direct care cost area, the administration and operations component, and the facility cost component as defined in subsection (c) of this section.

(9) SHL and CSS. The recommended payment rates for SHL and CSS are calculated by summing the attendant compensation cost area and the administration and operations cost area as defined in subsection (c) of this section.

(10) SL and RSS. The recommended payment cost areas are adjusted using modeled direct care worker hour-per-unit ratios updated by actual hours reported on the most recently audited cost report to calculate variable rates by LON. The recommended rates are calculated by summing the attendant compensation cost area, other direct care cost area, and the administration and operations component as defined in subsection (c) of this section. The facility cost area is calculated as determined in subsection (c) of this section but does not include room and board costs defined in subsection (c)(5)(A) of this section.

(11) Social work. The recommended payment rate is calculated using the weighted median social worker hourly cost from the most recently audited cost report, and the administration and operations cost component as determined in subsection (c) of this section. If HHSC lacks reliable cost report data, the rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(e) Other sources of cost information. If HHSC has determined that there is not sufficient reliable cost report data from which to set reimbursements and reimbursement ceilings for waiver services, reimbursements and reimbursement ceilings will be developed by using rates for similar services from other Medicaid programs, data from surveys, cost report data from other similar programs, consultation with other service providers or professionals experienced in delivering contracted services, and similar sources. If HHSC has insufficient cost data, the recommended payment rate for each service is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

(f) Refinement and adjustment. Refinement and adjustment of the rate components and model assumptions will be considered, as appropriate, by HHSC. All adopted rates are limited to available levels of appropriated state and federal funds as defined in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. ADVANCED TELECOMMUNICATIONS SERVICES AND OTHER COMMUNITY-BASED SERVICES

1 TAC §355.5902, §355.6907

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.5902. Reimbursement Methodology for Primary Home Care.

(a) General requirements. The Texas Health and Human Services Commission (HHSC) applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction).

(b) Cost reporting. Provider agencies must follow the cost-reporting guidelines as specified in §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures).

(1) Number of cost reports to be submitted. Every legal entity must submit a cost report unless the entity meets one or more of the conditions in §355.105(b)(4)(D) of this title.

(A) Contracted providers participating in the attendant compensation rate enhancement.

(i) At the same level of enhancement. If all the contracts under the legal entity participate in the enhancement at the same level of enhancement, the contracted provider must submit one cost report for the legal entity.

(ii) At different levels of enhancement. If all the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit one cost report for each level of enhancement.

(B) Contracted providers not participating in the attendant compensation rate enhancement. If all the contracts under the legal entity do not participate in the enhancement, the contracted provider must submit one cost report for the legal entity.

(C) Contractors participating and not participating in attendant compensation rate enhancement.

(i) At the same level of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate at the same level of enhancement, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for the contracts that do participate.

(ii) At different levels of enhancement. If some of the contracts under the legal entity do not participate in the enhancement and the rest of the contracts under the legal entity participate in the enhancement but they participate at more than one enhancement level, the contracted provider must submit:

(I) one cost report for the contracts that do not participate; and

(II) one cost report for each level of enhancement.

(2) Provider agencies are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. HHSC excludes from reimbursement determination unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by provider agencies. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations. Individual cost reports may not be included in the database used for reimbursement determination if:

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

(B) an auditor determines that reported costs are not verifiable.

(c) Reimbursement determination. Reimbursement is determined in the following manner.

(1) Cost determination by cost area. Allowable costs are combined into three cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(A) Service support cost area. This includes attendants and field supervisors' mileage reimbursement expenses. This also includes building, building equipment, and operation and maintenance costs; administration costs; and other service costs. Administration expenses equal to $0.18 per priority unit of service are allocated to priority. The administration costs remaining after this allocation are summed with the other service support costs.

(B) Non-priority attendants cost area. This includes non-priority attendants' salaries, wages, and benefits expenses. This cost area is specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(C) Priority attendants cost area. This includes priority attendants' salaries, wages, and benefits expenses. This cost area is specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

(2) Recommended reimbursement by cost area. For the service support cost area described in paragraph (1)(A) of this subsection the following is calculated.

(A) Projected costs. Each contract's total allowable costs, excluding depreciation and mortgage interest, per unit of service are projected from each contract's reporting period to the next ensuing reimbursement period, as described in §355.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. Reimbursement may be adjusted where new legislation, regulations, or economic factors affect costs as specified in §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(B) Projected cost per unit of service. To determine the projected cost per unit of service for each contract, the total projected allowable costs for the service support cost area are divided by total units of service, including non-priority services, priority services, and STAR+PLUS services, in order to calculate the projected cost per unit of service.

(C) Projected cost arrays. Each contract's projected allowable costs per unit of service are rank ordered from low to high, along with each contract's corresponding units of service for each cost area.

(D) Recommended reimbursement for the service support cost area. The total units of service for each contract are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The weighted median cost component is multiplied by 1.044 to calculate the recommended reimbursement for the service support cost area. The service support cost area recommended reimbursement is limited, if necessary, to available appropriations.

(3) Total recommended reimbursement.

(A) For non-priority clients. The recommended reimbursement is determined by summing the recommended reimburse-

ment described in paragraph (2) of this subsection and the cost area component from paragraph (1)(B) of this subsection.

(B) For priority clients. The recommended reimbursement is determined by summing the recommended reimbursement described in paragraph (2) of this subsection and the cost area component from paragraph (1)(C) of this subsection.

(d) Reimbursement determination authority. The reimbursement determination authority is specified in §355.101 of this title.

(e) Desk reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all provider agencies. The frequency and nature of the field audits are determined by HHSC to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and provider agencies will be notified of the results of a desk review or an audit in accordance with §355.107 of this title (relating to Notification of Exclusions and Adjustments). Provider agencies may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §355.110 of this title (relating to Informal Reviews and Formal Appeals).

(f) Factors affecting allowable costs. Provider agencies must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs) and §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(g) Reporting revenues. Revenues must be reported on the cost report in accordance with §355.104 of this title (relating to Revenues).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER H. ATTENDANT COST DETERMINATION

1 TAC §355.7051, §355.7052

STATUTORY AUTHORITY

The amendment and new rules are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

§355.7052. Reimbursement Methodology for Determining Attendant Cost Component.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) establishes the rate methodology for the attendant cost rate component used in the rate methodologies of long-term services and supports (LTSS) state plan and 1915(c), 1915(i) and 1115 waiver programs with personal attendant and attendant-like services.

(b) Meaning of attendant. An attendant is an unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). The following parameters apply to the attendant cost rate component.

(1) An attendant includes the following:

(A) a driver who is transporting individuals in the day activity and health services (DAHS), Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), and residential care (RC) and STAR+PLUS Home and Community-Based Services (STAR+PLUS HCBS) Assisted Living Facilities (ALF) programs and the Home and Community-Based Services supervised living and residential support services (HCS SL/RSS) and HCS and Texas Home Living (TxHmL) individualized skills and socialization settings;

(B) a medication aide in the HCS SL/RSS setting, ICF/IID, and RC and ALF programs; and

(C) direct care workers, direct care trainers, job coaches, employment assistance direct care workers, attendant supervisors, direct care worker supervisors, direct care trainer supervisors, job coach supervisors and supported employment direct care workers.

(2) Attendants do not include the director; administrator; assistant director; assistant administrator; clerical and secretarial staff; professional staff; other administrative staff; licensed staff; cooks and kitchen staff; maintenance and groundskeeping staff; activity director; Deaf-Blind with Multiple Disabilities (DBMD) Interveners I, II, or III; Qualified Intellectual Disability Professionals (QIDPs) or assistant QIDPs; foster care providers; and laundry and housekeeping staff.

(3) Staff other than attendants may deliver attendant services and be considered an attendant if they must perform attendant services that cannot be delivered by another attendant to prevent a break in service.

(c) Attendant cost center. This cost center will include employee compensation, contract labor costs, for attendants as defined in subsection (b) of this section.

(1) Attendant compensation is the allowable compensation for attendants defined in §355.103(b)(1) of this chapter (relating to Specifications for Allowable and Unallowable Costs) and required to be reported as either salaries and/or 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, except as noted in paragraph (3) of this subsection, are not to be included in this cost center.

(2) Contract labor refers to personnel for whom the contracted provider is not responsible for the payment of payroll taxes, such as Federal Insurance Contributions Act, Medicare, and federal and state unemployment insurance, and who perform tasks routinely performed by employees where allowed by program rules.

(3) The following costs are not included in the calculation of the attendant cost center.

(A) Costs of required trainings for direct care or personal attendant workers.

(B) Travel costs for direct care or personal attendant workers including mileage reimbursement or public transportation subsidies.

(C) Costs of personal protective equipment for direct care or personal attendant workers.

(4) For staff who provide attendant functions part time as specified in subsection (b)(3) of this section, the cost center includes only the proportion of staff compensation associated with the hours allowable attendant functions were performed.

(d) Programs with personal attendant services. The reimbursement methodology outlined in this section applies to services provided by personal attendants that meet the following parameters.

(1) An employee or subcontractor of an HHSC contractor, or an employee of an employer in the Consumer Directed Services (CDS) option, who provides the following services, as described in 26 TAC §52.1 (relating to Application):

(A) services in the Community Attendant Services program;

(B) services in the Family Care program;

(C) services in the Primary Home Care program;

(D) DAHS;

(E) RC;

(F) services in the Community Living Assistance and Support Services Program:

(i) community first choice personal assistance services/habilitation (CFC PAS/HAB);

(ii) employment assistance;

(iii) habilitation (transportation) and prevocational services;

(iv) in-home respite;

(v) service planning team meeting; or

(vi) supported employment;

(G) in the DBMD Program:

(i) CFC PAS/HAB;

(ii) chore services;

(iii) employment assistance;

(iv) individualized skills and socialization services;

(v) in-home respite;

(vi) intervener (excluding intervener I, II, and III);

(vii) licensed assisted living;

(viii) licensed home health assisted living;

(ix) residential habilitation (transportation); or

(x) service planning team meeting;

(H) in the HCS Program:

(i) CFC PAS/HAB;

(ii) employment assistance;

(iii) employment readiness;

(iv) individualized skills and socialization services;

(v) in-home and out-of-home respite;

(vi) supported employment;

(vii) supported home living (transportation); or

(viii) SL/RSS; and

(I) in the Texas Home Living Program:

(i) CFC PAS/HAB;

(ii) community support services (transportation);

(iii) employment assistance;

(iv) employment readiness;

(v) individualized skills and socialization services;

(vi) in-home and out-of-home respite; or

(vii) supported employment.

(2) An employee or subcontractor of an HHSC contractor who provides the following services in the Home and Community-Based Services--Adult Mental Health (HCBS-AMH) program, as described in 26 TAC §307.51 (relating to Purpose and Application):

(A) assisted living services;

(B) employment assistance;

(C) in-home respite;

(D) supported employment;

(E) supported home living services; or

(F) supervised living services.

(3) An employee or subcontractor of an HHSC contractor or an employee of an employer in the CDS option who provides:

(A) personal care services, as described in Chapter 363, Subchapter F of this title (relating to Personal Care Services); or

(B) CFC habilitation (CFC HAB) or CFC personal assistance services (CFC PAS), as described in Chapter 354, Subchapter A, Division 27 of this title (relating to Community First Choice).

(4) A provider, which has the meaning assigned in §353.2 of this title (relating to Definitions), or an employee of an employer in the CDS option who provides:

(A) in the STAR+PLUS program and STAR+PLUS Home and Community-based Services (HCBS) program:

(i) assisted living;

(ii) CFC PAS;

(iii) CFC HAB;

(iv) employment assistance;

(v) DAHS;

(vi) in-home respite care;

(vii) personal assistance services;

(viii) protective supervision; or

(ix) supported employment;

(B) in the STAR Health program and Medically Dependent Children Program (MDCP):

(i) CFC PAS;

(ii) CFC HAB;

(iii) employment assistance;

(iv) DAHS;

(v) flexible family support;

(vi) in-home respite;

(vii) personal care services; or

(viii) supported employment; and

(C) in the STAR Kids program and MDCP:

(i) CFC PAS;

(ii) CFC HAB;

(iii) employment assistance;

(iv) DAHS;

(v) flexible family support;

(vi) in-home respite;

(vii) personal care services; or

(viii) supported employment.

(5) An employee or subcontractor of an HHSC contractor, who provides ICF/IID program services, as described in 26 TAC §261.203 (relating to Definitions).

(e) Determination of attendant cost component. The attendant cost component is calculated as follows.

(1) For all programs with services as specified in subsection (d) of this section, except for DBMD, HCBS-AMH, HCS, ICF/IID, and TxHmL programs, HHSC will calculate an attendant cost rate component by calculating a median of attendant cost center data for each applicable attendant service, weighted by the applicable attendant service's units of service from the most recently examined cost report database for each program, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter (related to Determination of Inflation Indices).

(A) The weighted median cost component is multiplied by 1.044 for all attendant services specified in subsection (d) except for DAHS, RC, and STAR+PLUS ALF services. For these services, the weighted median cost component is multiplied by 1.07. The result is the attendant cost rate component.

(B) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing approach as defined in §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

(C) For DBMD and HCBS-AMH, the attendant cost component is modeled according to subparagraph (B) of this paragraph unless HHSC collects a cost report for the applicable program.

(2) For ICF/IID program services, HHSC will calculate an attendant cost rate component for day habilitation (DH) and residential services by calculating a median of attendant cost center data as defined in subsection (b) of this section for each DH and Residential services, weighted by ICF/IID units of service from the most recently examined ICF/IID cost report database, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter.

(A) The weighted median attendant cost component is adjusted by modeled direct care hours to unit ratios to determine attendant compensation rate components for each level of need (LON).

(B) The weighted median cost component is multiplied by 1.07 for both ICF/IID DH and residential services.

(C) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing analysis as defined in §355.105(h) of this chapter.

(3) For HCS and TxHmL programs, HHSC will calculate an attendant compensation rate component for each service by calculating a median of attendant cost center data as defined in subsection (b) of this section for each applicable attendant service, weighted by the applicable attendant service's units of service from the most recently examined HCS/TxHmL cost report database, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter.

(A) The weighted median cost component is multiplied by 1.044 for the following services:

(i) CFC PAS/HAB;

(ii) employment assistance;

(iii) in-home respite;

(iv) out-of-home respite in a camp;

(v) out-of-home respite in a respite facility;

(vi) out-of-home respite in a setting where host home / companion care (HH/CC) is provided;

(vii) out-of-home respite in a setting that is not listed;

(viii) supported employment; and

(ix) supported home living (transportation).

(B) The weighted median cost component is multiplied by 1.07 for the following services:

(i) individualized skills and socialization services;

(ii) out-of-home respite in an individualized skills and socialization facility;

(iii) out-of-home respite in a setting with SL or RSS is provided; and

(iv) SL/RSS.

(C) For services with rates that are variable by LON as specified in §355.723(b) of this chapter (relating to Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs), the weighted median attendant cost component is adjusted by modeled direct care hours to unit or direct care staff to individual ratios to determine attendant compensation rate components for each LON.

(D) If HHSC has insufficient cost data, the attendant compensation rate component will be established through a pro forma costing analysis as defined in §355.105(h) of this chapter.

(E) The attendant cost component for employment readiness is calculated as a blend of the cost component for individualized skills and socialization services.

(f) Determination of attendant cost component for CDS option services. Attendant services delivered through the CDS option as specified in subsection (d) of this section have an attendant cost component that is equal to the attendant cost component of the same service delivered through the provider agency option as specified in §355.114 of this chapter (relating to Consumer Directed Services Payment Option).

(g) The adopted attendant cost rate component is limited to available levels of appropriated state and federal funds as specified in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Karen Ray
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SUBCHAPTER M. MISCELLANEOUS PROGRAMS
DIVISION 7. COMMUNITY FIRST CHOICE

1 TAC §355.9090

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.321

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts new §355.321, concerning Reimbursement Methodology for Intellectual and Developmental Disabilities Nursing Facility Special Reimbursement Class.

Section 355.321 is adopted without changes to the proposed text as published in the July 11, 2025, issue of the *Texas Register* (50 TexReg 3966). The rule will not be republished.

BACKGROUND AND JUSTIFICATION

The new rule is necessary to comply with the 2026-27 General Appropriations Act, Senate Bill 1, 89th Legislature, Regular Session, 2025 (Article II, Health and Human Services Commission, Rider 31) (Rider 31). Rider 31 provides appropriations for HHSC to implement a new payment methodology for a new special reimbursement class to achieve improved care for long-term stay nursing facilities serving residents with intellectual and developmental disabilities.

COMMENTS

The 21-day comment period ended August 1, 2025.

During this period, HHSC did not receive any comments regarding the proposed rule.

STATUTORY AUTHORITY

The new rule is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 10. COMMUNITY DEVELOPMENT

PART 5. OFFICE OF THE GOVERNOR, ECONOMIC DEVELOPMENT AND TOURISM OFFICE

CHAPTER 176. ENTERPRISE ZONE PROGRAM

10 TAC §§176.1 - 176.5

The Office of the Governor ("Office") adopts amendments to 10 TAC §§176.1 - 176.5. Section 176.4 is adopted with a change to the proposed text as published in the May 2, 2025 issue of the *Texas Register* (50 TexReg 2663). Section 176.4 will be republished.

Sections 176.1, 176.2, 176.3, and 176.5 are adopted without changes to the proposed text as published in the May 2, 2025 issue of the *Texas Register* (50 TexReg 2663) and will not be republished.

REASONED JUSTIFICATION OF ADOPTED AMENDMENTS

The adopted amendment to rule §176.1 specifically addresses the participation of veterans in the program. The amendments also clarify that a single project may only have one concurrent designation for the same qualified business. The amendments further clarify that the window during which a project may begin making investments and creating jobs for program purposes is ninety business days, as specified in section 2303.003(1-b), Texas Government Code. The amendments also require the submission of applications and other written communications through a manner specified by the office, to include an electronic portal.

The adopted amendment to rule §176.2 removes a requirement that the required ordinance include a statement that the governing body is in full compliance with chapter 2303, Texas Government Code. The requirement is not established in statute and applicants otherwise demonstrate they are in compliance with that chapter in the application process. The amendments also clarify notice and posting requirements. Other changes enhance readability and make conforming redesignations of provisions to account for additions and deletions of regulatory text.

The adopted amendment to rule §176.3 specifically notes the veteran hiring requirements specified in Section 2303.402(a), Texas Government Code, for applicants' ease of reference. Other changes align regulatory text with current statutes and enhance the readability and clarity of the text.

The adopted amendments to rule §176.4 reduce the amount of application materials an applicant must provide, such as removing the requirement the application must be hole-punched and in a three-ring binder. Instead, applications must be submitted using the Office's electronic portal. Other changes align rules with the statutory allowance provided by section 2303.4052(b), Texas Government Code, which allows the submission of digital scans of certified copies of required documents. The amendments also clarify that applicants must include information related to full-time jobs, rather than any type of job. Other non-substantive changes modernize the regulatory text, enhance readability, and promote clarity. Finally, after proposing amendments to this rule in the May 2, 2025, issue of the *Texas Register*, the Office determined a citation in §176.4(e)(2)(B) text needed to be updated to change the citation from §176.2(2) to §176.2(a)(2).

The adopted amendment to rule §176.5 aligns rule text with statute by noting the Texas Comptroller of Public Accounts will report certain information to the Office on or before the 60th day after the end of the fiscal year, rather than October 1 of each year.

SUMMARY OF COMMENTS AND AGENCY RESPONSE:

The Office received no comments in response to this rulemaking.

TAKINGS IMPACT ASSESSMENT

Ms. Cruz has determined that there are no private real property interests affected by the adopted rules; therefore, the Office is not required to prepare a takings impact assessment pursuant to section 2007.043, Texas Government Code.

STATUTORY AUTHORITY

Section 2303.051(c), Texas Government Code, authorizes the Office to adopt rules necessary to carry out the purposes of chapter 2303, Texas Government Code.

CROSS REFERENCE TO STATUTE

No other statutes, articles, or codes are affected by the adopted rules.

§176.4. Application for Designation of Enterprise Projects.

(a) An application must be submitted through the online portal and must contain all information and documentation required under the Act and this chapter, as applicable. Each application for enterprise project designation must be typed directly on the form provided by the Bank.

(b) An application that is submitted with four or more material deficiencies will be declined as incomplete. Material deficiencies are items such as the governing body application certification, the qualified business application certification, or any other required tabbed item.

(c) The applicant shall file with the Bank one original application for designation as an enterprise project. All applications for enterprise project designation must be received by the Office no earlier than one week before, and no later than 11:59 p.m. Central Standard Time, on the first business day of the following months: September, December, March and June. Further, all applications include a non-refundable application fee in the form of a certified check or money order made payable to the Office of the Governor. The application is not considered to be received unless it is received on the online portal with the non-refundable application fee submitted under separate cover to Office of the Governor, Economic Development and Tourism, Texas Economic Development Bank, Attn: Financial Services, Post Office Box 12428, Austin, Texas 78711. The application fee must clearly show the name of the nominating jurisdiction, as well as the name of the qualified business. Both the application and the application fee must be received by the application deadline. Applications received after a deadline will not be accepted, and must be resubmitted to the Bank in the prescribed timeframe to be considered for designation during the next application deadline.

(d) Applications received during a quarterly round will be reviewed and scored by the Bank in accordance with the Act, this chapter and the goals of the program.

(e) The application for designation of an enterprise project must contain the following information and documentation, as applicable:

(1) The participants. The application must contain the name, street address, mailing address, telephone number, and

electronic mail address for each of the following involved in the designation of a qualified business as an enterprise project:

(A) the applicant governing body and the applicant governing body's liaison; and

(B) the qualified business, the primary business's representative and the local business liaison. The local business liaison must be located at the qualified business site.

(2) The applicant. The application must contain the following information and documentation concerning the applicant:

(A) a statement signed by the governing body liaison certifying that the contents of the application are true and correct to the best information and belief of the liaison, and that he or she has read the Act and this chapter and is familiar with the provisions thereof;

(B) a certified copy of the nominating ordinance or order under §176.2(a)(2) of this title (relating to Participation in the Program), or if an ordinance or order has already been passed nominating a project for designation, a certified copy of a resolution from the applicant governing body nominating the qualified business for designation as an enterprise project and containing:

(i) nomination of the project or activity as an enterprise project;

(ii) a statement as to whether the project or activity is located in an area designated as an enterprise zone, and, if applicable, that the project is located in an area that is also designated as a defense base development authority established under Chapter 379B, Local Government Code, a federal empowerment zone, a federal enterprise community, or a renewal community;

(iii) reference by number to the nominating ordinance or order indicating participation in the program, with a statement that the local incentives described in the previously issued ordinance or order electing to participate in the enterprise zone program are the same as those made available to the project or activity;

(iv) the active designation period of the project; and

(v) if the project or activity is nominated as a double jumbo enterprise project or a triple jumbo enterprise project, a statement that the designation will count as two or three designations, respectively, against the total number of designations allowed, as applicable.

(C) the block group of the primary business address of the qualified business site, verifiable by the local appraisal district;

(D) the poverty rate for the block group of the primary business address of the qualified business site, or the poverty rate of the distressed county in which the qualified business site is located;

(E) an official census map, which clearly identifies the location of the proposed project and the census area where it is located;

(F) a description of the municipality's or county's procedures and efforts to facilitate and encourage participation by and negotiation between all affected entities in the jurisdiction in which the qualified business is located including a description of the business activity that has occurred in the area within the last year. This description must demonstrate the cooperation among the public and private sectors;

(G) a description of the local effort made by the municipality or county and other affected entities to achieve development and revitalization of the area as described in the Act, §2303.405(c). This includes a brief historical description of the trade and business conducted in the area.

(3) The project. The application must contain the following information and documentation concerning the proposed project:

(A) a statement signed by the primary business representative and the local business liaison certifying that the contents of the application are true and correct to their best information and belief, and that they have read the Act and this chapter and are familiar with the provisions thereof;

(B) a description and introduction of the business applying for the project designation, which includes:

(i) a copy of the articles of incorporation, or the dba statement under which the business operates, filed with the Secretary of State of the State of Texas. The name under which the business is applying for designation must be the same as the business paying state taxes and creating and/or retaining jobs to obtain program benefits;

(ii) the principal owners and history of the business;

(iii) a resolution for corporations or a certificate of authority that provides signatory authority to a person or persons to submit the enterprise project application and sign any contracts or forms on behalf of the business for the enterprise project;

(iv) the number of business locations, total sales, and number of employees in the State of Texas, the United States, and outside the United States;

(v) the federal tax identification number, and/or the Texas Comptroller tax identification number, as applicable, for all participating entities of a controlled group;

(vi) a description of the business' products and services, including NAICS code;

(vii) a description of the business' export history, if applicable; and

(viii) an organizational chart that indicates the business structure, as well as the role of each entity participating in the project;

(C) the plans of the business for expansion, revitalization, and other activity at the qualified business site for the designation period of the project including:

(i) a description of the project location and intended use;

(ii) a summary of short and long-term plans for expansion at the qualified business site;

(iii) the amount of capital investment to be made at the qualified business site during the designation period;

(iv) the status of any required local, state or federal permits or licenses that must be obtained to enable the project to be initiated and completed as represented in the enterprise project application;

(v) a tabular summary of the current number of full-time, part-time jobs which includes the titles and/or Standard Occupational Classification by six-digit code and salary ranges of jobs to be maintained at the qualified business site. Full-time positions will be used for baseline information;

(vi) a tabular summary of the number of new full-time jobs, the titles and/or Standard Occupational Classification by six-digit code and salary ranges of full-time jobs to be created;

(vii) a tabular summary of the number of full-time jobs, the titles and/or Standard Occupational Classification by six-digit

code and salary ranges of full-time jobs to be retained, if applying for retained job benefit; and

(viii) the total projected annual payroll for the jobs that are being considered for benefit;

(D) commitments from the business that include:

(i) a completed form provided by the Bank, certifying the business as a qualified business;

(ii) a statement from a franchise or subsidiary, if applicable, stating that the business will maintain separate payroll and tax records of the business activity conducted at the qualified business site;

(iii) the percentage of new or additional employees hired to occupy the jobs being claimed for benefit that are residents of any enterprise zone in the state, that are economically disadvantaged, or that are veterans;

(iv) a description of the efforts of the business to develop and revitalize the area as described in the Act, §2303.405(e); and

(v) a statement certifying that the business, or a branch, division, or department of the business, does not and will not knowingly employ an undocumented worker.

(f) Concurrent enterprise project designations. A qualified business that currently has an enterprise project designation may apply for one additional enterprise project designation at the same qualified business site. To receive the additional enterprise project designation the governing body must complete an enterprise project application with all of the required nominations and attachments. Additionally, the application must include a breakdown of capital investment and new and/or retained jobs for each designation, clearly delineating what capital investment and jobs will apply to which designation, with timelines for all.

(g) Name change. If the name of a qualified business that has received an enterprise project designation has changed, the Bank may approve the name change for the enterprise project designation. The designated enterprise project must apply for a name change to the Bank no later than 18 months after the enterprise project designation expires, or the business will not be eligible for program benefits. The name change of a project designation by a qualified business does not extend the original designation period, which is applicable to the original and subsequent designee, and which will end on the last day of the original designation period. The receive Bank approval for a name change, the qualified business must submit through the applicant governing body:

(1) a completed Name Change Application, along with a non-refundable cashiers check or money order made payable to Office of the Governor, for a processing fee;

(2) a written explanation by the designee of the reasons for the name change, the date the name change occurred and any changes to the commitments made by the business in the original enterprise project application, if applicable; and

(3) written acknowledgment from the applicant governing body that it is aware of the name change for the project as a qualified business operating at the qualified business site within its jurisdiction.

(h) Assignment or Assumption. The Bank may approve the assignment or assumption of a state-designated enterprise project that has transferred through a sale to another entity that will commit to continue operations at the qualified business site in the way originally committed within the initial enterprise project application, or which otherwise demonstrates to the satisfaction of the Bank that the assignment or assumption is warranted to avoid disruption of operations and loss of jobs. The transfer of a project designation by a qualified business does not extend the original designation period, which is applicable to the original and subsequent designee and which will end on the last day of the original designation period. The designated enterprise project must apply to the Bank, through the appropriate governing body, for designation assignment or assumption no later than 18 months after the enterprise project designation expires, or the business will not be eligible for program benefits. The following must be submitted through the applicant governing body to the Bank:

(1) official action by the governing body in the form of a resolution approving the transfer of the enterprise designation to the purchaser;

(2) a completed Enterprise Project Assignment Application, along with a non-refundable cashiers check or money order made payable to Office of the Governor for a processing fee;

(3) a written relinquishment from the designated project's qualified business to the governing body and Bank to release all claim to the project designation and any benefits represented thereunder and agreeing to the assignment of the designation as of a specific date by the purchaser seeking to assume the designation;

(4) a written certification from the purchaser on a form to be provided by the Bank that the purchaser will be a qualified business under the Act, §2303.402;

(5) a letter of commitment from the purchaser addressed to the governing body and the Bank in the same format as the letter of commitment filed in the original application for project designation by the initial qualified business. The letter should outline any modifications proposed by the purchaser to the original commitments made by the qualified business holding the project designation, including capital investment and jobs to be created or retained, as applicable, and a statement as to why the assignment is essential to their operations at the qualified business site;

(6) a Comptroller of Public Accounts tax identification number and federal tax identification number for the purchaser; and

(7) a copy of the purchasers' articles of incorporation filed with the State of Texas Secretary of State, or the dba statement under which the business operates.

(i) A qualified business may be designated as an enterprise project for no less than one year and no longer than five years. The designation of a qualified business as an enterprise project shall remain in effect during the period beginning on the date of the designation and ending on the earliest of:

(1) the date requested in the application for designation as an enterprise project as indicated in the nominating ordinance, order or resolution, as applicable;

(2) five years after the date the designation is made;

(3) the last day that completes the original project designation period of a qualified business that has assumed the designation of the enterprise project designation through or purchase of a designated qualified business for the purpose of continuing its operations at the applicable qualified business; or

(4) the date the Bank notifies the qualified business and the governing body that the qualified business is not in compliance with any requirement for designation as an enterprise project.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 21, 2025.

TRD-202503034
Adriana Cruz
Executive Director
Office of the Governor, Economic Development and Tourism Office
Effective date: September 10, 2025
Proposal publication date: May 2, 2025
For further information, please call: (512) 463-2000

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TITLE 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 12. COAL MINING REGULATIONS
SUBCHAPTER G. SURFACE COAL MINING AND RECLAMATION OPERATIONS, PERMITS, AND COAL EXPLORATION PROCEDURES SYSTEMS
DIVISION 2. GENERAL REQUIREMENTS FOR PERMITS AND PERMIT APPLICATIONS

16 TAC §12.108

The Railroad Commission of Texas (Commission) adopts amendments to §12.108, relating to Permit Fees, without changes to the proposed text as published in the July 4, 2025, issue of the *Texas Register* (50 TexReg 3848) and will not be republished. The Commission adopts the amendments to implement provisions of Senate Bill 1, 89th Texas Legislature (Regular Session, 2025), and, specifically, Article VI, Railroad Commission Rider 5, which requires the amounts appropriated from general revenue for state fiscal years (FY) 2026 and 2027 to cover the cost of permitting and inspecting coal mining operations. The Rider is contingent upon the Commission assessing fees during the 2026-2027 biennium sufficient to generate revenue to cover the general revenue appropriations. The Commission amends the annual fees required by coal mining permittees in subsection (b).

The Texas State Legislature appropriated the applicable funds in Senate Bill 1 based on fees collected as set forth in Rider 5, including fees appropriated for both the coal mining program and a separate, existing program for uranium exploration permitting. The uranium program cost is subtracted from the total annual appropriation to determine the cost of the coal regulatory program. The Commission's coal mining regulatory program is partially funded with a 50 percent cost reimbursement grant from the United States Department of the Interior, Office of Surface Mining Reclamation and Enforcement. The remaining 50 percent is funded by the fees collected in §12.108.

The Commission received no comments on the proposal.

The Commission amends the fees set forth in subsection (b) by splitting the annual fee for each acre of land within a permit area covered by a reclamation bond on December 31st of each year, currently at $12.85, into two fees. The Commission amends paragraph (1) to remain at the current fee amount of $12.85 for each bonded acre of land that has met the Phase I reclamation release requirements of §12.313(a)(1) of this title (relating to Criteria and Schedule for Release of Performance Bond) based on the number of bonded acres of land identified by the applicant as meeting the requirements of §12.313(a)(1), as shown on the map required by §12.142(2)(C) of this title (relating to Operation Plan: Maps and Plans) and approved by the Commission. The Commission amends paragraph (2) to include a fee of $29.80 for the bonded acres of land that have not met the Phase I reclamation release requirements of §12.313(a)(1) based on the number of bonded acres of land identified by the applicant as not meeting the requirements of §12.313(a)(1), as shown on the map required by §12.142(2)(C) and approved by the Commission. The annual permit fee in re-numbered paragraph (3) remains at the current amount of $6,170 per permit. The Commission anticipates that annual fees in these new amounts will result in revenue of $4,650,102, for the coal regulatory program in each year of the 2026-2027 biennium.

The Commission adopts the amendments under Texas Natural Resources Code §134.011, §134.013, and §134.055, which authorize the Commission to promulgate rules pertaining to surface coal mining operations.

Statutory Authority: Texas Natural Resources Code §134.011, §134.013 and §134.055.

Cross-reference to statute: Texas Natural Resources Code §134.011, §134.013 and §134.055.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 19, 2025.

TRD-202502986
Natalie Dubiel
Assistant General Counsel
Railroad Commission of Texas
Effective date: September 8, 2025
Proposal publication date: July 4, 2025
For further information, please call: (512) 475-1295

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TITLE 22. EXAMINING BOARDS

PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 275. CONTINUING EDUCATION

22 TAC §275.2

The Texas Optometry Board (Board) adopts amendments to 22 TAC Title 14 Chapter 275, Continuing Education §275.2 - Required Education. The Board adopts this rule with no changes to the proposed text as published in the April 11, 2025, issue of the *Texas Register* (50 TexReg 2372). The adopted rule will not be republished.

BACKGROUND AND JUSTIFICATION

Section 481.0764(f), Texas Health and Safety Code, expired on August 31, 2023. This statute required a prescriber of opioids to take an annual hour of continuing education relating to opioid prescribing best practices. As the section requiring continuing education related to opioid prescribing best practices has expired, the Board is repealing the requirement from its rules.

COMMENTS

The 30-day comment period ended on May 11, 2025. During this period and subsequently, the Board did not receive any comments regarding the proposed rules.

STATUTORY AUTHORITY

This rule is adopted under the Texas Optometry Act, Texas Occupations Code, §351.151 and under §351.308 of the Tex. Occ. Code which requires continuing education as a condition for renewal of a license.

No other sections are affected by the amendments.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 19, 2025.

TRD-202502997
Janice McCoy
Executive Director
Texas Optometry Board
Effective date: September 8, 2025
Proposal publication date: April 11, 2025
For further information, please call: (512) 305-8500

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 289. RADIATION CONTROL

SUBCHAPTER F. LICENSE REGULATIONS

25 TAC §289.253

The executive commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Department of State Health Services (DSHS), adopts an amendment to §289.253, concerning Radiation Safety Requirements for Well Logging Services Operations and Tracer Studies.

Section 289.253 is adopted without changes to the proposed text as published in the June 13, 2025, issue of the *Texas Register* (50 TexReg 3554). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

The amendment is necessary for Texas (an Agreement State) to comply with United States Nuclear Regulatory Commission (NRC) procedures, which require Agreement State rules to be compatible with NRC regulations. The amendment corrects the record retention requirements for well logging field stations and temporary job sites as defined in §289.253(cc).

Specifically, the amendment updates §289.253(cc)(2), Records/documents for inspection by the department, to reference only those records listed in the equivalent NRC regulation, 10 CFR §39.73 (Documents and records required at field stations). Additionally, §289.253(cc)(4), Records/documents for inspection by the department, is updated to reference only those records listed in the equivalent NRC regulation, 10 CFR §39.75 (Documents and records required at temporary job sites). The items which must be retained for inspection by the department are listed in Figure: 25 TAC §289.253(ee)(5).

The amendment updates, corrects, improves, and clarifies the rule language and incorporates plain language where appropriate.

COMMENTS

The 31-day comment period ended July 14, 2025.

During this period, DSHS did not receive any comments regarding the proposed rule.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §524.0151 and Texas Health and Safety Code §1001.075, which authorize the executive commissioner of HHSC to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001; and Texas Health and Safety Code Chapter 401 (the Texas Radiation Control Act), which provides for DSHS radiation control rules and regulatory program to be compatible with federal standards and regulation; §401.051, which provides the required authority to adopt rules and guidelines relating to the control of sources of radiation; §401.052, which provides authority for rules providing for transportation and routing of radioactive material and waste in Texas; §401.103, which provides authority for licensing and registration for transportation of sources of radiation; §401.104 which provides for rulemaking authority for general or specific licensing of radioactive material and devices or equipment using radioactive material; §401.224, which provides rulemaking authority relating to the packaging of radioactive waste; and Chapter 401, Subchapter J, which authorizes enforcement of the Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 22, 2025.

TRD-202503035
Cynthia Hernandez
General Counsel
Department of State Health Services
Effective date: September 11, 2025
Proposal publication date: June 13, 2025
For further information, please call: (512) 834-6655

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 271. COMMUNITY CARE SERVICES ELIGIBILITY

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to §271.1, concerning Definitions of Program Terms; §271.5, concerning Community Services Interest Lists; §271.7, concerning Enrollment; §271.51, concerning Eligibility for Services; §271.53, concerning Income and Income Eligibles; §271.55, Determination of Countable Income; §271.57, concerning Income from Excludable Sources; §271.59, concerning Income

from Exempt Sources; §271.61, concerning Age; §271.63, concerning Need; §271.65, concerning Indian-related Exemptions; §271.69, concerning Family Care; §271.71, concerning Home Delivered Meals; §271.73, concerning Adult Foster Care; §271.75, concerning Special Services to Persons with Disabilities; §271.77, concerning Day Activity and Health Services; §271.79, concerning Case Management Services; §271.81, concerning Primary Home Care or Community Attendant Services; §271.83, concerning Time Allocation for Escort Services; §271.85, concerning Residential Care; §271.87, concerning Emergency Care; §271.89, concerning Resource Limits; §271.91, concerning Countable Resources; §271.93, concerning Resource Exclusions; §271.95, concerning Emergency Response Services; §271.97, concerning Residential Care Services; §271.151, concerning Application for Services; §271.153, concerning Recertification; §271.155, concerning Denial, Reduction, and Termination of Benefits; §271.159, concerning Adult Foster Care Client Rights and Responsibilities, and the repeal of §271.3, concerning Definitions.

Section 271.5 is adopted with changes to the proposed text as published in the May 16, 2025, issue of the *Texas Register* (50 TexReg 2898). This rule will be republished.

Sections 271.1, 271.7, 271.51, 271.53, 271.55, 271.57, 271.59, 271.61, 271.63, 271.65, 271.69, 271.71, 271.73, 271.75, 271.77, 271.79, 271.81, 271.83, 271.85, 271.87, 271.89, 271.91, 271.93, 271.95, 271.97, 271.151, 271.153, 271.155, 271.159, and the repeal of §271.3 are adopted without changes to the proposed text as published in the May 16, 2025, issue of the *Texas Register* (50 TexReg 2898). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

Senate Bill (S.B.) 200, 84th Legislature, Regular Session, 2015, abolished the Texas Department of Aging and Disability Services (DADS) and transferred its functions to the Texas Health and Human Services Commission (HHSC), including Community Care for Aged and Disabled (CCAD). The program name was subsequently renamed to Community Care Services Eligibility (CCSE) on September 1, 2016. The rules for CCSE were administratively transferred from Title 40 Texas Administrative Code (TAC) to Title 26. The purpose of this adoption is to update references and terms in the rules to reflect the transition of the program from DADS to HHSC.

The amendments replace outdated references to "DADS" and "CCAD" with "HHSC" and "CCSE," which are the appropriate oversight agency and program. Additionally, there are references to outdated terms and program names such as "food stamps" or "aid to families with dependent children." The adoption updates those references to align 26 TAC, Part 1, Chapter 271, with both the agency's person-centered language policy and Texas Government Code Chapter 392. Eligibility requirements for the program are not changing.

COMMENTS

The 31-day comment period ended June 16, 2025.

During this period, HHSC did not receive any comments regarding the proposed rules.

A minor editorial change was made to §271.5 to add the closing parenthesis in a citation.

SUBCHAPTER A. DEFINITIONS

26 TAC §271.1

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Human Resources Code §117.080(e) which authorizes the executive commissioner of HHSC to adopt rules necessary to implement that section, including requirements applicable to Centers for Independent Living (CIL) providing independent living services under the program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 21, 2025.

TRD-202503023
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: September 10, 2025
Proposal publication date: May 16, 2025
For further information, please call: (817) 458-1902

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SUBCHAPTER B. INTEREST LISTS

26 TAC §271.3

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Human Resources Code §117.080(e) which authorizes the executive commissioner of HHSC to adopt rules necessary to implement that section, including requirements applicable to Centers for Independent Living (CIL) providing independent living services under the program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 21, 2025.

TRD-202503024
Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 16, 2025
For further information, please call: (817) 458-1902

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26 TAC §271.5, §271.7

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Human Resources Code §117.080(e) which authorizes the exec-

utive commissioner of HHSC to adopt rules necessary to implement that section, including requirements applicable to Centers for Independent Living (CIL) providing independent living services under the program.

§271.5. Community Services Interest Lists.

(a) HHSC maintains, for each HHSC region, a community services interest list for each community care services eligibility service or program authorized under Title XX of the Social Security Act.

(b) A person or responsible person may request in person, by phone, or in writing that HHSC add a person's name to a Title XX of the Social Security Act community services interest list. The person making the request must provide a Texas address for the person.

(c) HHSC adds a person's name to a community services interest list if:

(1) a request is made in accordance with subsection (b) of this section; or

(2) an applicant's name is on the interest list for an HHSC region and the applicant or a responsible person notifies HHSC that the applicant has moved to another HHSC region and requests that the applicant's name be added to the interest list for the HHSC region to which the applicant has moved.

(d) HHSC adds an applicant's name to a community services interest list with an interest list request date as follows:

(1) for a request to add an applicant's name to the interest list made in accordance with subsection (b) of this section, the date of the request; or

(2) for a request to add an applicant's name to the interest list made in accordance with subsection (c)(2) of this section, the date of the original request made in accordance with subsection (b) of this section.

(e) HHSC removes an applicant's name from a community services interest list if:

(1) the applicant or responsible person requests that the applicant's name be removed from the interest list;

(2) the applicant moves out of Texas, unless the applicant is a military family member living outside of Texas:

(A) while the military member is on active duty; or

(B) for less than one year after the former military member's active duty ends;

(3) the applicant is a military family member living outside of Texas for more than one year after the former military member's active duty ends;

(4) the applicant or responsible person declines an offer of a community care service or program when contacted by HHSC, as described in §271.7 of this subchapter (relating to Interest Lists) unless the applicant is a military family member living outside of Texas:

(A) while the military member is on active duty; or

(B) for less than one year after the former military member's active duty ends;

(5) the applicant is deceased; or

(6) HHSC denies an applicant's eligibility for the community care service or program and the applicant has had an opportunity to exercise the right to appeal the decision in accordance with Title 1 Texas Administrative Code (TAC), Part 15, §357.3 (relating to Authority and Right to Appeal) or §271.155 of this chapter (relating to Denial, Reduction, and Termination of Benefits) and did not appeal the decision, or appealed and did not prevail.

(f) If HHSC removes an applicant's name from a community services interest list in accordance with subsection (e)(1) - (4) of this section and, within 90 calendar days after the name was removed, HHSC receives an oral or written request to reinstate the applicant's name on the interest list, HHSC:

(1) reinstates the applicant's name to the interest list with an interest list request date described in subsection (d)(1) or (2) of this section; and

(2) notifies the applicant in writing that the applicant's name has been reinstated to the interest list in accordance with paragraph (1) of this subsection.

(g) If HHSC removes an applicant's name from a community services interest list in accordance with subsection (e)(1) - (4) of this section and, more than 90 calendar days after the name was removed, HHSC receives an oral or written request to reinstate the applicant's name on the community services interest list, HHSC:

(1) adds the applicant's name to the community services interest list with a request date of:

(A) the date HHSC receives the oral or written request to reinstate; or

(B) because of extenuating circumstances as determined by HHSC, the original request date described in subsection (d)(1) or (2) of this section; and

(2) notifies the applicant in writing that the applicant's name has been added to the community services interest list in accordance with paragraph (1) of this subsection.

(h) If HHSC removes an applicant's name from a community services interest list in accordance with subsection (e)(6) of this section and HHSC subsequently receives an oral or written request to reinstate the applicant's name on the community services interest list, HHSC:

(1) adds the applicant's name to the community services interest list with a request date of the date HHSC receives the oral or written request to reinstate; and

(2) notifies the applicant in writing that the applicant's name has been added to the community services interest list in accordance with paragraph (1) of this subsection.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 21, 2025.

TRD-202503025
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: September 10, 2025
Proposal publication date: May 16, 2025
For further information, please call: (817) 458-1902

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SUBCHAPTER C. ELIGIBILITY

26 TAC §§271.51, 271.53, 271.55, 271.57, 271.59, 271.61, 271.63, 271.65, 271.69, 271.71, 271.73, 271.75, 271.77,

271.79, 271.81, 271.83, 271.85, 271.87, 271.89, 271.91, 271.93, 271.95, 271.97

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Human Resources Code §117.080(e) which authorizes the executive commissioner of HHSC to adopt rules necessary to implement that section, including requirements applicable to Centers for Independent Living (CIL) providing independent living services under the program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TRD-202503026
Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: May 16, 2025
For further information, please call: (817) 458-1902

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SUBCHAPTER D. CASE MANAGEMENT

26 TAC §§271.151, 271.153, 271.155, 271.159

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; and Texas Human Resources Code §117.080(e) which authorizes the executive commissioner of HHSC to adopt rules necessary to implement that section, including requirements applicable to Centers for Independent Living (CIL) providing independent living services under the program.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TRD-202503027
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: September 10, 2025
Proposal publication date: May 16, 2025
For further information, please call: (817) 458-1902

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 9. TEXAS COMMISSION ON JAIL STANDARDS

CHAPTER 263. LIFE SAFETY RULES

SUBCHAPTER A. GENERAL

37 TAC §263.1

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.1 (relating to life safety in county jails) under Subchapter A General, Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3101). The rule will not be republished.

The adoption of this rule requires county jail facilities to be designed, constructed maintained, staffed and operated to comply with the standards as adopted by the Texas Department of Insurance.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 25, 2025.

TRD-202503066
Brandon Wood
Executive Director
Texas Commission on Jail Standards
Effective date: September 14, 2025
Proposal publication date: May 23, 2025
For further information, please call: (512) 850-9668

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SUBCHAPTER B. DESIGN AND MATERIALS

37 TAC §263.12

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.12 (relating to life safety in county jails) under Subchapter B Design and Materials Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3102). The rule will not be republished.

The adoption of this rule adds language which updates the references to the National Fire Protection Associations' standards.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 25, 2025.

TRD-202503067

Brandon Wood
Executive Director
Texas Commission on Jail Standards
Effective date: September 14, 2025
Proposal publication date: May 23, 2025
For further information, please call: (512) 850-9668

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37 TAC §263.15

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.15 (relating to life safety in county jails) under Subchapter B Design and Materials, Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3103). The rule will not be republished.

The adoption of this rule requires county jail facilities to illuminate stairways at 10 foot candle brightness and to arrange in such a way that failure of any lighting unit or bulb will not leave any area in darkness.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 25, 2025.

TRD-202503068
Brandon Wood
Executive Director
Texas Commission on Jail Standards
Effective date: September 14, 2025
Proposal publication date: May 23, 2025
For further information, please call: (512) 850-9668

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37 TAC §263.19

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.19 (relating to life safety in county jails) under Subchapter B Design and Materials Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3103). The rule will not be republished.

The adoption of this rule corrects grammar and clarifies a reference with a full title.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 25, 2025.

TRD-202503069
Brandon Wood
Executive Director
Texas Commission on Jail Standards
Effective date: September 14, 2025
Proposal publication date: May 23, 2025
For further information, please call: (512) 850-9668

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SUBCHAPTER C. DETECTION AND ALARM SYSTEMS

37 TAC §263.30

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.30 (relating to life safety in county jails) under Subchapter C Detection and Alarm Systems Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3104) and the Correction of Error notice published contemporaneously in this issue. The rule will not be republished.

The adoption of this rule clarifies references and conforms to recommended language as provided by the State Fire Marshal's Office during TCJS' four year rule review.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on August 25, 2025.

TRD-202503070
Brandon Wood
Executive Director
Texas Commission on Jail Standards
Effective date: September 14, 2025
Proposal publication date: May 23, 2025
For further information, please call: (512) 850-9668

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37 TAC §263.32

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.32 (relating to life safety and testing of fire alarm systems in county jails) under Subchapter C Detection and Alarm Systems Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3104).

The adoption of this rule adds language which specifies how fire alarm systems shall be tested in county jails.

No comments were received during the public comment period. No further article, statute, or code is affected by this adoption. The rule will not be republished.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

§263.32. Periodic Testing.

The fire alarm system shall be tested in accordance with the inspection, testing, and maintenance schedules in NFPA 72, National Fire Alarm and Signaling Code and shall be tested at least on calendar quarterly intervals.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Brandon Wood
Executive Director
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For further information, please call: (512) 850-9668

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37 TAC §263.33

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.33 (relating to life safety and testing of fire alarm systems in county jails) under Subchapter C Detection and Alarm Systems Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3105). The rule will not be republished.

The adoption of this rule adds language which adds a reference to the National Fire Protection Association regarding how fire alarm systems shall be supervised.

No comments were received during the public comment period. No further article, statute, or code is affected by this adoption. The rule will not be republished.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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SUBCHAPTER E. LIFE SAFETY AND EMERGENCY EQUIPMENT

37 TAC §263.50

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.50 (relating to life safety in county jails) under Subchapter E Life Safety and Emergency Equipment Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3105). The rule will not be republished.

The adoption of this rule adds language which corrects grammatical mistakes in this rule.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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37 TAC §263.51

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.51 (relating to life safety smoke management in county jails) under Subchapter E Life Safety and Emergency Equipment Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3106). The rule will not be republished.

The adoption of this rule adds language which corrects grammatical mistakes in this rule.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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37 TAC §263.52

The Texas Commission on Jail Standards (TCJS) adopts amendments to §263.52 (relating to life safety, standpipes and hoses in county jails) under Subchapter E Life Safety and Emergency Equipment Chapter 263 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed

in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3108). The rule will not be republished.

The adoption of this rule adds titles for references to National Fire Protection Association chapters and corrects grammatical errors.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009.

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 279. SANITATION

37 TAC §279.1

The Texas Commission on Jail Standards (TCJS) adopts amendments to §279.1 (relating to sanitation plans and hand washing in county jails) in Chapter 279 Part 9 of Title 37 of the Texas Administrative Code without changes to the text as proposed in the May 23, 2025, issue of the *Texas Register* (50 TexReg 3108). The rule will not be republished.

The adoption of this rule will require county jails to establish a method to allow hand washing prior to meals being served in holding cells.

No comments were received during the public comment period.

Statutory authority to adopt this rule comes from Texas Government Code 511.009

No further article, statute, or code is affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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