Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 1. ADMINISTRATION

PART 4. OFFICE OF THE SECRETARY OF STATE

CHAPTER 81. ELECTIONS

SUBCHAPTER A. VOTER REGISTRATION

1 TAC §§81.13, 81.15, 81.23, 81.25

The Office of the Secretary of State (Office) proposes amendments to 1 TAC §§81.13, 81.15, 81.23, and 81.25 concerning disbursement of funds under Chapter 19 of the Texas Election Code. These rules designate which goods and services are reimbursable with Chapter 19 funds and outline the procedures that county voter registrars must follow to obtain such reimbursement.

The proposed amendments are intended to remove a reference to outdated grant management standards; implement statutory changes resulting from House Bill 1217, enacted by the 88th Legislature, Regular Session; extend the deadline to submit Chapter 19 funding requests; clarify the procedures for the submission of travel reimbursements; and identify certain voter registration-related materials that are reimbursable with Chapter 19 funds.

SECTION-BY-SECTION SUMMARY

The revisions to §81.13 remove a reference to the Uniform Grant Management Standards (UGMS), which have been retired and replaced with the Texas Grant Management Standards (TxGMS). The revisions to this section also implement House Bill 1217 (88th Legislature, Regular Session), which authorizes the use of Chapter 19 funds if the registrar's county has a population of less than 55,000, to defray the cost to the registrar's county of keeping the polling places in the county open during the early voting period as required under Texas Election Code §§85.005(c), 85.006(e), and 85.064(d).

The revisions to §81.15 extend the deadline to submit Chapter 19 funding requests from six (6) months to twelve (12) months from the date of payment to vendor, or prior to the deadline resulting from the Comptroller's Master Schedule of Fiscal Year-End Close Events, whichever comes first.

The revisions to §81.23 clarify that travel reimbursements must be submitted for each traveler consistent with the deadlines set out in §81.15.

The revisions to §81.25 clarify the distinction between a promotional item and an educational item in connection with voter registration drive activities.

FISCAL NOTE

Christina Adkins, Director of Elections, has determined that for each year of the first five years that the proposed amended rules will be in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the proposed amendments. In addition, the Office does not anticipate that enforcing or administering the proposed amended rules will result in any reductions in costs or in any additional costs to the Office, the state, or local governments. The Office also does not anticipate that there will be any loss or increase in revenue to the Office, the state, or local governments as a result of enforcing or administering the proposed amended rules.

PUBLIC BENEFIT

Ms. Adkins has determined that for each year of the first five years that the proposed amended rules will be in effect, the public benefit expected as a result of adopting the proposed amendments will be increased clarity with respect to the allowable uses of Chapter 19 funds and the procedures for the disbursement of state funds to defray certain expenses of voter registrars. The proposed amended rules also will implement legislative changes pertaining to the reimbursement of expenses incurred by certain counties to conduct early voting by personal appearance pursuant to Chapter 85 of the Texas Election Code.

COSTS TO REGULATED PERSONS

The proposed amendments do not impose any costs on regulated persons, including another state agency, a special district, or a local government. Accordingly, the Office has determined that Texas Government Code §2001.0045 does not apply to the proposed amended rules.

IMPACT ON LOCAL EMPLOYMENT

There is no effect on local economy for the first five years that the proposed amendments will be in effect. Therefore, no local employment impact statement is required under Texas Government Code §§2001.022 and 2001.024(a)(6).

FISCAL IMPACT ON SMALL BUSINESSES, MICRO-BUSINESSES, AND RURAL COMMUNITIES

The proposed amended rules will have no direct adverse economic impact on small businesses, micro-businesses, or rural communities. Accordingly, the preparation of an economic impact statement and a regulatory flexibility analysis, as specified in Texas Government Code §2006.002, is not required.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Texas Government Code §2001.0221, the Office provides the following government growth impact statement for the proposed amendments. For each year of the first five years that the proposed amended rules will be in effect, the Office has determined the following:

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

(2) implementation of the proposed rules will not require the creation of new employee positions or the elimination of existing employee positions;

(3) implementation of the proposed rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the proposed rules will not require an increase or decrease in fees paid to the agency;

(5) the proposed rules will not create a new regulation but will expand and clarify existing regulations;

(6) the proposed rules will not limit or repeal an existing regulation;

(7) the proposed rules will not increase or decrease the number of individuals subject to the rules' applicability; and

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

REQUEST FOR PUBLIC COMMENTS

Comments or questions on the proposed amended rules may be submitted in writing and directed to Christina Adkins, Director of Elections, Office of the Secretary of State, P.O. Box 12060, Austin, Texas 78711-2060, or by e-mail to elections@sos.texas.gov. Comments submitted electronically should include "Proposed Chapter 19 Rules" in the subject line. Comments will be accepted for thirty (30) days from the date of publication of the proposed amended rules in the *Texas Register.* Comments should be organized in a manner consistent with the organization of the proposed amendments.

STATUTORY AUTHORITY

The proposed amendments are authorized by Texas Election Code §§19.002(b), 19.004, and 31.003. Texas Election Code §19.002(b) authorizes the Office to prescribe procedures relating to the disbursement of Chapter 19 funds. Texas Election Code §19.004 authorizes the Office to implement provisions related to disbursing state funds to defray expenses of the voter registrar's office in connection with voter registration. Texas Election Code §31.003 directs the Office to obtain and maintain uniformity in the application, operation, and interpretation of the Texas Election Code and other election laws, including through the preparation of detailed and comprehensive written directives and instructions relating to and based on such laws.

CROSS REFERENCE TO STATUTE

The proposed amended rules implement Chapter 19 of the Texas Election Code. No other statute, code, or article is affected by the proposed amendments.

§81.13. Allowable Uses of Chapter 19 Funds.

(a) Chapter 19 funds expenditures must comply with the criteria of "reasonable and necessary" as established by Texas Grant Management Standards (TxGMS) [~~Uniform Grant Management Standards (UGMS)~~] and may only be used for the following activities:

(1) Increase the number of registered voters in the state.

(2) Maintain and report an accurate list of the number of registered voters.

(3) Increase the efficiency of the voter registration office through the use of technological equipment.

(4) If the registrar's county has a population of less than 55,000, defray the cost to the registrar's county of keeping the polling places in the county open during the early voting period as required under Texas Election Code §§85.005(c), 85.006(e), and 85.064(d). In elections where the county clerk is the early voting clerk and the commissioners court has not created a county elections administrator under Texas Election Code §31.031, the costs must be in consultation and agreement with the county clerk or the county officer to whom election duties and functions have been transferred as defined in Texas Election Code §31.091(1).

(b) All Chapter 19 funding requests submitted to the Agency must identify which of these purposes the requested item(s) will benefit.

(c) All Chapter 19 requests must include a certification that the Commissioners Court did not consider the availability of Chapter 19 funds in adopting the county budget for the office of voter registrar.

(d) If there is a question regarding whether an item or service is payable from Chapter 19 funds, the Agency will review the eligibility prior to the purchase upon request by the county.

§81.15. Funding Period.

(a) After June 1 of each year funding becomes available to the counties as defined in §19.002 of the Election Code and remains available for 27 months, expiring on August 31. However, the Comptroller imposes a deadline prior to August 31 for any documents or transactions for expiring appropriations. Accordingly, counties will be notified of the deadline when the "Comptroller's Master Schedule of Fiscal Year-End Close Events" is published. Funding requests must be submitted prior to the applicable date as determined by the Secretary of State.

(b) [~~Except for travel reimbursement requests,~~] Chapter 19 funding requests must be received within twelve (12) [~~six (6)~~] months of payment to vendor or prior to the deadline described in subsection (a) of this section, whichever comes first.

[~~(c) Travel expense reimbursement requests must be submitted within 30 days of the completion of travel.~~]

§81.23. Travel Using Chapter 19 Funds Authorized.

(a) Chapter 19 funds may be used to pay travel expenses incurred by the voter registrar and full-time permanent voter registration staffers to attend voter registration and/or election administration seminars and demonstrations that directly advance voter registration efforts.

(b) All voter registrars who seek reimbursement from Chapter 19 funds should plan their travel to achieve maximum economy and efficient means of transportation.

(c) The following limitations apply to Chapter 19 travel:

(1) The lowest available rates and fares shall be utilized.

(2) Reimbursements will be made based on actual costs.

(3) Lodging, per diem, and mileage rates may not exceed those set by the Texas Comptroller of Public Accounts.

(4) Reimbursements for lodging, per diem (including partial per diem), and mileage rates may not be charged to Chapter 19 unless the employee conducts travel beyond 25 miles of his or her designated headquarters.

(5) Travel by personal car is reimbursable at the rate set by the Texas Comptroller of Public Accounts per mile with mileage computed using the originating county seat as the departure point and computing final mileage using the mapping tool on the Chapter 19 web-based application.

(6) If more than one person is traveling from the same headquarters to the same destination, the travelers are to ride together in a single automobile if practicable.

(7) The rental of luxury cars will be disallowed, except in special circumstances requiring the use of large cars, i.e., several employees are traveling together or large volumes of equipment or supplies are being transported.

(8) Chapter 19 funds will not cover expenses for first class accommodations, tips, gratuities, valet parking or alcoholic beverages.

(d) Chapter 19 travel reimbursements must be submitted for each traveler consistent with §81.15 of this title (relating to Funding Period) [~~within 30 days of the completion of travel~~] via the Chapter 19 web-based application.

(e) Travel reimbursement requests must include the itemized amounts for airfare, rental cars, mileage, meals, lodging, seminar registration fees, and miscellaneous expenses. All receipts must be maintained in accordance with §81.21 of this title (relating to Records Maintenance and Payment Reviews).

(f) Travel advances will be approved, on a case-by-case basis. Travel advance funding will not be made for meals, hotel taxes or miscellaneous expenses. Travel advance requests must be submitted through the web-based application in the form of a travel request and include a Chapter 19 Purchase Request for each traveler. No further Chapter 19 Purchase Request will be processed until the final accounting of any advanced travel is received.

§81.25. Voter Registration Drives Encouraged.

(a) Pursuant to §81.12 of this title (relating to Applicable Sections of the Texas Election Code), efforts to increase the number of registered voters in the county are payable with Chapter 19 funds.

(b) Voter registration drive efforts include but are not limited to mailouts of applications to households, insertion of applications into newspapers, distributing applications at public locations, and other forms of advertising.

(c) "Promotional items" are not payable with Chapter 19 funds. Examples of non-payable promotional items include but are not limited to memorabilia, models, gifts, souvenirs, and other such novelties or items of nominal, non-educational value. Materials with public information value, such as items that provide a website address or other information relevant to voter registration, are permissible. Items purchased with Chapter 19 funds may include only the county and title of the voter registrar's office.

(d) Names of specific individuals may not be included on such materials. Chapter 19 funded voter registration drives must not promote a particular party, candidate, or issue. Chapter 19 funds may not be used for food and drink purchases, except for travel expenses allowed under §81.23 of this title (relating to Travel Using Chapter 19 Funds Authorized).

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304084

Adam Bitter
General Counsel
Office of the Secretary of State
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 463-5650

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SUBCHAPTER F. PRIMARY ELECTIONS

1 TAC §§81.101, 81.107, 81.116, 81.120

The Office of the Secretary of State (Office) proposes amendments to 1 TAC §§81.101, 81.107, 81.116, and 81.120. The amendments concern the financing of primary elections with state funds, including the determination of necessary and appropriate expenses relating to the proper conduct of primary elections by party officials and procedures for requesting reimbursement by the parties for such expenses.

The proposed amendments are intended to clarify the procedures relating to the payment of expenses incurred in connection with primary elections and implement statutory changes resulting from Senate Bill 1052, enacted by the 88th Legislature, Regular Session.

SECTION-BY-SECTION SUMMARY

The revisions to §81.101 remove the requirement for vendors of election supplies to submit primary and runoff estimate costs.

The revisions to §81.107 direct county party chairs to submit required documentation related to primary-election expenses concurrent with, or soon after, submitting final cost reports.

The revisions to §81.116 correct a typographical error in the formula used for estimating voter turnout for the primary election.

The revisions to §81.120 implement Senate Bill 1052 (88th Legislature, Regular Session), which allows election judges or clerks to be paid for up to two hours of work before the polls open on election day.

FISCAL NOTE

Christina Adkins, Director of Elections, has determined that for each year of the first five years that the proposed amended rules will be in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the proposed amendments. In addition, the Office does not anticipate that enforcing or administering the proposed amended rules will result in any reductions in costs or in any additional costs to the Office, the state, or local governments. The Office also does not anticipate that there will be any loss or increase in revenue to the Office, the state, or local governments as a result of enforcing or administering the proposed amended rules.

PUBLIC BENEFIT

Ms. Adkins has determined that for each year of the first five years that the proposed amended rules will be in effect, the public benefit expected as a result of adopting the proposed amendments will be the proper conduct of the 2024 primary elections by party officials and increased clarity with respect to the procedures for the payment of expenses incurred in connection with those elections.

COSTS TO REGULATED PERSONS

The proposed amendments do not impose any costs on regulated persons, including another state agency, a special district,

or a local government. Accordingly, the Office has determined that Texas Government Code §2001.0045 does not apply to the proposed amended rules.

IMPACT ON LOCAL EMPLOYMENT

There is no effect on local economy for the first five years that the proposed amendments will be in effect. Therefore, no local employment impact statement is required under Texas Government Code §§2001.022 and 2001.024(a)(6).

FISCAL IMPACT ON SMALL BUSINESSES, MICRO-BUSINESSES, AND RURAL COMMUNITIES

The proposed amended rules will have no direct adverse economic impact on small businesses, micro-businesses, or rural communities. Accordingly, the preparation of an economic impact statement and a regulatory flexibility analysis, as specified in Texas Government Code §2006.002, is not required.

GOVERNMENT GROWTH IMPACT STATEMENT

Pursuant to Texas Government Code §2001.0221, the Office provides the following government growth impact statement for the proposed amendments. For each year of the first five years that the proposed amended rules will be in effect, the Office has determined the following:

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

(2) implementation of the proposed rules will not require the creation of new employee positions or the elimination of existing employee positions;

(3) implementation of the proposed rules will not require an increase or decrease in future legislative appropriations to the agency;

(4) the proposed rules will not require an increase or decrease in fees paid to the agency;

(5) the proposed rules will not create a new regulation but will expand and clarify existing regulations;

(6) the proposed rules will not limit or repeal an existing regulation;

(7) the proposed rules will not increase or decrease the number of individuals subject to the rules' applicability; and

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

REQUEST FOR PUBLIC COMMENTS

Comments or questions on the proposed amended rules may be submitted in writing and directed to Christina Adkins, Director of Elections, Office of the Secretary of State, P.O. Box 12060, Austin, Texas 78711-2060, or by e-mail to elections@sos.texas.gov. Comments submitted electronically should include "Proposed 2024 Primary Rules" in the subject line. Comments will be accepted for thirty (30) days from the date of publication of the proposed amended rules in the *Texas Register.* Comments should be organized in a manner consistent with the organization of the proposed amendments.

STATUTORY AUTHORITY

The proposed amendments are authorized by Texas Election Code §§31.003 and 173.006. Texas Election Code §31.003 directs the Office to obtain and maintain uniformity in the application, operation, and interpretation of the Texas Election Code and other election laws, including through the preparation of detailed and comprehensive written directives and instructions relating to and based on such laws. Texas Election Code §173.006 authorizes the Office to adopt rules to reduce the cost of primary elections or facilitate the holding of primary elections within the amount appropriated by the legislature for that purpose. Texas Election Code §§172.117, 172.122, and 172.128 of the Texas Election Code also provide the Office with rulemaking authority relating to the conduct of primary elections.

CROSS REFERENCE TO STATUTE

The proposed amended rules implement Chapters 172 and 173 of the Texas Election Code. No other statute, code, or article is affected by the proposed amendments.

§81.101. Primary and Runoff Election Cost Reporting; Receipt of State Funds.

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

(1) SOS--Office of the Secretary of State.

(2) Primary--An election held by a political party under Chapter 172 of the Texas Election Code to select its nominees for public office, and, unless the context indicates otherwise, the term includes a presidential primary election.

(3) Runoff--An election held to determine the nomination if no candidate for nomination to a particular office receives the vote required for nomination in the general primary election.

(4) County election officer--County election administrator, county clerk, or county tax assessor-collector, depending on the county, responsible for election duties in the county.

(5) Vendor--Any company with a voting system certified for use in Texas by the SOS.

(b) This subchapter applies to the use and management of all primary funds.

(c) Approval by the Secretary of State (SOS) of a primary cost estimate does not relieve the recipient of primary funds including, but not limited to, the state chair of a political party, the county chair of a political party, the county election officer, or a voting system vendor, of their responsibility to comply with administrative rules issued by the SOS, or with any statute governing the use of primary funds.

(d) The SOS shall provide a primary cost estimate for each county political party broken into three categories, as applicable:

(1) The SOS will provide an estimate for each expense incurred by the county chair based on 75% of the final approved "non-contracted" costs less non-state appropriated financing sources (e.g., filing fees) for the most recent comparable election for which data is available as determined by the SOS. In order to receive the primary estimate payment, the chair must submit to the SOS a primary cost estimate via the online primary finance system prescribed by the SOS. If data is not available to create a pre-populated cost estimate or if the chair wishes to amend the pre-populated estimate, the chair may enter the appropriate data in the SOS online primary finance system.

(2) The SOS will provide an estimate for each expense incurred by the county election officer based on 75% of the final approved "contracted" costs for the most recent comparable election for which data is available as determined by the SOS. In order to receive the primary estimate payment, the county election officer must submit to the SOS a primary cost estimate via the online primary finance system prescribed by the SOS. If data is not available to create a pre-populated cost

estimate or if the county election officer wishes to amend the pre-populated estimate, the county election officer may enter the appropriate data in the SOS online primary finance system.

~~[(3) Pursuant to §173.0833 of the Texas Election Code, vendors that provide services and materials for use in a primary election shall bill the SOS directly if the vendor opts to receive an estimate payment. The submission shall comply with the following requirements:]~~

~~[(A) In October preceding the March primary election, vendors shall submit, in the electronic format prescribed by the SOS, data for each county primary election for which the vendor is providing services or materials.]~~

~~[(B) Only expenses that are billable to the primary fund may be included. Expenses including, but not limited to, early voting kits and supplies, "I Voted" stickers, and party convention supplies, must appear on a separate invoice billed to the county election officer or the party, as appropriate.]~~

~~[(C) If a cost is to be split between both parties, the split costs must be reported separately.]~~

~~[(D) The vendor must identify whether the county chair or the county election officer is ordering the service. The county chair earns five (5) percent calculated against the cost of the services ordered by the chair, which is paid out by the SOS to the county chair as part of the final cost report, and the county election officer earns ten (10) percent of the cost of the services ordered by the county election officer, which is included in the estimate and final payments issued by SOS.]~~

~~[(E) The SOS will not make estimates available to the county chairs or the county election officers until the SOS receives the vendor submission described in this section.]~~

(e) If a runoff election is conducted, the estimate payments will be calculated and paid following the same process prescribed in subsection (d) of this section with the following exceptions:

(1) Filing fees are not factored into the calculation.

(2) The vendor must provide the estimated runoff costs in the electronic format prescribed by the SOS within five (5) days after the date of the canvass of the primary election results.

(f) After the primary or runoff election, as applicable, the actual expenditures must be reported to SOS as follows:

(1) The vendors must submit data in the electronic format prescribed by the SOS that identifies the final costs and includes all applicable fields prescribed by the SOS.

(A) Only expenses that are billable to the primary fund may be included. Expenses including, but not limited to, early voting kits and supplies, "I Voted Stickers", and party convention supplies, must appear on a separate invoice billed to the county election officer or the party, as appropriate.

(B) If a cost is to be split between both parties, the split costs must be reported separately.

(C) The vendor must identify whether the county chair or the county election officer is ordering the service. The county chair earns five (5) percent calculated against the cost of the services ordered by the chair, and the county election officer earns ten (10) percent of the cost of the services ordered by the county election officer.

(D) The SOS will not make final payments to the county chairs or the county election officers until the SOS receives the vendor submission described in this section.

(2) The county chair and the county election officer, if an election service contract is executed between the county executive committee and the county election officer, must submit actual expenditures in the electronic format prescribed by the SOS.

(A) Costs incurred by the county chair shall be reported to the SOS by the county chair. Those costs will be calculated consistent with §81.119 of this chapter (relating to County Chair's Compensation).

(B) Costs incurred by the county election officer shall be reported to the SOS by the county election officer. Those costs will be calculated consistent with §81.131 of this chapter (relating to Contracting with the County Election Officer).

(g) Section 173.0832 of the Texas Election Code provides for direct payment from the SOS to a county election officer who conducts a primary election under an election services contract. The SOS requires all county election officers conducting election services for a primary election to receive direct payment from the SOS.

(h) Pursuant to §173.0341 of the Texas Election Code, a state chair, or the designee of a state chair, may enter into an agreement with a county chair, utilizing a form prescribed by the SOS, under which the state chair will act as a fiscal agent for the county party.

§81.107. Primary-Fund Records.

(a) The county chair shall preserve all records relating to primary-election expenses until the later of:

(1) 22 months following the primary elections; or

(2) the conclusion of any relevant litigation or official investigation.

(b) In order to receive approval of a final cost report, the county chair shall transmit copies of receipts, bills, invoices, contracts, competitive bids, petty-cash receipts for items and services and copies of all monthly bank statements, electronic bookkeeping records (i.e., Quicken or Quickbooks) or check register, and any other related materials documenting primary-fund expenditures. Purchase requisitions are not considered receipts and may not be remitted as such. The SOS reserves the right to request all receipts and related documentation.

(1) The SOS primary finance system will not permit final cost reports to be submitted if any required documentation has not been uploaded to the system.

(2) If the county chair or county election officer indicates that the required documents will be submitted in hardcopy form, the submitter will have thirty (30) days to submit such documents to the SOS. If the SOS does not receive the required documents within that time period, the SOS will reject the final cost report.

(c) Unless otherwise provided by the SOS, not later than August 31 of the year in which the primary elections occur, the county chair shall:

(1) comply with all final cost reporting requirements;

(2) return all unexpended and uncommitted primary funds upon SOS approval of the final cost report.

(d) If the SOS determines that a final cost report needs remediation, the SOS will return the report to the submitter with instructions for resubmission.

(e) [~~(d)~~] Failure to comply with subsection (c) or (d) of this section may result in forfeiture of county chair compensation as stipulated in §81.119 of this chapter (relating to County Chair's Compensation).

(f) [~~(e)~~] If the chair does not file a final cost report, the matter may be reported to the Attorney General's Office for misappropriation of funds in accordance with §81.113 of this chapter (relating to Misuse of State Funds).

§81.116. Estimating Voter Turnout.

(a) The county chair shall use the formula set out in the following figure, with necessary modifications as determined by the chair, to determine the estimated voter turnout for each precinct for the primary elections. This formula is a guideline and must be adjusted if the local political situation indicates a higher voter turnout than that derived by the formula.

Figure: 1 TAC §81.116(a)

[~~Figure: 1 TAC §81.116(a)~~]

(b) After estimating the voter turnout for each precinct, the county chair shall use the guidelines set forth in §§81.117, 81.124, and 81.125 of this chapter (relating to the Number of Election Workers per Polling Place, Number of Ballots per Voting Precinct, and Number of Direct Record Electronic (DRE) Units or Precinct Ballot Counters per Voting Precinct) to determine the necessary personnel, supplies, and equipment for each precinct (i.e., ballots, election judges and clerks, voting devices, or machines).

(c) After estimating the need for personnel, supplies, and equipment for each precinct, the county chair shall combine all precinct data to determine the total countywide estimate.

(d) The county chair may use the estimate calculated under subsection (c) of this section to determine the estimated cost of the election.

§81.120. Compensation for Election-Day Workers.

(a) Except as provided by subsection (b) of this section, the compensation paid to polling-place judges, clerks, early-voting-ballot board members, or persons working at the central counting station for the general-primary and primary-runoff elections shall be equal to the hourly rate paid by the county for such workers in county elections up to not exceed $12 per hour from the primary fund. All workers must attend a training class certified by the SOS. Online pollworker training classes are available on the SOS website.

(b) The county chair may pay technical support personnel at the central counting station (appointed under Texas Election Code §§127.002, 127.003, or 127.004) compensation which is more than $12 per hour, but costs may not exceed those paid to county staff for comparable work.

(c) Except as provided by this section, a judge or clerk may be paid only for the actual time spent on election duties performed in the polling place or central counting station, including up to two hours of work before the polls open. If an election worker elects to donate his or her compensation to the county party, signed documentation referencing that fact, by the election worker and chair, must be placed in the primary records.

(d) The county chair may allow one election worker from each polling place up to one hour before election day to annotate the precinct list of registered voters.

(e) The county chair is authorized to pay members of the early voting ballot board.

(1) Members of the early voting ballot board may only be compensated for the actual number of hours worked up to $12 per hour from the primary fund.

(2) Additionally, members may reconvene to process provisional or late ballots. The provisional ballot/late counting process must be completed not later than the 7th day after the primary or runoff primary elections.

(f) Compensation for the election judge or clerk who delivers and picks up the election supplies on election day may not exceed $25 per polling place location.

(g) Except as provided by subsection (f) of this section the county chair may not pay an election-day worker for travel time, delivery of supplies, or attendance at the precinct convention.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304085
Adam Bitter
General Counsel
Office of the Secretary of State
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 463-5650

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PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE SUBCHAPTER O. DELIVERY SYSTEM AND PROVIDER PAYMENT INITIATIVES

1 TAC §353.1302

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1302, concerning Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

BACKGROUND AND PURPOSE

The purpose of the proposal is to pursue modifications to the Quality Incentive Payment Program (QIPP) beginning in state fiscal year 2025 (i.e., September 1, 2024-August 31, 2025) to simplify the program structure; reduce the administrative burden of operating the program for HHSC and participating providers; and continue incentivizing Texas nursing facilities (NFs) to improve quality and innovation in the provision of services.

HHSC sought and received approval from the Centers for Medicare and Medicaid Services (CMS) to create QIPP in state fiscal year 2018. HHSC has not made modifications to the program since state fiscal year 2022. Directed payment programs authorized under 42 C.F.R. § 438.6(c) are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

Since the inception of QIPP, HHSC has seen an increase in the number of eligible non-state government-owned (NSGO) NFs, which equates to approximately 75 percent of the facilities eligible to participate in QIPP. The proposed amendment would modify the eligibility criteria for NSGO NFs. Beginning in state fiscal year 2025, the eligibility criteria related to the NF being located in the same Regional Healthcare Partnership (RHP) as, or within 150 miles of, the non-state governmental entity taking

ownership of the facility would be amended to require the NSGO NF to be located in the state of Texas in the same county as, or county contiguous to, the non-state governmental entity taking ownership of the facility.

The proposed amendment would also require an NSGO NF that is eligible to participate in QIPP due to an active partnership, to produce certain documentation in connection with the enrollment application that demonstrates active partnership between the NF and the governmental entity exists. The amendments to the active partnership criteria will enable HHSC to confirm NSGO eligibility at the time of program enrollment.

Beginning in state fiscal year 2026, QIPP-enrolled NFs that undergo a change of ownership (CHOW) that changes the class of the facility during the program period will be removed from the program for the remainder of the program period after the CHOW effective date. This amendment will reduce the administrative burden of reconfirming eligibility by classification and modification to the program scorecards.

The proposed amendment would also modify the funding allocations and frequency of QIPP payment distributions beginning in state fiscal year 2025: Component 1 would be equal to 44 percent of the program funding and would shift to being paid quarterly; Component 2 would be equal to 20 percent of the program funding and would shift to being paid quarterly; Component 3 would be equal to 20 percent of the program funding and would continue to be paid quarterly; and Component 4 would be equal to 16 percent of the program funding and would continue to be paid quarterly. The amendments to the funding allocations simplify the allocation formulas and provide more transparency of each component's program funding size. The frequency of the QIPP payment distribution will align with QIPP quality metrics, pursuant to 1 Texas Administrative Code §353.1304.

HHSC proposes other minor clarifying or grammatical amendments to improve the readability of the rule text.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1302(c)(1)(B) makes clarifying edits, moves examples of active partnership activities from subparagraph (B)(i) - (iii) to new subparagraph (E)(i) - (iii), and adds new subparagraphs (C) and (D) to provide further details concerning eligibility criteria for non-state government-owned NFs for different program periods.

The proposed amendment to §353.1302(g) makes clarifying edits in paragraphs (1), (2), (3), and (4), and revises the component funding allocations in paragraphs (1), (2), and (3).

The proposed amendment to §353.1302(h) makes clarifying edits in paragraph (1) related to the frequency of the distribution of QIPP payments.

The proposed amendment to §353.1302(i) adds new paragraph (3) that requires HHSC to remove an NF that undergoes a CHOW that changes the class of the facility during the program period, beginning in state fiscal year 2026 and renumbers paragraph (3).

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will not create a new rule;

(6) the proposed rule will not expand, limit or repeal an existing rule;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities.

The rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be the ability of Medicaid managed care clients to have continued access to care and to incentivize providers to improve the quality of services provided, resulting from the lessened administrative burden of supporting continued provider operations.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule does not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rule.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R024" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.0055, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

§353.1302. Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019.

(a) Introduction. This section establishes the Quality Incentive Payment Program (QIPP) for nursing facilities (NFs) providing services under Medicaid managed care on or after September 1, 2019. QIPP is designed to incentivize NFs to improve quality and innovation in the provision of NF services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this and other sections of this subchapter may be defined in §353.1301 (relating to General Provisions) or §353.1304 (relating to Quality Metrics for the Quality Incentive Payment Program for Nursing Facilities on or after September 1, 2019) of this subchapter.

(1) CHOW application--An application filed with HHSC for a NF change of ownership (CHOW).

(2) Program period--A period of time for which an eligible and enrolled NF may receive the QIPP amounts described in this section. Each QIPP program period is equal to a state fiscal year (FY) beginning September 1 and ending August 31 of the following year.

(3) Network nursing facility--A NF located in the state of Texas that has a contract with a Managed Care Organization (MCO) for the delivery of Medicaid covered benefits to the MCO's enrollees.

(4) Non-state government-owned NF--A network nursing facility where a non-state governmental entity located in the state of Texas holds the license and is a party to the NF's Medicaid provider enrollment agreement with the state.

(5) Private NF--A network nursing facility not owned by a governmental entity located in the state of Texas, and holds a license.

(6) Regional Healthcare Partnership (RHP)--A collaboration of interested participants that work collectively to develop and submit to the state a regional plan for health care delivery system reform as defined and established under Chapter 354, Subchapter D, of this title (relating to Texas Healthcare Transformation and Quality Improvement Program).

(7) Runout Period--A period of 23 months following the end of the program period during which the MCO may make adjustments to the MCO member months.

(c) Eligibility for participation in QIPP. A NF is eligible to participate in QIPP if it complies with the requirements described in this subsection.

(1) The NF is a non-state government-owned NF.

(A) The non-state governmental entity that owns the NF must certify the following facts on a form prescribed by HHSC.

(i) That it is a non-state government-owned NF where a non-state governmental entity holds the license and is party to the facility's Medicaid contract; and

(ii) That all funds transferred to HHSC via an intergovernmental transfer (IGT) for use as the state share of payments are public funds.

(B) For the program periods beginning on or before September 1, 2023, but on or after September 1, 2019, the [~~The~~] NF must be located in the state of Texas in the same RHP as, or within 150 miles of, the non-state governmental entity taking ownership of the facility;[~~,~~] must be owned by the non-state governmental entity for no less than four years prior to the first day of the program period;[~~,~~] or must be able to certify in connection with the enrollment application that they can demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF. [~~The following criteria demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF.~~]

~~f(i)~~ ~~Monthly meetings (in-person or virtual) with NF administrative staff to review the NF's clinical and quality operations and identify areas for improvement. Meetings should include patient observations; regulatory findings; review of CASPER reports, quality measures, grievances, staffing, risk, incidents, accidents, and infection control measures; root cause analysis, if applicable; and design of performance improvement plans.~~]

~~f(ii)~~ ~~Quarterly joint trainings on topics and trends in nursing home care best practices or on needed areas of improvement.~~]

~~f(iii)~~ ~~Annual, on-site inspections of the NF by a non-state governmental entity-sponsored Quality Assurance team.~~]

(C) For the program period beginning September 1, 2024, the NF must be located in the state of Texas in the same county as, or if separate counties, a contiguous county of, the non-state governmental entity taking ownership of the facility; must be owned by the non-state governmental entity for no less than four years prior to the first day of the program period; or must be able to provide documentation of activities that demonstrate an active partnership that have occurred in the prior two months before application as well as a detailed plan for maintaining the partnership in the months following the application date through the end of the program period.

(D) For program periods beginning on or after September 1, 2025, the NF must be located in the state of Texas in the same county as, or if separate counties, a contiguous county of, the non-state governmental entity taking ownership of the facility; must be owned by the non-state governmental entity for no less than four years prior to the first day of the program period; or must be able to provide documentation of activities that demonstrate an active partnership that have

occurred in the prior nine months before application as well as a detailed plan for maintaining the partnership in the months following the application date through the end of the program period.

(E) The following criteria demonstrate an active partnership between the NF and the non-state governmental entity that owns the NF.

(i) Monthly meetings (in-person or virtual) with NF administrative staff to review the NF's clinical and quality operations and identify areas for improvement. Meetings should include patient observations; regulatory findings; review of Certification And Survey Provider Enhanced Reports (CASPER) reports, quality measures, grievances, staffing, risk, incidents, accidents, and infection control measures; root cause analysis, if applicable; and design of performance improvement plans.

(ii) Quarterly joint trainings on topics and trends in nursing home care best practices or on needed areas of improvement.

(iii) Annual, on-site inspections of the NF by a non-state governmental entity-sponsored Quality Assurance team.

(2) The NF is a private NF. The NF must have a percentage of Medicaid NF days of service that is greater than or equal to 65 percent. For each private NF, the percentage of Medicaid NF days is calculated by summing the NF's Medicaid NF fee-for-service and managed care days of service, including dual-eligible demonstration days of service, and dividing that sum by the facility's total days of service in all licensed beds. Medicaid hospice days of service are included in the denominator but excluded from the numerator.

(A) The days of service will be annualized based on the NF's latest cost report or accountability report but from a year in which HHSC required the submission of cost reports.

(B) HHSC will exclude any calendar days that the NF was closed due to a natural or man-made disaster. In such cases, HHSC will annualize the days of service based on calendar days when the NF was open.

(d) Data sources for historical units of service. Historical units of service are used to determine an individual private NF's QIPP eligibility status and the distribution of QIPP funds across eligible and enrolled NFs.

(1) All data sources referred to in this subsection are subject to validation using HHSC auditing processes or procedures as described under §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

(2) Data sources for the determination of each private NF's QIPP eligibility status are listed in priority order below. For each program period, the data source must be from a cost-reporting year and must align with the NF's fiscal year.

(A) The most recently available Medicaid NF cost report for the private NF. If no Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the private NF. If no Medicaid Direct Care Staff Rate Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the private NF. If no Medicaid NF cost report for a prior owner of the private NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF. If no Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the private NF is available, the private NF is not eligible for participation in QIPP.

(3) Data sources for determination of distribution of QIPP funds across eligible and enrolled NFs are listed in priority order below. For each program period, the data source must be from a cost-reporting year and must align with the NF's fiscal year.

(A) The most recently available Medicaid NF cost report for the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no Medicaid NF cost report is available, the data source in subparagraph (B) of this paragraph must be used.

(B) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for the NF. If the Staffing and Compensation Report covers less than a full year, reported values are annualized to represent a full year. If no Staffing and Compensation Report is available, the data source in subparagraph (C) of this paragraph must be used.

(C) The most recently available Medicaid NF cost report for a prior owner of the NF. If the cost report covers less than a full year, reported values are annualized to represent a full year. If no Medicaid NF cost report for a prior owner of the NF is available, the data source in subparagraph (D) of this paragraph must be used.

(D) The most recently available Medicaid Direct Care Staff Rate Staffing and Compensation Report for a prior owner of the NF. If the Staffing and Compensation Report covers less than a full year, reported values are annualized to represent a full year.

(e) Conditions of Participation. As a condition of participation, all NFs participating in QIPP must do the following.

(1) The NF must submit a properly completed enrollment application on a form prescribed by HHSC by the due date determined by HHSC. The enrollment period must be no less than 30 calendar days, and the final date of the enrollment period will be at least nine days prior to the IGT notification.

(2) The entity that owns the NF must certify, on a form prescribed by HHSC, that no part of any payment made under the QIPP will be used to pay a contingent fee; and that the entity's agreement with the nursing facility does not use a reimbursement methodology containing any type of incentive, direct or indirect, for inappropriately inflating, in any way, claims billed to Medicaid, including the NF's receipt of QIPP funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If a provider has changed ownership in the past five years in a way that impacts eligibility for the program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider, and which reference the administration of, or payment from, this program.

(4) The NF must ensure that HHSC has access to the NF records referenced in subsection (c) of this section and the data for the NF from one of the data sources listed in subsection (d) of this section. Participating facilities must ensure that these records and data are accurate and sufficiently detailed to support legal, financial, and statistical information used to determine a NF's eligibility during the program period.

(A) The NF must maintain these records and data through the program period and until at least 90 days following the conclusion of the runout period.

(B) The NF will have 14 business days from the date of a request from HHSC to submit to HHSC the records and data.

(C) Failure to provide the records and data could result in adjustments pursuant to §353.1301(k) of this subchapter.

(5) Report all quality data denoted as required as a condition of participation in subsection (g) of this section.

(6) Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(f) Non-federal share of QIPP payments. The non-federal share of all QIPP payments is funded through IGTs from sponsoring non-state governmental entities. No state general revenue is available to support QIPP.

(1) HHSC will share suggested IGT responsibilities for the program period with all QIPP eligible and enrolled non-state government-owned NFs at least 15 days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under the QIPP program, plus eight percent, for the program period as determined by HHSC; forecast STAR+PLUS NF member months for the program period as determined by HHSC; and the distribution of historical Medicaid days of service across non-state government-owned NFs enrolled in QIPP for the program period. HHSC will also share estimated maximum revenues each eligible and enrolled NF could earn under QIPP for the program period. Estimates are based on HHSC's suggested IGT responsibilities and an assumption that all enrolled NFs will meet 100 percent of their quality metrics. The purpose of sharing this information is to provide non-state government-owned NFs with information they can use to determine the amount of IGT they wish to transfer.

(2) Sponsoring governmental entities will determine the amount of IGT they wish to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 15 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity wishes to transfer to HHSC and whether the sponsoring governmental entity intends to accept Component One payments.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC. The second half of the IGT amount will be transferred by a date determined by HHSC. The IGT deadlines and all associated dates will be published on the HHSC QIPP webpage by January 15 of each year.

(4) Reconciliation. HHSC will reconcile the actual amount of the non-federal funds expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) QIPP capitation rate components. QIPP funds will be paid to MCOs through four components of the STAR+PLUS NF managed care per member per month (PMPM) capitation rates. The MCOs' distribution of QIPP funds to the enrolled NFs will be based on each NF's performance related to the quality metrics as described in §353.1304 of this subchapter. The NF must have had at least one Medicaid client in the care of that NF for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to:

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2019, [~~The total value of Component One will be equal to~~] 110 percent of the estimated amount of the non-federal share of the QIPP.

(ii) For program periods beginning on or after September 1, 2024, 44 percent of total program value for the program period.

(B) Interim allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Private NFs are not eligible for payments from Component One.

(D) For program periods beginning on or before September 1, 2023, but on or after September 1, 2019, the [~~The~~] interim allocation of funds across qualifying non-state government-owned NFs will be reconciled to the actual distribution of Medicaid NF days of service across these NFs during the program period as captured by HHSC's Medicaid contractors for fee-for-service and managed care 120 days after the last day of the program period.

(E) For program periods beginning on or before September 1, 2023, but on or after September 1, 2019, NFs must report quality data as described in §353.1304 of this subchapter as a condition of participation in the program.

(F) For program periods beginning on or after September 1, 2024, payments to NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(2) Component Two.

(A) The total value of Component Two will be equal to: [~~a percent of remaining QIPP funds after accounting for the funding of Component One and Component Four.~~]

(i) For the program periods beginning on or before September 1, 2020, but on or after [~~period~~] September 1, 2019, [~~through August 31, 2021, the percent will be equal to~~] 30 percent of total program value for the program period after accounting for the funding of Component One and Component Four.

(ii) For the program periods [~~period~~] beginning on or before September 1, 2023, but on or after September 1, 2021, [~~the percent will be equal to~~] 40 percent of total program value for the program period after accounting for the funding of Component One and Component Four.

(iii) For program periods beginning on or after September 1, 2024, 20 percent of total program value for the program period.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Payments [~~Monthly payments~~] to NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter or, if applicable in a program period, a

uniform rate increase for which a NF must report quality data as described in §353.1304 of this subchapter as a condition of participation in the program.

(3) Component Three.

(A) The total value of Component Three will be equal to: [~~a percent of remaining QIPP funds after accounting for the funding of Component One and Component Four.~~]

(i) For the program periods beginning on or before September 1, 2020, but on or before [~~period~~] September 1, 2019, [~~through August 31, 2021, the percent will be equal to~~] 70 percent total program value for the program period after accounting for the funding of Component One and Component Four .

(ii) For the program periods [~~period~~] beginning on or before September 1, 2023, but on or after September 1, 2021, [~~the percent will be equal to~~] 60 percent after accounting for the funding of Component One and Component Four.

(iii) For the program period beginning September 1, 2024, 20 percent of the program period funds.

(B) Allocation of funds across qualifying non-state government-owned and private NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Payments [~~Quarterly payments~~] to NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(4) Component Four.

(A) The total value of Component Four will be equal to 16 percent of the total program value for the program period [~~funds of the QIPP~~].

(B) Allocation of funds across qualifying non-state government-owned NFs will be proportional, based upon historical Medicaid days of NF service.

(C) Payments [~~Quarterly payments~~] to non-state government-owned NFs will be triggered by achievement of performance requirements as described in §353.1304 of this subchapter.

(D) Private NFs are not eligible for payments from Component Four.

(5) Funds that are non-disbursed due to failure of one or more NFs to meet performance requirements will be distributed across all QIPP NFs based on each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined.

(h) Distribution of QIPP payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each PMPM associated with each QIPP-enrolled NF broken down by QIPP capitation rate component, quality metric, and payment period. For example, for a NF, HHSC will calculate the portion of each PMPM associated with that NF that would be paid from the MCO to the NF as follows.

(A) Component One.

(i) For the program periods beginning on or before September 1, 2023, but on or after September 1, 2019, monthly [~~Monthly~~] payments from Component One as a uniform rate increase will be equal to the total value of Component One for the NF divided by twelve.

(ii) For program periods beginning on or after September 1, 2024, quarterly payments from Component One associated with each quality metric will be equal to the total value of Component One associated with the quality metric divided by four.

(B) Component Two.

(i) For the program periods beginning on or before September 1, 2023, but on or after September 1, 2019, monthly [~~Monthly~~] payments from Component Two associated with each quality metric will be equal to the total value of Component Two associated with the quality metric divided by twelve.

(ii) For program periods beginning on or after September 1, 2024, quarterly payments from Component Two associated with each quality metric will be equal to the total value of Component Two associated with the quality metric divided by four.

(C) Component Three. For program periods beginning on or after September 1, 2019, quarterly [~~Quarterly~~] payments from Component Three associated with each quality metric will be equal to the total value of Component Three associated with the quality metric divided by four.

(D) Component Four. For program periods beginning on or after September 1, 2019, quarterly [~~Quarterly~~] payments from Component Four associated with each quality metric will be equal to the total value of Component Four associated with the quality metric divided by four.

(E) Allocation Across Quality Metrics

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2019, for [~~For~~] purposes of the calculations described in subparagraphs (B), (C), and (D) of this paragraph, each quality metric will be allocated an equal portion of the total dollars included in the component.

(ii) For program periods beginning on or after September 1, 2024, for purposes of the calculations described in subparagraph (A) of this paragraph, achievement in 1 metric earns 90 percent and achievement in 2 metrics earns 100 percent of total dollars included in the component. For the calculations described in subparagraphs (B), (C), and (D) of this paragraph, each quality metric will be allocated an equal portion of the total dollars included in the component.

(F) In situations where a NF does not have enough data for all quality metrics to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component. If a NF does not have enough data for any quality metrics to be calculated, no funds will be earned.

(2) MCOs will distribute payments to enrolled NFs as they meet their reporting and quality metric requirements. Payments will be equal to the portion of the QIPP PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the QIPP PMPM. In the event of a CHOW, the MCO will distribute the payment to the owner of the NF at the time of the payment.

(i) Changes of ownership.

(1) A NF undergoing a CHOW from privately owned to non-state government-owned [~~government owned~~] or from non-state government-owned [~~government owned~~] to privately-owned will only be eligible to enroll as the new class of facility if HHSC received a completed CHOW application no later than 30 days prior to the first day of the enrollment period. All required documents pertaining to the CHOW (i.e., HHSC must have a complete application for a change of ownership license as described under 26 TAC §554.201 (relating to Criteria for Licensing) and 26 TAC §554.210 (relating to Change of

Ownership and Notice of Changes) must be submitted in the timeframe required by HHSC.

(2) If an enrolled NF changes ownership, including to a new class of facility following the enrollment period or during the program period, the NF under the new ownership must meet the eligibility requirements described in this section for the new owner's facility class in order to continue QIPP participation during the program period.

(3) For program periods beginning on or after September 1, 2025, if an enrolled NF undergoes a CHOW that changes the class of the facility, from privately owned to non-state government-owned or from non-state government-owned to privately owned, during the program period, the enrolled NF will be removed from the program for the remainder of the program period after the CHOW effective date.

(4) [~~(3)~~] An enrolled NF must notify the MCOs it has contracts with of a potential CHOW at least 30 days before the anticipated date of the CHOW. Notification is considered to have occurred when the MCO receives the notice.

(j) Changes in operation. If an enrolled NF closes voluntarily or ceases to provide NF services in its facility, the NF must notify the HHSC Provider Finance Department by email at qipp@hhs.texas.gov [~~qipp@hhsc.state.tx.us~~]. Notification is considered to have occurred when HHSC receives the notice.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304038
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (737) 867-7817

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1 TAC §353.1306, §353.1307

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §353.1306, concerning the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021 and to §353.1307 concerning Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program.

BACKGROUND AND PURPOSE

The purpose of the proposal is to pursue modifications to the Comprehensive Hospital Increase Reimbursement Program (CHIRP) payments beginning with the State Fiscal Year (SFY) 2025 rating period to promote the advancement of the quality goals and strategies the program is designed to advance.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services (CMS) to create CHIRP for SFY 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment Program (DSRIP). One component of CHIRP existed as a stand-alone directed payment program for SFY 2018 - SFY 2021, but that component was fully folded into CHIRP beginning in SFY 2022. HHSC did not make significant modifications to CHIRP since its inception in SFY 2022. Directed payment programs authorized under 42 C.F.R. § 438.6(c), including CHIRP, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

The proposed amendments create a new a pay-for-performance incentive payment through a third component in CHIRP, the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA). The classes of hospitals that may participate in APHRIQA will be determined by HHSC on an annual basis, and the decision will be made by HHSC to identify the classes of hospitals and amount of funding based on the factors detailed in the rule, including the extent to which a hospital class contributes toward advancing the goals and objectives identified in the state's managed care quality strategy. HHSC will prioritize transitioning payments to pay-for-performance for classes or providers that, based on HHSC's financial models, receive payments that are projected to potentially exceed the cost of care provided and with reference to which HHSC's modeling indicates that the transition with will stabilize overall funding for the Medicaid program and Medicaid providers. For state fiscal years beginning with SFY 2025, HHSC does not anticipate that behavioral health hospitals or rural hospitals will be included in a pay-for-performance program.

The funds for payment of the APHRIQA component will be transitioned from the existing uniform rate increase components of the Uniform Hospital Rate Increase Payment (UHRIP) and the Average Commercial Incentive Award (ACIA) and will be paid using a scorecard that directs managed care organizations to pay providers for performance achievements on quality outcome measures. Payments will be distributed under APHRIQA on a monthly, quarterly, semi-annual, or annual basis that aligns with the measurement period determined for quality metrics reporting.

The proposed amendments will meet the need to continue program evolution and development for year 4 (Fiscal Year 2025) of CHIRP to further the goals of the Texas Healthcare Transformation and Quality Improvement Program 1115 demonstration waiver and will lead to continued quality improvements in the healthcare delivery system in Texas.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1306 introduces the APHRIQA as the third component of CHIRP for program periods beginning on after September 1, 2024.

The proposed amendments to subsection (b) adds new paragraph (2) to define the Average Commercial Reimbursement (ACR) Upper Payment Limit (UPL) and renumbers existing definitions accordingly.

The proposed amendments to subsection (c) update the Conditions of Participation to include description of the new optional pay-for-performance component as described in (g)(4).

The proposed amendments to subsections (d) and (e) update the language to include both percentage rate increases and other types of payments, such as pay-for-performance quality based payments, to the classes of participating hospitals and the eligibility requirements for participating hospitals.

The proposed amendments to subsection (g) more precisely describe the methodology for the ACIA component, contain the

methodology for the new APHRIQA component, and include an update to a reference to subsection (h).

The proposed amendments to subsection (h) describe the distribution mechanics of the APHRIQA component payment.

The proposed amendments to subsections (j) - (l) renumber the subsections to subsections (i) - (k).

The proposed amendment adds a new subsection (l) that limits the review period for data or calculation corrections to the period of time before the first half of Intergovernmental Transfer (IGT) is required.

The proposed amendments to §353.1307 conform the rule to the new CHIRP pay-for-performance APHRIQA component and makes the language in this CHIRP quality rule more consistent with the language in the Quality Incentive Payment Program (QIPP) quality rule in §353.1304, another pay-for-performance directed payment program.

The proposed amendments to subsection (a) make the language more consistent with the QIPP quality rule.

The proposed amendments to subsection (b) delete terms that are not used in the rule.

The proposed amendments to subsection (c) make the language more consistent with the QIPP quality rule and provide that metrics may change from one program period to the next.

The proposed amendments add a new subsection (d) which specifies that achievement of performance requirements will trigger payments. The proposed amendment renumbers the remaining subsections in §353.1307 accordingly, given the addition of a new subsection (d).

The proposed amendments to subsection (f) (formerly §354.1307(e)) delete duplicative language that is included later in the rule and shorten the timeframe for participating hospitals to furnish information and data related to quality metrics and performance requirements that is requested by HHSC.

The proposed amendments to subsection (g) (formerly §354.1307(f)) change the dates by which the proposed metrics and performance requirements will be published to give participating hospitals more notice on what the measures and requirements may be.

The proposed amendments to subsection (h) (formerly §354.1307(g)) changes the dates by which the final metrics and performance requirements will be published to give participating hospitals more notice on what the final measures and requirements will be and authorizes HHSC to substitute measures for those suggested or published by HHSC if CMS requires the substituted measures.

The proposed amendments to subsection (i) make the language more consistent with the QIPP quality rule and clarify that CMS may require HHSC to substitute proposed measures with alternate measures for CMS to approve the program.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will not create a new rule;

(6) the proposed rules will expand existing rules;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities.

The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public benefit will be the ability of Medicaid managed care clients to have continued access to care and to incentivize providers to improve the quality of services provided.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

A public hearing to receive comments on the proposal will be held by HHSC through a webinar. The meeting date and time will be posted on the HHSC Communications and Events Website at https://hhs.texas.gov/about-hhs/communications-events and the HHSC Provider Finance Hospitals website at https://pfd.hhs.texas.gov/hospitals-clinic/hospital-ser-

vices/comprehensive-hospital-increase-reimbursement-program.

If you have any questions, please contact the Provider Finance Department Hospital Finance section at pfd_hospitals@hhsc.state.tx.us.

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Mail Code H-400, P.O. Box 13247, Austin, Texas 78711-3247, or by email to pfd_hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R020" in the subject line.

STATUTORY AUTHORITY

The amendments are proposed under Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendments affect Texas Government Code, Chapters 531 and 533, and Texas Human Resources Code, Chapter 32.

§353.1306. Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021.

(a) Introduction. This section establishes the Comprehensive Hospital Increase Reimbursement Program (CHIRP) for program periods on or after September 1, 2021, wherein the Health and Human Services Commission (HHSC) directs a managed care organization (MCO) to provide a uniform reimbursement increase to hospitals in the MCO's network in a designated service delivery area (SDA) for the provision of inpatient services, outpatient services, or both. This section also describes the methodology used by HHSC to calculate and administer such reimbursement increases. CHIRP is designed to incentivize hospitals to improve access, quality, and innovation in the provision of hospital services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions).

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services.

(2) Average Commercial Reimbursement (ACR) Upper Payment Limit (UPL)--A calculated estimation of what an average commercial payor pays for the same Medicaid services.

(3) [~~(2)~~] Children's hospital--A children's hospital as defined by §355.8052 of this title (relating to Inpatient Hospital Reimbursement).

(4) [~~(3)~~] Inpatient hospital services--Services ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician or dentist, or a subset of these services identified by HHSC. Inpatient hospital services do not include skilled nursing facility or intermediate care facility services furnished by a hospital with swing-bed approval, or any other services that HHSC determines should not be subject to the rate increase.

(5) [~~(4)~~] Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this title (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities).

(6) [~~(5)~~] Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services.

(7) [~~(6)~~] Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients of a hospital under the direction of a physician or dentist, or a subset of these services identified by HHSC. HHSC may, in its contracts with MCOs governing rate increases under this section, exclude from the definition of outpatient hospital services such services as are not generally furnished by most hospitals in the state, or such services that HHSC determines should not be subject to the rate increase.

(8) [~~(7)~~] Program period--A period of time for which HHSC will contract with participating MCOs to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(9) [~~(8)~~] Rural hospital--A hospital that is a rural hospital as defined in §355.8052 of this title.

(10) [~~(9)~~] State-owned non-IMD hospital--A hospital that is owned and operated by a state university or other state agency that is not primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental disease.

(11) [~~(10)~~] Urban hospital--An urban hospital as defined by §355.8052 of this title.

(c) Conditions of Participation. As a condition of participation, all hospitals participating in CHIRP must allow for the following.

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 21 calendar days and the final date of the enrollment period will be at least nine days prior to the IGT notification.

(A) In the application, the hospital must select whether it will participate in the optional program components [~~component~~] described in subsections [~~subsection~~] (g)(3) and (g)(4) of this section. A hospital cannot participate in the program component described in subsection (g)(3) or (g)(4) of this section without also participating in the program component described in subsection (g)(2) of this section.

(B) All hospitals must submit certain necessary data to calculate the ACR gap. However, a hospital may indicate that it does

not wish to participate in the optional program component described in subsection (g)(3) of this section.

(C) A hospital is required to maintain all supporting documentation at the hospital for any information provided under subparagraph (B) of this paragraph for a period of no less than 5 years.

(D) For a program period that begins on or after September 1, 2021, any hospital that did not report the data described in subparagraph (B) of this paragraph in the application for the program must report the data within four months of Centers for Medicare and Medicaid Services (CMS) approval of the program.

(2) The entity that owns the hospital must certify, on a form prescribed by HHSC, that no part of any payment made under the CHIRP will be used to pay a contingent fee and that the entity's agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(4) All quality metrics for which a hospital is eligible based on class, as described in subsection (d) of this section, must be reported by the participating hospital.

(5) Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(d) Classes of participating hospitals.

(1) HHSC may direct the MCOs in an SDA that is participating in the program described in this section to provide a uniform percentage rate increase or another type of payment to all hospitals within one or more of the following classes of hospital with which the MCO contracts for inpatient or outpatient services:

(A) children's hospitals;

(B) rural hospitals;

(C) state-owned non-IMD hospitals;

(D) urban hospitals;

(E) non-state-owned IMDs; and

(F) state-owned IMDs.

(2) If HHSC directs rate increases or other payments to more than one class of hospital within the SDA, the percentage rate increases or other payments directed by HHSC may vary between classes of hospital.

(e) Eligibility. HHSC determines eligibility for rate increases and other payments by SDA and class of hospital.

(1) Service delivery area. Only hospitals in an SDA that includes at least one sponsoring governmental entity are eligible for a rate increase.

(2) Class of hospital. HHSC will identify the class or classes of hospital within each SDA described in paragraph (1) of this subsection to be eligible for a rate increase or other payment. HHSC will consider the following factors when identifying the class or classes of hospital eligible for a rate increase or other payment and the percent increase applicable to each class:

(A) whether a class of hospital contributes more or less significantly to the goals and objectives in HHSC's managed care quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;

(B) which class or classes of hospital the sponsoring governmental entity wishes to support through IGTs of public funds, as indicated on the application described in subsection (c) of this section;

(C) the estimated Medicare gap for the class of hospitals, based upon the upper payment limit demonstration most recently submitted by HHSC to CMS;

(D) the estimated ACR gap for the class or individual hospitals, as indicated on the application described in subsection (c) of this section; and

(E) the percentage of Medicaid costs incurred by the class of hospital in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section.

(f) Services subject to rate increase and other payment.

(1) HHSC may direct the MCOs in an SDA to increase rates for all or a subset of inpatient services, all or a subset of outpatient services, or all or a subset of both, based on the service or services that will best advance the goals and objectives of HHSC's managed care quality strategy.

(2) In addition to the limitations described in paragraph (1) of this subsection, rate increases for a state-owned IMD or non-state-owned IMD are limited to inpatient psychiatric hospital services provided to individuals under the age of 21 and to inpatient hospital services provided to individuals 65 years or older.

(3) CHIRP rate increases will apply only to the in-network managed care claims billed under a hospital's primary National Provider Identifier (NPI) and will not be applicable to NPIs associated with non-hospital sub-providers owned or operated by a hospital.

(g) CHIRP capitation rate components. For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, CHIRP funds will be paid to MCOs through two components of the managed care per member per month (PMPM) capitation rates. For program periods beginning on or after September 1, 2024, CHIRP funds will be paid to MCOs through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of CHIRP [~~CHRIP~~] funds to the enrolled hospitals may be based on each hospital's performance related to the quality metrics as described in §353.1307 of this subchapter (relating to Quality Metrics for [~~and Required Reporting Used to Evaluate the Success of~~] the Comprehensive Hospital Increase Reimbursement Program). The hospital must have provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) In determining the percentage increases [~~percentages~~] described under subsection (h)(1) [~~(i)(1) and (2)~~] of this section, HHSC will consider:

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on the amount of IGT the sponsoring governmental entities propose to transfer to HHSC to support the non-federal share

of the increased rates for the first six months of a program period, as indicated on the applications described in subsection (c) of this section;

(B) the class or classes of hospital determined in subsection (e)(2) of this section;

(C) the type of service or services determined in subsection (f) of this section;

(D) actuarial soundness of the capitation payment needed to support the rate increase;

(E) available budget neutrality room under any applicable federal waiver programs;

(F) hospital market dynamics within the SDA; and

(G) other HHSC goals and priorities.

(2) The Uniform Hospital Rate Increase Payment (UHRIP) is the first component.

(A) The total value of UHRIP will be equal to a percentage of the estimated Medicare gap on a per class basis.

(B) Allocation of funds across hospital classes will be proportional to the combined Medicare gap of each hospital class within an SDA to the total Medicare gap of all hospital classes within the SDA.

(3) The Average Commercial Incentive Award (ACIA) is the second component.

(A) The total value of ACIA will be equal to a percentage of the ACR gap less payments received under UHRIP, subject to the limitations described by subparagraph (B) of this paragraph.

(B) The maximum ACIA payments for each class will be equal to a percentage of the total estimated ACR UPL [~~gap~~] for the class, less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA. For program periods beginning on or before September 1, 2023, but on or after [~~the program period proposed to begin on~~] September 1, 2021, [~~and program periods thereafter,~~] the percentage is 90 percent. For program periods beginning on or after September 1, 2024, the percentage may not exceed 90 percent.

(C) The ACIA payment for the class will be equal to the minimum of the sum of the ACIA payment in subparagraph (A) of this paragraph and the limit in subparagraph (B) of this paragraph. If the amount calculated under subparagraph (B) of this paragraph is negative, the maximum, aggregated ACIA payments for that class will be equal to zero.

(D) [~~(C)~~] The ACIA payment for each provider will be equal to the amount in subparagraph (A) of this paragraph multiplied by the amount determined in subparagraph (C) of this paragraph for the class divided by the sum of the preliminary ACIA payment determined in subparagraph (A) of this paragraph for the class, rounded down to the nearest percentage. [~~Allocation of funds across hospitals will be proportional to each participating hospital's individual ACR gap to the total ACR gap for all participating hospitals in the SDA.~~] For example, if two hospitals in a class in an SDA both have anticipated base payments of $100 and UHRIP payments of $50, but one hospital has an estimated ACR UPL of $400 and an ACR gap of $300 between its base payment and ACR UPL [~~the estimate payment it would have received from a commercial payor~~], and the other hospital has an estimated ACR UPL of $600 and an ACR gap of $500 [~~$100~~], HHSC will first reduce the gaps by the UHRIP payment of $50 to a gap of $250 and $450 [~~$50~~], respectively. The preliminary ACIA rates are 250 percent and 450 percent. These are the amounts available under subparagraph (A) of this paragraph. HHSC would then sum the ACR UPLs for the two hospitals to get $1000 available to the class and apply the percentage in subparagraph (B) of this paragraph (e.g., 50 percent of the gap), which results in an ACR UPL of $500. Then HHSC will subtract the $200 in base payments and $100 in UHRIP payments from the reduced ACR UPL for a total of $200 of maximum ACIA payments under subparagraph (B) of this paragraph. The amount under subparagraph (A) for the class was $700, and the limit under subparagraph (B) of this paragraph is $200, so all provider in the SDA will have their ACIA percentage multiplied by $200 divided by $700 to stay under the $200 cap. The individual ACIA rates would be 71 percent (e.g., 200/700*250 percent) and 128 percent (e.g., 200/700*450 percent), respectively. The estimated ACIA payments would be $71 and $128. [~~HHSC would then apply a uniform percentage of the gap (e.g., 50 percent of the gap) and would calculate an ACIA payment of $125 and $25, respectively.~~] HHSC will then direct the MCOs to pay a percentage increase for the first hospital of 71 [~~125~~] percent in addition to the 50 percent increase under UHRIP for the first hospital for a total increase of 121 [~~175~~] percent above the contracted base rate, and 128 [~~25~~] percent in addition to the 50 percent increase under UHRIP for the second hospital for a total increase of 178 [~~75~~] percent.

(4) For program periods beginning on or after September 1, 2024, the Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA) is the third component.

(A) The total value of APHRIQA will be equal to the sum of:

(i) a percentage of the Medicare gap, not to exceed 100 percent, on a per class basis less the amount determined in paragraph (2)(A) of this subsection; and

(ii) a percentage of the total estimated ACR UPL, not to exceed 90 percent, on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

(B) Allocation of funds across hospitals will be calculated by allocating to each hospital the sum of:

(i) the difference in the amount the hospital is estimated to be paid under paragraph (2)(A) of this subsection and the amount they would be paid if the percentage described in paragraph (2)(A) of this subsection were the same percentage cited in subparagraph (A)(i) of this paragraph; and

(ii) the difference in the amount the hospital is estimated to be paid under paragraph (3)(C) of this subsection and the amount they would be paid if the percentage described in paragraph (3)(B) of this subsection were the same percentage cited in subparagraph (A)(ii) of this paragraph.

(h) Distribution of CHIRP payments. [~~CHIRP payments will be based upon actual utilization and will be paid as a percentage increase above the contracted rate between the MCO and the hospital.~~]

(1) CHIRP payments for UHRIP and ACIA components will be based upon actual utilization and will be paid as a percentage increase above the contracted rate between the MCO and the hospital. The determination of percentage of rate increase will be as follows.

(A) HHSC will determine the percentage of rate increase applicable to one or more classes of hospital by program component.

(B) UHRIP rate increases will be determined by HHSC to be the percentage that is estimated to result in payments for the class

that are equivalent to the amount described under subsection (g)(2)(A) of this section.

(C) ACIA will be determined by HHSC to be a percentage that is estimated to result in payments for the hospital that are equivalent to the amount described under subsection (g)(3)(D) of this section.

(2) For program periods beginning on or after September 1, 2024, CHIRP payments for the APHRIQA component will be based on achievement of performance measures established in accordance with §353.1307 of this subchapter.

(A) MCOs will be directed by HHSC to pay hospitals on a monthly, quarterly, semi-annual, or annual basis that aligns with the applicable performance achievement measurement period under §353.1307 of this subchapter.

(B) MCOs will be required to distribute payments to providers within 20 business days of notification by HHSC of provider achievement results.

(C) Funds that are not earned by a provider due to failure to achieve performance requirements will be redistributed to other hospitals in the same hospital SDA and class based on each hospital's proportion of total earned APHRIQA funds in the SDA. If no other hospital in the SDA and class receives performance payments, unearned funds will be redistributed to all hospitals in the SDA based on each hospital's proportion of total earned APHRIQA funds and projected to be paid to the hospitals through UHRIP and ACIA.

(3) HHSC will limit the amounts paid to providers determined pursuant to this subsection to no more than the levels that are supported by the amount described in subsection (i)(3) of this section. Nothing in this section may be construed to limit the authority of the state to require the sponsoring governmental entities to transfer additional funds to HHSC following the reconciliation process described in §353.1301(g) of this subchapter, if the amount previously transferred is less than the non-federal share of the amount expended by HHSC in the SDA for this program.

(4) After determining the percentage of rate increase using the process described in paragraph (1) of this subsection, HHSC will modify its contracts with the MCOs in the SDA to direct the percentage rate increases.

~~[(i) Determination of percentage of rate increase.]~~

~~[(1) HHSC will determine the percentage of rate increase applicable to one or more classes of hospital by program component.]~~

~~[(A) UHRIP rate increases will be determined by HHSC to be the percentage that is estimated to result in payments for the class that are equivalent to the amount described under subsection (g)(2)(A) of this section.]~~

~~[(B) ACIA will be determined by HHSC to be a percentage that is estimated to result in payments for the hospital that are equivalent to the amount described under subsection (g)(3)(A) of this section.]~~

~~[(2) HHSC will limit the percentage rate increases determined pursuant to this subsection to no more than the levels that are supported by the amount described in subsection (j)(3) of this section. Nothing in this section may be construed to limit the authority of the state to require the sponsoring governmental entities to transfer additional funds to HHSC following the reconciliation process described in §353.1301(g) of this subchapter, if the amount previously transferred is less than the non-federal share of the amount expended by HHSC in the SDA for this program.]~~

~~[(3) After determining the percentage of rate increase using the process described in paragraphs (1) and (2) of this subsection, HHSC will modify its contracts with the MCOs in the SDA to direct the percentage rate increases.]~~

(i) [~~(j)~~] Non-federal share of CHIRP payments. The non-federal share of all CHIRP payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support CHIRP.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all CHIRP hospitals at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars to be available under the CHIRP program for the program period as determined by HHSC, plus eight percent; and forecast member months for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under CHIRP for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled hospitals will meet 100 percent of their quality metrics and maintain consistent utilization with the prior year.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC no later than 21 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website no later than March 15 of each year.

(j) [~~(k)~~] Effective date of rate increases. HHSC will direct MCOs to increase rates under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(k) [~~(l)~~] Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(l) Data correction request. Any provider-requested data or calculation correction must be submitted prior to the date on which the first half of the IGT amount is due under subsection (i)(3) of this section.

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during the program period with the amount of funds transferred to HHSC by the spon-

soring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(n) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

§353.1307. Quality Metrics for [and Required Reporting Used to Evaluate the Success of] the Comprehensive Hospital Increase Reimbursement Program.

(a) Introduction. This section establishes the quality metrics for [and required reporting that may be used in] the Comprehensive Hospital Increase Reimbursement Program (CHIRP).

(b) Definitions. [The following definitions apply when the terms are used in this section and in metrics and performance requirements developed under subsections (f) and (g) of this section.] Terms that are used in this and other sections of this subchapter [section] may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1306 of this subchapter (relating to the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021).

[(1) Baseline--An initial standard used as a comparison against performance in each metric throughout the program period to determine progress in the CHIRP quality metrics.]

[(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparison against an individual hospital or hospital class's progress throughout the program period.]

[(3) Measurement period--The time period used to measure achievement of a quality metric.]

(c) Quality metrics. For each program period, HHSC will designate one or more quality metrics [that HHSC will evaluate] for each CHIRP capitation rate component as described in §353.1306(g) of this subchapter. Any quality metric included in CHIRP will be evidence-based and will be identified as a structure, process, or outcome measure. HHSC may modify quality metrics from one program period to the next. The proposed quality metrics for a program period will be presented to the public for comment in accordance with subsection (g) of this section.

[(1) Each quality metric will be identified as a structure, process, or outcome measure.]

[(2) Each quality metric will be evidence-based.]

(d) Performance requirements. For each program period, HHSC will specify the performance requirements associated with designated quality metrics. The proposed performance requirements for a program period will be presented to the public for comment in accordance with subsection (g) of this section. Achievement of performance requirements will trigger payments as described in §353.1306 of this subchapter.

(e) [(d)] Quality metrics and program evaluation. HHSC will use reported performance of quality metrics to evaluate the degree to which the arrangement advances at least one of the goals and objectives that are incentivized by the payments described under §353.1306(g) of this subchapter.

(1) All quality metrics for which a hospital is eligible based on class must be reported by the participating hospital as a condition of participation.

(2) Participating hospitals must stratify any reported data by payor type and must report data according to requirements published under subsection (h) [(f)] of this section.

(f) [(e)] Participating Hospital Reporting Frequency.

(1) Participating hospitals will be required to report on quality metrics semiannually unless otherwise specified by the metric. [The reported information will be used to conduct interim evaluations of the program.]

(2) Participating hospitals will also be required to furnish information and data related to quality metrics [measures] and performance requirements established in accordance with subsection (g) [(f)] of this section within 20 [30] calendar days after a request from HHSC for more information.

(g) [(f)] Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than November 15 of the calendar year that precedes [January 31 preceding] the first month of the program period. The notice must be published either by publication on HHSC's website or in the *Texas Register.* The notice required under this section will include the following:

(A) instructions for interested parties to submit written comments to HHSC regarding the proposed metrics and performance requirements; and

(B) the date, time, and location of a public hearing.

(2) Written comments will be accepted within [for] 15 business days of [following] publication. There will also be a public hearing within that 15-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(h) [(g)] Quality metric publication [Publication of Final Metrics and Performance Requirements]. Final quality metrics and performance requirements will be provided through the CHIRP quality webpage on HHSC's website on or before December 31 [February 28] of the calendar year that precedes [that also contains] the first month of the program period. [If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year, HHSC will provide notice of the changes through HHSC's website.]

(i) Alternate measures may be substituted for measures proposed under subsection (g) of this section or published under subsection (h) of this section if required by the Centers for Medicare and Medicaid Services for federal approval of the program. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after December 31, HHSC will provide notice of the changes through HHSC's website.

(j) [(h)] Evaluation Reports.

(1) HHSC will evaluate the success of the program based on a statewide review of reported metrics. HHSC may publish more detailed information about specific performance of various participating hospitals, classes of hospitals, or service delivery areas.

(2) HHSC will publish interim evaluation findings regarding the degree to which the arrangement advanced the established goal and objectives of each capitation rate component.

(3) HHSC will publish a final evaluation report within 270 days of the conclusion of the program period.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304077
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 487-3480

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1 TAC §353.1309

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1309, concerning the Texas Incentives for Physicians and Professional Services.

BACKGROUND AND PURPOSE

The purpose of the proposal is to pursue modifications to the Texas Incentives for Physicians and Professional Services (TIPPS) program to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services to create TIPPS for SFY 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment (DSRIP) program. HHSC has not made significant modifications to TIPPS since its inception in SFY 2022.

Directed payment programs authorized under 42 C.F.R. §438.6(c), including TIPPS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC has determined that TIPPS contains certain provisions that pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC will, therefore, propose certain clarifying amendments and other modifications with the intention of reducing administrative complexity and advancing the program toward improved quality of services provided to Medicaid clients by participating providers.

In SFY 2025, the proposed rule amendment will shift the program structure. For SFY 25, Component One will be 90 percent of the total program value paid as a uniform rate increase at time of claim adjudication, and Component Two will equal to 0 percent of the total program value. For SFY 2026, Component One will be 55 percent of the total program value paid as a uniform rate increase at time of claim adjudication; and Component Two will be equal to 35 percent of the total program value, based on a pay-for-performance model based on achievement of quality measures and paid through a scorecard. Component Three will remain as it is currently for future years, comprising 10 percent of the total program value, based on a uniform rate increase percentage paid at time of claim adjudication for an identified set of procedure codes.

HHSC met with participating providers and discussed multiple options. HHSC considered moving the program to a majority pay for performance component in SFY 2025. Some providers were in support of this change, while others requested more time. Those opposed to a SFY 2025 shift to pay-for-performance requested more time so that providers would be aware of the quality measures that would be used in the pay-for-performance model before implementation. HHSC is interested in feedback on the proposed option and may consider modifying the rules upon adoption or in subsequent program periods.

HHSC also proposes to determine the network status of an enrolling provider for an entire program period based on the submission of supporting documentation through the enrollment process.

HHSC proposes other minor clarifying or grammatical revisions to improve the readability of the rule text.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1309(b) provides additional definitions related to network status and plan code and reorganizes existing definitions to place all definitions in alphabetical order.

The proposed amendments to §353.1309(c) include definitions for minimum denominator requirements for program periods beginning on or after September 1, 2023, but on or after September 1, 2021, and then clarifies that no minimum denominator volume is required for program periods beginning on or after September 1, 2024, and after.

The proposed amendment to §353.1309(e) is expanded to clarify the program conditions of participation. First, the proposal clarifies that a provider must be located in the same SDA a participating SGE for each program period. Secondly, the proposal describes the manner in which network status will be determined during enrollment each year.

The proposed amendment to §353.1309(g) outlines the new structure of Components One and Two in SFY 2025, SFY 2026, and program periods subsequent to SFY 2026.

The proposed amendment to §353.1309(h)(1) explains the calculation and distribution of payments, after accounting for all other program changes.

Other revisions are made to numbering and editing for clarity and consistency.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will not create a new rule;

(6) the proposed rule will not expand, limit, or repeal an existing rule;

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

(8) HHS system has insufficient information to determine the proposed rule's effect on the state's economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities to comply with the proposed rule because participation in the program is voluntary.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public will benefit from the proposed rule because it will increase the provider's ability to fully understand the rules that govern the TIPPS program.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because participation in the program is optional.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Acute Care Services, Mail Code H-400 at 4601 W. Guadalupe St. Austin, Texas 78751 or via email at pfd_tipps@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R010" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendments implement Texas Government Code Chapter 531, Texas Government Code, Chapter 533, and Texas Human Resources Code Chapter 32.

§353.1309. Texas Incentives for Physicians and Professional Services.

(a) Introduction. This section establishes the Texas Incentives for Physicians and Professional Services (TIPPS) program. TIPPS is designed to incentivize physicians and certain medical professionals to improve quality, access, and innovation in the provision of medical services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1311 of this subchapter (relating to Quality Metrics for the Texas Incentives for Physicians and Professional Services Program).

(1) Health Related Institution (HRI) physician group--A network physician group owned or operated by an institution named in Texas Education Code §63.002.

(2) Indirect Medical Education (IME) physician group--A network physician group contracted with, owned, or operated by a hospital receiving either a medical education add-on or a teaching medical education add-on as described in §355.8052 of this title (relating to Inpatient Hospital Reimbursement) for which the hospital is assigned or retains billing rights for the physician group.

(3) Intergovernmental Transfer (IGT) Notification--Notice and directions regarding how and when IGTs should be made in support of the program.

(4) Network physician group--A physician group located in the state of Texas that has a contract with a Managed Care Organization (MCO) for the delivery of Medicaid covered benefits to the MCO's enrollees.

(5) Network Status--A provider's network status with a contracted Managed Care Organization (MCO), as determined by the national provider identification (NPI) number and Plan Code combination.

(6) [~~(5)~~] Other physician group--A network physician group other than those specified under paragraphs (1) and (2) of this subsection.

(7) Plan code--An unique 2-digit alphanumeric code established by HHSC denoting the individual managed care organization, program, and service delivery area.

(8) [~~(6)~~] Program period--A period of time for which an eligible and enrolled physician group may receive the TIPPS amounts described in this section. Each TIPPS program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

[~~(7) Total program value--The maximum amount available under the TIPPS program for a program period, as determined by HHSC.~~]

[~~(8) Suggested IGT responsibility--Notice of potential amounts that a governmental entity may wish to consider transferring in support of the program.~~]

(9) Suggested IGT responsibility--Notice of potential amounts that a governmental entity may wish to consider transferring in support of the program.

(10) Total program value--The maximum amount available under the TIPPS program for a program period, as determined by HHSC.

(c) Eligibility for participation in TIPPS. A physician group is eligible to participate in TIPPS if it complies with the requirements described in this subsection.

(1) Physician group composition. A physician group must indicate the eligible physicians, clinics, and other locations to be considered for payment and quality measurement purposes in the application process.

(2) Minimum volume. For program periods beginning on or after September 1, 2023, but on or after September 1, 2021, physician [~~Physician~~] groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 50 percent of the quality metrics in each component [~~Component~~] to be eligible to participate in the component [~~Component~~]. For program periods beginning on or after September 1, 2024, no minimum denominator volume is required.

(3) The physician group is:

(A) an HRI physician group;

(B) an IME physician group; or

(C) any other physician group that:

(i) can achieve the minimum volume during program periods beginning on or after September 1, 2023, but on or after September 1, 2021, as described in paragraph (2) of this subsection;

(ii) is located in a service delivery area with at least one sponsoring governmental entity; and

(iii) for program periods beginning on or after September 1, 2023, but on or after September 1, 2021, served at least 250 unique Medicaid managed care clients in the prior state fiscal year. For program periods beginning on or after September 1, 2024, no minimum volume is required.

(d) Data sources for historical units of service and clients served. Historical units of service are used to determine a physician group's eligibility status and the estimated distribution of TIPPS funds across enrolled physician groups.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's NPI [~~national provider identification (NPI)~~] number and taxonomy code combination that are billed as a professional encounter only.

(2) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine eligibility status of other physician groups for program periods beginning on or after September 1, 2023, but on or after September 1, 2021.

(3) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine distribution of TIPPS funds across eligible and enrolled physician groups.

(4) In the event of a disaster, HHSC may use data from a different state fiscal year at HHSC's discretion.

(5) The data used to estimate eligibility and distribution of funds will align with the data used for purposes of setting the capitated rates for managed care organizations for the same period.

(6) HHSC will calculate the estimated rate that an average commercial payor would have paid for the same services using either data that HHSC obtains independently or data that is collected from providers through the application process described in subsection (c) of this section.

(7) If HHSC is unable to compute an actuarially sound payment rate based on private payor information described in paragraph (6) of this subsection for any services, then those services will be removed from consideration from the TIPPS program.

(8) All services billed and delivered at a Federally Qualified Health Center, dental services, and ambulance services are excluded from the scope of the TIPPS program.

(9) Encounter data used to calculate payments for this program must be designated as paid status. Encounters reported as a paid status, but with zero or negative dollars as a reported paid amount will not be included in the data used to calculate payments for the TIPPS program.

(10) If a provider with the same Tax Identification Number as the payor is being paid more than 200 percent of the Medicaid reimbursement on average for the same services in a one-year period, then a related-party-adjustment will be applied to the encounter data for those encounters. This adjustment will apply a calculated average payment rate from the rest of the provider pool to the related-parties paid units of service.

(e) Conditions of Participation. As a condition of participation, all physician groups participating in TIPPS must allow for the following.

(1) The physician group must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period will be no less than 21 calendar days, and the final date of the enrollment period will be at least nine days prior to the release of suggested IGT responsibilities.

(2) Enrollment is conducted annually, and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the suggested IGT responsibilities under subsection (f)(1) of this section. For each program period, a physician group must be located in a Service Delivery Area (SDA) in which at least one sponsoring governmental entity that agrees to transfer to HHSC some or all of the non-federal share under this section is also located. An SDA is designated by HHSC for each provider, or provider group with multiple locations, based on the SDA in which the majority of a provider group's claims are billed. Services that are provided outside of a designated SDA may be included in the designated SDA.

(3) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(4) [~~(2)~~] The entity that bills on behalf of the physician group must certify, on a form prescribed by HHSC, that no part of any TIPPS payment will be used to pay a contingent fee nor may the entity's agreement with the physician group use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the physician group's receipt of TIPPS funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(5) [~~(3)~~] If a provider has changed ownership in the past five years in a way that impacts eligibility for the TIPPS program, the

provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, the TIPPS program.

(6) [~~(4)~~] Report all quality data denoted as required as a condition of participation in §353.1311(d)(1) of this subchapter.

(7) [~~(5)~~] Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(f) Non-federal share of TIPPS payments. The non-federal share of all TIPPS payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support TIPPS.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all TIPPS eligible and enrolled HRI physician groups and IME physician groups at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under the TIPPS program for the program period as determined by HHSC, plus eight percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across HRI physician groups and IME physician groups, plus estimated utilization for eligible and enrolled other physician groups within the same service delivery area, for the program period. HHSC will also communicate estimated maximum revenues each eligible and enrolled physician group could earn under TIPPS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled physician groups will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 21 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website by March 15 of each year.

(4) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(g) TIPPS capitation rate components. TIPPS funds will be paid to Managed Care Organizations (MCOs) through three components of the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of TIPPS funds to the enrolled physician groups will be based on each physician group's performance related to the quality metrics as described in §353.1311 of this subchapter. The physician group must have provided at least one Medicaid service to a Medicaid client in each reporting period to be eligible for payments.

(1) Component One.

(A) For program periods beginning on or after September 1, 2023, but on or after September 1, 2021, the [~~The~~] total value of Component One will be equal to 65 percent of total program value.

(i) [~~(B)~~] Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid clients served.

(ii) [~~(C)~~] Monthly payments to HRI and IME physician groups will be a uniform rate increase.

(iii) [~~(D)~~] Other physician groups are not eligible for payments from Component One.

(iv) [~~(E)~~] Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) [~~(F)~~] HHSC will reconcile the interim allocation of funds across qualifying HRI and IME physician groups to the actual distribution of Medicaid clients served across these physician groups during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(vi) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(vii) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(B) For the program period beginning on September 1, 2024, the total value of Component One will be equal to 90 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase paid at time of claim adjudication.

(iii) Other physician groups are not eligible for payments from Component One.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(C) For program periods beginning on or after September 1, 2025, the total value of component one will be equal to 55 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be a uniform rate increase paid at time of claim adjudication.

(iii) Other physician groups are not eligible for payments from Component One.

(iv) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) For program periods beginning on or after September 1, 2023, but on or after September 1, 2021, the [~~The~~] total value of Component Two will be equal to 25 percent of total program value.

(i) [~~(B)~~] Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) [~~(C)~~] Payments to physician groups will be a uniform rate increase.

(iii) [~~(D)~~] Other physician groups are not eligible for payments from Component Two.

(iv) [~~(E)~~] Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(v) [~~(F)~~] HHSC will reconcile the interim allocation of funds across qualifying HRI and IME physician groups to the actual distribution of Medicaid clients served across these physician groups during the program period as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(B) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(C) If a provider eligible for TIPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(D) For the program period beginning September 1, 2024, Component Two will be equal to 0 percent of the program.

(E) For program periods beginning on or after September 1, 2025, the total value of Component Two will be equal to 35 percent of the total program value.

(i) Allocation of funds across qualifying HRI and IME physician groups will be proportional, based upon historical Medicaid utilization.

(ii) Payments to physician groups will be made through a pay-for-performance model based on achievement of quality measures and paid through a scorecard.

(iii) Other physician groups are not eligible for payments from Component Two.

(3) Component Three.

(A) The total value of Component Three will be equal to 10 percent of total program value.

(B) Allocation of funds across physician groups will be proportional, based upon actual Medicaid utilization of specific procedure codes as identified in the final quality metrics or performance requirements described in §353.1311 of this subchapter.

(C) Payments to physician groups will be a uniform rate increase.

(D) Providers must report quality data as described in §353.1311 of this subchapter as a condition of participation in the program.

(h) Distribution of TIPPS payments.

(1) Before the beginning of the program period, HHSC will calculate the portion of each PMPM associated with each TIPPS enrolled practice group broken down by TIPPS capitation rate component and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs and the MCO network status at the time of the application under subsection (e)(1) of this section. For example, for a physician group, HHSC will calculate the portion of each PMPM associated with that group that would be paid from the MCO to the physician group as follows.

(A) Payments [~~Monthly payments~~] from Component One.

(i) For program periods beginning on or after September 1, 2023, but on or after September 1, 2021, payments will be monthly and will be equal to the total value of Component One for the physician group divided by twelve.

(ii) For program periods beginning on or after September 1, 2024, payments will be made as a uniform percentage increase paid at the time of claim adjudication.

(B) Payments [~~Semi-annual payments~~] from Component Two.

(i) For program periods beginning on or after September 1, 2023, but on or after September 1, 2021, payments will be semi-annual and will be equal to the total value of Component Two for the physician group divided by 2.

(ii) For the program period beginning on September 1, 2024, no payments will be made for Component Two.

(iii) For program periods beginning on or after September 1, 2025, payment will be made on a scorecard basis at payments based on the reporting of quality measures and paid through a scorecard at the time of achievement.

(C) Payments from Component Three will be equal to the total value of Component Three attributed as a uniform rate increase based upon historical utilization.

(2) MCOs will distribute payments to enrolled physician groups as directed by HHSC. Payments will be equal to the portion of the TIPPS PMPM associated with the achievement for the time period in question multiplied by the number of member months for which the MCO received the TIPPS PMPM.

(i) Changes in operation. If an enrolled physician group closes voluntarily or ceases to provide Medicaid services, the physician group must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(j) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(k) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 2, 2023.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 707-6071

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1 TAC §353.1315

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1315, concerning the Rural Access to Primary and Preventive Services Program.

BACKGROUND AND PURPOSE

The purpose of the proposal is to pursue modifications to the Rural Access to Primary and Preventive Services (RAPPS) to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services to create RAPPS for state fiscal year (SFY) 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment program (DSRIP). HHSC has not made significant modifications to RAPPS since its inception in SFY 2022. Directed payment programs authorized under 42 C.F.R. §438.6(c), including RAPPS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC has determined that RAPPS contains certain provisions that pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC, therefore, will propose certain clarifying amendments and other modifications with the intention of reducing administrative complexity and burden for participants.

The proposed amendment also consolidates RAPPS into a single component paid via Component 1 only for SFY 2025 and after. All payments will be directed to be paid by the managed care organization (MCO) as a lump sum payment based on a scorecard issued by HHSC. This proposed rule amendment reduces the administrative burden on providers and managed care organizations, as the payments will no longer be made via the claim adjudication process and will be exclusively made via the monthly scorecard outside of the claims process.

HHSC considered but did not propose two other options for decreasing the administrative complexity of the program. First, HHSC considered consolidating the program components into a singular component by consolidating all payments into the current component two. This would have eliminated the necessity for the program to use a scorecard and to have a post-program period reconciliation to actual utilization. However, this would require MCOs to pay all program funds at the time of claim adjudication as a uniform rate increase.

The second option HHSC considered was to update the fee-for-service freestanding rural health clinic (RHC) rates to reflect the updated RHC rates being paid through RAPPS, establish a minimum fee schedule for MCOs that references the fee-for-service rates, and eliminate RAPPS. HHSC is interested in receiving comments on either of these alternative options and may consider modifying the rules upon adoption or in subsequent program periods to reflect these options.

HHSC also proposes to determine the network status of an enrolling provider for an entire program period based on the submission of supporting documentation at the time of enrollment.

HHSC proposes several other minor clarifying or grammatical amendments to improve the readability of the rule text.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1315(b) amends terms "network RHC" to add a hyphen to a phrase and "rural health clinic" to add a section symbol.

The proposed amendment to §353.1315(e) corrects grammar, punctuation, and updates certain words for clarity.

The proposed amendment to §353.1315(f) adds subparagraph (A) and (B) to paragraph (1) to provide additional detail related to enrollment and timelines for updates to provider information

The proposed amendment to §353.1315(h) adds language to specify that the program will be consolidated to a single component paid via the scorecard for program periods beginning on or after September 1, 2024 and to clarify that the reconciliation will be based on actual utilization by National Provider Identifiers (NPI) and that an NPI that was not previously included in the monthly scorecard may be paid through the reconciliation.

The proposed amendment to §353.1315(i) adds language to further specify that modeling will be based on enrolled NPIs, and Component 2 will apply to program periods beginning on or before September 1, 2023. A reference is also updated.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will not create a new rule;

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

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities to comply with the proposed rule because participation in the program is voluntary.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be the ability of Medicaid managed care clients to have continued access to care by incentivizing providers to improve the quality of services delivered through reduced administrative burden.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule does not impose any additional costs on small businesses, micro-businesses, or rural communities.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Hospital Finance, HHSC Provider Finance Department, Hospital Services, Mail Code H-400 at 4601 W. Guadalupe St., Austin, Texas 78751 or by email to pfd_hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R009" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

§353.1315. Rural Access to Primary and Preventive Services Program.

(a) Introduction. This section establishes the Rural Access to Primary and Preventive Services (RAPPS) program. RAPPS is designed to incentivize rural health clinics (RHCs) to improve quality, access, and innovation in the provision of medical services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Other terms used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1317 of this subchapter (relating to Quality Metrics for [~~the~~] Rural Access to Primary and Preventive Services Program).

(1) Freestanding rural health clinic (RHC)--A network RHC that is not affiliated with a hospital.

(2) Hospital-based RHC--A network RHC that is affiliated with a hospital.

(3) Intergovernmental transfer (IGT) notification--Notice and directions regarding how and when IGTs should be made in support of RAPPS.

(4) Network RHC--An RHC located in the state of Texas that has a contract with a managed care organization (MCO) for the delivery of Medicaid-covered [~~Medicaid covered~~] services to the MCO's enrollees.

(5) Program period--A period of time for which the Texas Health and Human Services Commission (HHSC) contracts with MCOs to pay increased capitation rates for the purpose of making RHC payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(6) Rural health clinic (RHC)--Has the meaning assigned by 42 U.S.C. §[~~Section~~]1396d(l)(1).

(7) Suggested IGT responsibility--Notice of potential amounts that a sponsoring governmental entity may wish to consider transferring in support of RAPPS.

(8) Total program value--The maximum amount available under the RAPPS program for a program period, as determined by HHSC.

(c) Classes of RHCs.

(1) HHSC may direct an MCO to provide an increased payment or percentage rate increase for certain services to all RAPPS-enrolled RHCs in one or more of the following classes of RHCs with which the MCO contracts for Medicaid services:

(A) hospital-based RHCs; and

(B) freestanding RHCs.

(2) If HHSC directs rate increases or payments to more than one RHC class in the service delivery area (SDA), the rate increases or payments may vary by RHC class. HHSC will consider the following factors in identifying the amount of the rate increase or payment for each class:

(A) the RHC class's contribution to the goals and objectives in the HHSC managed care quality strategy, as required in 42 C.F.R. §438.340, relative to other classes;

(B) the class or classes of RHC the sponsoring governmental entity wishes to support through IGTs of public funds, as indicated on the application described in subsection (f) of this section; and

(C) the actuarial soundness of the capitation payment needed to support the rate increase or payment.

(d) Eligibility. An RHC is eligible to participate in RAPPS if it meets the requirements described in this subsection.

(1) Location. The RHC must be located in an SDA with at least one sponsoring governmental entity.

(2) Minimum number of Medicaid managed care encounters. The RHC must have provided at least 30 Medicaid managed care encounters in the prior state fiscal year.

(e) Data sources for historical units of service and clients served. Historical units of service are used to determine an RHC's eligibility status and the estimated distribution of RAPPS funds across enrolled RHCs.

(1) HHSC will use encounter data and will identify encounters based on [~~upon~~] the billing provider's national provider identification (NPI) number and provider type code.

(2) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine the eligibility status of an RHC.

(3) HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine the distribution of RAPPS funds across enrolled RHCs.

(4) In the event that the historical data are not deemed appropriate for use by actuarial standards, HHSC may utilize data from a different state fiscal year at HHSC's discretion.

(5) The data used to estimate eligibility and distribution of funds will align with the data used for purposes of setting the capitation rates for MCOs for the same period.

(6) To determine total program value, HHSC will calculate the estimated rate that Medicare would have paid for the same services using either each RHC's state fiscal year 2019 federal cost report or its last submitted cost report. For RHCs where a filed cost report was not found, the RHC's Medicare payments will be estimated using the SDA weighted average ratio of Medicare encounter-based reimbursements divided by MCO reimbursement data.

(7) Encounter data used to calculate RAPPS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status[~~,~~] but with a reported paid amount of zero or negative dollars[~~,~~] will be excluded from the data used to calculate RAPPS payments.

(8) If a provider with the same Tax Identification Number as the payor is being paid more than 200 percent of the Medicaid reimbursement on average for the same services in a one-year period, then a related party adjustment [~~related-party-adjustment~~] will be applied to the encounter data for those encounters. This adjustment will apply a calculated average payment rate from the rest of the provider pool to the related party's [~~related-party's~~] paid units of service.

(f) Conditions of Participation. As a condition of participation, all RHCs participating in RAPPS, as well as any entities billing on their behalf, must meet the following requirements.

(1) The RHC must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period will be no less than 21 calendar days, and the final date of the enrollment period will be at least nine calendar days prior to the release of suggested IGT responsibilities.

(A) Enrollment is conducted annually and participants may not join the program after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the IGT notification under subsection (g)(3) of this section.

(B) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(2) An entity that bills on behalf of the RHC must certify, on a form prescribed by HHSC, that no part of any RAPPS payment will be used to pay a contingent fee and that the entity's agreement with the RHC does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the RHC's receipt of RAPPS funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If an RHC has changed ownership in the past five years in a way that impacts eligibility for RAPPS, the RHC must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the RHC and which reference the administration of, or payments from, RAPPS.

(4) Report all quality data denoted as required as a condition of participation in subsection (h) of this section.

(5) Failure to meet any conditions of participation described in this subsection will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(g) Non-federal share of RAPPS payments. The non-federal share of all RAPPS payments is funded with IGTs from sponsoring governmental entities. No state general revenue is available to support RAPPS.

(1) HHSC will communicate the following information for the program period to all RAPPS-enrolled hospital-based RHCs and sponsoring governmental entities at least 10 calendar days prior to the IGT declaration of intent deadline:

(A) suggested IGT responsibilities for the program period, which will be based on:

(i) the maximum funding amount available under RAPPS for the program period as determined by HHSC, plus ten percent;

(ii) forecasted member months for the program period as determined by HHSC; and

(iii) the distribution of historical Medicaid utilization across RHCs, plus the estimated utilization for enrolled RHCs within the same SDA, for the program period; and

(B) the estimated maximum revenues each enrolled RHC could earn under RAPPS for the program period[~~, which~~] will be based on HHSC's suggested IGT responsibilities and the assumption that all enrolled RHCs will meet 100 percent of their quality metrics.

(2) The estimated maximum revenues each enrolled RHC could earn under RAPPS for the program period, which will be based on HHSC's suggested IGT responsibilities and the assumption that all enrolled RHCs will meet 100 percent of their quality metrics.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred, no fewer than 14 business days before IGT transfers are due. The IGT notification will instruct sponsoring governmental entities as to the required IGT amounts. Required IGT amounts will include all costs associated with RHC payments and rate increases, including costs associated with MCO premium taxes, risk margin, and administration, plus ten percent.

(4) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on the HHSC website by March 15 of each year.

(h) RAPPS capitation rate components. RAPPS funds will be paid to MCOs through [~~two components of~~] the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of RAPPS funds to the enrolled RHCs will be based on each RHC's performance related to the quality metrics as described in §353.1317 of this subchapter. The RHC must have [~~had~~] provided at least one Medicaid service to a Medicaid client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 75 percent of total program value for program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, Component One will be 100 percent of the total program value.

(B) Allocation of funds across qualifying RHCs will be based on [~~upon~~] historical Medicaid utilization and RHC class.

(C) Monthly payments to RHCs will be paid prospectively.

(D) HHSC will reconcile the interim allocation of funds across RAPPS-enrolled RHCs to the actual Medicaid utilization across these RHCs during the program period as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(i) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(ii) If a provider eligible for RAPPS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(E) Providers must report quality data as described in §353.1317 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) The total value of Component Two will be equal to 25 percent of the total program value for program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, the total value of Component Two will be equal to zero percent of the total program value.

(B) Allocation of funds across qualifying RHCs will be based upon actual Medicaid utilization of specific procedure codes as identified in the final quality metrics and performance requirements described in §353.1317 of this subchapter.

(C) A percent increase on all applicable services will begin when an RHC demonstrates achievement of performance requirements as described in §353.1317 of this subchapter during the reporting period.

(D) Providers must report quality data as described in §353.1317 of this subchapter as a condition of participation in the program.

(i) Distribution of RAPPS payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each monthly prospective payment associated with each RAPPS-enrolled RHC broken down by RAPPS capitation rate component and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs at the time of the application under subsection (f)(1) of this section. For example, for an RHC, HHSC will calculate the portion of each monthly prospective payment associated with that RHC that would be paid from the MCO to the RHC as follows.

(A) Monthly payments from Component One will be equal to the total value of Component One for the RHC divided by twelve.

(B) For program periods beginning on or before September 1, 2023, payments [~~Payments~~] from Component Two will be equal to the total value of Component Two attributed as a rate increase for specific services based upon historical utilization.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, an RHC must achieve quality metrics to be eligible for full payment as determined by performance requirements described in §353.1317(d) of this subchapter.

(2) An MCO will distribute payments to an enrolled RHC based on criteria established under this subsection [~~(i) of this section~~].

(j) Changes in operation. If a RAPPS-enrolled RHC closes voluntarily or ceases to provide Medicaid services, the RHC must notify the HHSC Provider Finance Department by electronic mail to an address designated by HHSC, by hand delivery, United States (U.S.) mail, or by special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(k) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(l) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) and §353.1301(k) of this subchapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304037
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 487-3480

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1 TAC §353.1320

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1320, concerning the Directed Payment Program for Behavioral Health Services.

BACKGROUND AND PURPOSE

The purpose of the proposal is to pursue modifications to the Directed Payment Program for the Behavioral Health Services (DPP BHS) program to simplify the program structure, provide additional details concerning certain enrollment-related processes and procedures, and reduce the administrative burden of operating the program for HHSC and participating providers.

HHSC sought and received authorization from the Centers for Medicare and Medicaid Services to create DPP BHS for state fiscal year 2022 as part of the financial and quality transition from the Delivery System Reform Incentive Payment (DSRIP) program. HHSC has not made significant modifications to DPP BHS since its inception in state fiscal year 2022.

Directed payment programs authorized under 42 C.F.R. §438.6(c), including DPP BHS, are expected to continue to evolve over time so that the program can continue to advance the quality goal or objective the program is intended to impact.

HHSC has determined that DPP BHS contains certain provisions pose administrative complexity that may impede HHSC's and the participating providers' ability to use the program to advance a quality goal or strategy. HHSC, therefore, will propose certain clarifying amendments and other modifications with the intention of reducing administrative complexity and burden for participants.

The proposed rule amendment also consolidates DPP BHS into a single component to be paid via a scorecard, Component One only, for state fiscal year 2025 and after, so all payments will be paid by managed care organization as a lump sum payment based on a scorecard issued by HHSC. This proposed rule amendment reduces the administrative burden on providers and managed care organizations, as the payments will no longer be made via the claim adjudication process and will be exclusively made via the monthly scorecard outside of the claims process.

HHSC proposes to change the eligible provider classes to only have one eligible provider class now that all participating providers have achieved CCBHC certification.

HHSC considered, but did not propose two other options for decreasing the administrative complexity of the program. First, HHSC considered consolidating the program components into a singular component by consolidating all payments into the current Component Two. This would have eliminated the necessity for the program to use a scorecard and to have a post-program period reconciliation to actual utilization. However, this would require MCOs to pay all program funds at the time of claim adjudication as a uniform rate increase. The second option HHSC considered was to authorize the CCBHC billing code or codes as part of the Medicaid fee schedule, establish a minimum fee schedule for MCOs that references the fee-for-service rate for those codes, and eliminate DPP BHS. HHSC is interested in receiving comments on either of these alternative options and may consider modifying the rules upon adoption or in program periods beginning on or after September 1, 2025, to reflect these options.

HHSC also proposes to determine the network status of an enrolling provider for an entire program period based on the submission of supporting documentation through the enrollment process.

HHSC proposes other minor clarifying or grammatical revisions to improve the readability of the rule text.

SECTION-BY-SECTION SUMMARY

The proposed amendment makes minor capitalization, typographical, and renumbering updates throughout.

The proposed amendment adds language to §353.1320(c)(1) to provide that for program periods beginning on or after September 1, 2024, all providers participating must be Certified Community Behavioral Health Clinics (CCBHC).

The proposed amendment adds language to existing §353.1320(e)(1), and adds new §353.1320(e)(3), to provide additional detail related to enrollment and timelines for updates to provider information and to clarify that providers must submit all claims under their own National Provider Identifier (NPI) as the billing provider.

The proposed amendment removes language from §353.1320(h) and adds language to §353.1320(h)(1)(A), §353.1320(h)(1)(D) and §353.1320(h)(2)(A) to specify that the program will be consolidated to a single component paid via the scorecard for program periods beginning on or after September 1, 2024, and to clarify that the reconciliation will be based on actual utilization by NPI and that an NPI that was not previously included in the monthly scorecard may be paid through the reconciliation.

The proposed amendment adds language to §353.1320(i)(1) to further specify that modeling will be based on enrolled NPIs and the MCO network status at the time of enrollment and that Component Two will apply only to program periods beginning on or before September 1, 2023.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rule will not create a new rule;

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

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities to comply with the proposed rule because participation in the program is voluntary.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public will benefit from the proposed rule because it will increase the provider's ability to fully understand the rules that govern the DPP-BHS program.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because participation in the program is optional.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC Provider Finance Department, Acute Care Services, Mail Code H-400 at 4601 W. Guadalupe St., Austin, Texas 78751 or via email at pfd_dppbhs@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R008" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which provides the Executive Commissioner with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

The amendment implements Texas Government Code Chapter 531, Texas Government Code, Chapter 533, and Texas Human Resources Code Chapter 32.

§353.1320. Directed Payment Program for Behavioral Health Services.

(a) Introduction. This section establishes the Directed Payment Program for Behavioral Health Services (DPP BHS). DPP BHS is designed to incentivize behavioral health providers to improve quality, access, and innovation in the provision of medical and behavioral health services to Medicaid recipients through the use of metrics that are expected to advance at least one of the goals and objectives of the state's managed care quality strategy.

(b) Definitions. The following definitions apply when the terms are used in this section. Terms that are used in this section may be defined in §353.1301 of this subchapter (relating to General Provisions) or §353.1322 of this subchapter (relating to Quality Metrics for the Directed Payment Program for Behavioral Health Services).

(1) Average Commercial Reimbursement (ACR) gap--The difference between what an average commercial payor is estimated to pay for the services and what Medicaid actually paid for the same services.

(2) Certified Community Behavioral Health Clinic [~~community behavioral health clinic~~] (CCBHC)--A clinic certified by the state in accordance with federal criteria and with the requirements of the Protecting Access to Medicare Act of 2014 (PAMA).

(3) CCBHC cost-reporting gap--The difference between what Medicaid pays for services and what the reimbursement would be based on the CCBHC cost-reporting methodology.

(4) Community Mental Health Center [~~mental health center~~] (CMHC)--An entity that is established under Texas Health and Safety Code §534.0015 and that:

(A) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility.

(B) Provides 24-hour-a-day emergency care services.

(C) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services.

(D) Provides screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission.

(5) Intergovernmental transfer (IGT) notification--Notice and directions regarding how and when IGTs should be made in support of DPP BHS.

(6) Local Behavioral Health Authority [~~behavioral health authority~~] (LBHA)--An entity that is designated under Texas Health and Safety Code §533.0356.

(7) Program period--A period of time for which the Texas Health and Human Services (HHSC) contracts with participating managed care organizations (MCOs) to pay increased capitation rates for the purpose of provider payments under this section. Each program period is equal to a state fiscal year beginning September 1 and ending August 31 of the following year.

(8) Providers--For program periods on or before August 31, 2022, an entity described in paragraph (4) of this subsection. For program periods on or after September 1, 2022, an entity described in paragraph (4) or (6) of this subsection.

(9) Suggested IGT responsibility--Notice of potential amounts that a sponsoring governmental entity may wish to consider transferring in support of DPP BHS.

(10) Total program value--The maximum amount available under the Directed Payment Program for Behavioral Health Services for a program period, as determined by HHSC.

(c) Classes of participating providers.

(1) HHSC may direct the MCOs to provide a uniform percentage rate increase or a uniform dollar increase to all providers within

one or more of the following classes of providers with which the MCO contracts for services:

(A) For program periods beginning on or before September 1, 2023, providers [~~Providers~~] that are certified CCBHCs[~~;~~] and providers that are not certified CCBHCs.

(B) For program periods beginning on or after September 1, 2024, providers who are certified CCBHCs. [~~Providers that are not certified CCBHCs.~~]

(2) If HHSC directs rate or dollar increases to more than one class of providers within the service delivery area [~~(SDA)~~], the rate or dollar increases directed by HHSC may vary between classes.

(d) Data sources for historical units of service. Historical units of service are used to determine a provider's eligibility status to receive the estimated distribution of program funds across enrolled providers.

(1) HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number.

(2) The most recently available Medicaid encounter data for a complete state fiscal year will be used to determine the distribution of program funds across eligible and enrolled providers.

(3) In the event that the historical data are not deemed appropriate for use by actuarial standards, HHSC may use data from a different state fiscal year at the discretion of the HHSC actuaries.

(4) The data used to estimate the distribution of funds will align to the extent possible with the data used for purposes of setting the capitation rates for MCOs for the same period.

(5) HHSC will calculate the estimated rate that an average commercial payor or Medicare would have paid for similar services or based on the CMS-approved [~~CMS approved~~] CCBHC cost report rate methodology using either data from Medicare cost reports or collected from providers.

(6) Encounter data used to calculate DPP BHS payments must be designated as paid status with a reported paid amount greater than zero. Encounters reported as paid status, but with a reported paid amount of zero or negative dollars, will be excluded from the data used to calculate DPP BHS payments.

(e) Conditions of Participation. As a condition of participation, all providers participating in the program must allow for the following.

(1) The provider must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 21 calendar days, and the final date of the enrollment period will be at least nine calendar days prior to the release of suggested IGT responsibilities.

(A) Enrollment is conducted annually, and participants may not join the after the enrollment period closes. Any updates to enrollment information must be submitted prior to the publication of the IGT suggestion under subsection (j)(1) of this section.

(B) Network status for providers for the entire program period will be determined at the time of enrollment based on the submission of documentation through the enrollment process that shows an MCO has identified the provider as having a network agreement.

(2) The entity that bills on behalf of the provider must certify, on a form prescribed by HHSC, that no part of any payment made under the program will be used to pay a contingent fee and that the entity's agreement with the provider does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Medicaid program, including the provider's receipt of program funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

(3) If a provider contracts with another entity to provide DPP BHS-eligible services on behalf of the provider, the provider must submit all claims to the MCO using an NPI assigned to the provider as the billing provider's NPI.

(4) [~~(3)~~] If a provider has changed ownership in the past five years in a way that impacts eligibility for DPP BHS, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, DPP BHS.

(5) [~~(4)~~] Report all quality data denoted as required as a condition of participation in subsection (h) of this section.

(6) [~~(5)~~] Failure to meet any conditions of participation described in this section will result in removal of the provider from the program and recoupment of all funds previously paid during the program period.

(f) Determination of percentage of rate and dollar increase.

(1) HHSC will determine the percentage of rate or dollar increase applicable to providers by program component.

(2) HHSC will consider the following factors when determining the rate increase:

(A) the estimated Medicare gap for providers, based upon the upper payment limit demonstration most recently submitted by HHSC to the Centers for Medicare and Medicaid Services (CMS);

(B) the estimated Average Commercial Reimbursement (ACR) gap for the class or individual providers, as indicated in data collected from providers;

(C) the estimated gap for providers, based on the CCBHC cost-reporting methodology that is consistent with the CMS guidelines;

(D) the percentage of Medicaid costs incurred by providers in providing care to Medicaid managed care clients that are reimbursed by Medicaid MCOs prior to any rate increase administered under this section; and

(E) the actuarial soundness of the capitation payment needed to support the rate increase.

(g) Services subject to rate and dollar increase. HHSC may direct the MCOs to increase rates or dollar amounts for all or a subset of provider services.

(h) Program capitation rate components. Program funds will be paid to MCOs through [~~two components of~~] the managed care per member per month (PMPM) capitation rates. The MCOs' distribution of program funds to the enrolled providers will be based on each provider's performance related to the quality metrics as described in §353.1322 of this subchapter. The provider must have provided at least one Medicaid service to a Medicaid managed care client for each reporting period to be eligible for payments.

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of the total program value for program periods beginning on or before September 1, 2023. For program periods beginning on or

after September 1, 2024, Component One will be 100 percent of the total program value.

(B) Allocation of funds across all qualifying providers [~~CMHCs~~] will be proportional, based upon historical Medicaid utilization.

(C) Monthly payments to providers will be a uniform rate increase.

(D) The interim allocation of funds across qualifying providers will be reconciled to the actual Medicaid utilization across these providers during the program period, as captured by Medicaid MCOs contracted with HHSC for managed care 120 days after the last day of the program period.

(i) Redistribution resulting from the reconciliation will be based on actual utilization of enrolled NPIs.

(ii) If a provider eligible for DPP BHS payments was not included in the monthly scorecards, the provider may be included in the reconciliation by HHSC.

(E) Providers must report quality data as described in §353.1322 of this subchapter as a condition of participation in the program.

(2) Component Two.

(A) The total value of Component Two will be equal to 35 percent of the total program value program periods beginning on or before September 1, 2023. For program periods beginning on or after September 1, 2024, the total value of Component Two will be equal to 0 percent of the total program value.

(B) Allocation of funds across all qualifying providers will be based upon historical Medicaid utilization.

(C) Payments to providers will be a uniform rate increase.

(D) Providers must report quality data as described in §353.1322 of this subchapter as a condition of participation in the program.

(i) Distribution of the Directed Payment Program for Behavioral Health Services payments.

(1) Prior to the beginning of the program period, HHSC will calculate the portion of each payment associated with each enrolled provider broken down by program capitation rate component and payment period. The model for scorecard payments and the reconciliation calculations will be based on the enrolled NPIs and the MCO network status at the time of the application under subsection (e)(1) of this section. For example, for a provider, HHSC will calculate the portion of each payment associated with that provider that would be paid from the MCO to the provider as follows.

(A) Monthly payments in the form of a uniform dollar increase for Component One will be equal to the total value of Component One attributed based upon historical utilization of the provider divided by twelve. An annual reconciliation will be performed for each provider based on actual utilization.

(B) For program periods beginning on or before September 1, 2023, [~~Ongoing~~] rate increases from Component Two will be a uniform percentage rate increase on applicable services calculated based on the total value of Component Two for the providers divided by historical utilization of the respective services.

(C) For purposes of the calculation described in subparagraph (B) of this paragraph, a provider must achieve a minimum number of measures as identified in §353.1322 of this subchapter to be eligible for full payment.

(2) MCOs will distribute payments to enrolled providers based on criteria established under paragraph (1) of this subsection.

(j) Non-federal share of DPP BHS payments. The non-federal share of all DPP BHS payments is funded through IGTs from sponsoring governmental entities. No state general revenue that is not otherwise available to providers is available to support DPP BHS.

(1) HHSC will communicate suggested IGT responsibilities for the program period with all DPP BHS eligible and enrolled providers at least 10 calendar days prior to the IGT declaration of intent deadline. Suggested IGT responsibilities will be based on the maximum dollars available under DPP BHS for the program period as determined by HHSC, plus 10 percent; forecasted member months for the program period as determined by HHSC; and the distribution of historical Medicaid utilization across providers, for the program period. HHSC will also communicate estimated maximum revenues each eligible and enrolled provider could earn under DPP BHS for the program period with those estimates based on HHSC's suggested IGT responsibilities and an assumption that all enrolled providers will meet 100 percent of their quality metrics.

(2) Sponsoring governmental entities will determine the amount of IGT they intend to transfer to HHSC for the entire program period and provide a declaration of intent to HHSC 21 business days before the first half of the IGT amount is transferred to HHSC.

(A) The declaration of intent is a form prescribed by HHSC that includes the total amount of IGT the sponsoring governmental entity intends to transfer to HHSC.

(B) The declaration of intent is certified to the best knowledge and belief of a person legally authorized to sign for the sponsoring governmental entity but does not bind the sponsoring governmental entity to transfer IGT.

(3) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred no fewer than 14 business days before IGT transfers are due. HHSC will instruct sponsoring governmental entities as to the IGT amounts necessary to fund the program at estimated levels. IGT amounts will include the non-federal share of all costs associated with the provider rate increase, including costs associated with MCO (Capitation) premium taxes, risk margin, and administration, plus 10 percent.

(4) Sponsoring governmental entities will transfer the first half of the IGT amount by a date determined by HHSC, but no later than June 1. Sponsoring governmental entities will transfer the second half of the IGT amount by a date determined by HHSC, but no later than December 1. HHSC will publish the IGT deadlines and all associated dates on its Internet website by March 15 of each year.

(k) Effective date of rate and dollar reimbursement increases. HHSC will direct MCOs to increase reimbursements under this section beginning the first day of the program period that includes the increased capitation rates paid by HHSC to each MCO pursuant to the contract between them.

(l) Changes in operation. If an enrolled provider closes voluntarily or ceases to provide Medicaid services, the provider must notify the HHSC Provider Finance Department by electronic mail to an address designated by HHSC, by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide Medicaid services. Notification is considered to have occurred when HHSC Provider Finance Department receives the notice.

(m) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during each program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period using the methodology described in §353.1301(g) of this subchapter.

(n) Recoupment. Payments under this section may be subject to recoupment as described in §353.1301(j) - (k) of this subchapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304035
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 707-6071

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CHAPTER 354. MEDICAID HEALTH SERVICES

SUBCHAPTER J. MEDICAID THIRD PARTY RECOVERY

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes in Texas Administrative Code (TAC), Title 1, Part 15, Chapter 354, Subchapter J, concerning Medicaid Third Party Recovery, amendments to §§354.2301, 354.2302, 354.2311, 354.2313, 354.2315, 354.2321, 354.2322, 354.2331 - 354.2334, 354.2341, 354.2343, 354.2344, and 354.2354 - 354.2356.

BACKGROUND AND PURPOSE

The federal Consolidated Appropriations Act of 2022 (H.R. 2471) amended §1902(a)(25)(I) of the Social Security Act to require a state plan for medical assistance to make certain assurances to the Secretary of Health and Human Services that state law imposes certain requirements on responsible third party health insurers.

Senate Bill (SB) 1342, 88th Legislature, Regular Session 2023, implemented H.R. 2471 by amending Texas Human Resources Code §32.0424. SB 1342 also repealed Texas Human Resources Code §32.042. Section 32.0424 requires a third party health insurer to: (i) provide certain insurance coverage information, upon timely request, to HHSC or HHSC's designee; (ii) with some exceptions, accept authorization from HHSC or HHSC's designee that an item or service is covered by Medicaid as if that authorization is a prior authorization made by the third party health insurer; and (iii) respond within 60 days to an inquiry from HHSC or HHSC's designee regarding a claim for payment for health care submitted to the third party health insurer. Further, Texas Human Resources Code §32.0424 defines "third party health insurer" to mean a health insurer or other person or arrangement that is legally responsible by state or federal law or private agreement to pay some or all claims for health care items or services provided to an individual.

One purpose of the proposed rules is to implement the recent changes to the Texas Human Resources Code as it applies to Medicaid Third Party Recovery. Additionally, the proposed rules implement other changes made to §1902(a)(25)(I) of the Social Security Act prior to H.R. 2471, such as obligating the state to require health insurers to accept the State's right of recovery and assignment to the State of any right to payment for an item or service for which payment has been made under Medicaid and to agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim or the type or format of the claim form. The proposed revisions also add and update definitions; clarify the sections of the proposed rules that would apply to managed care organizations; add HHSC's right, based on the United States Supreme Court decision in *Gallardo v. Marstiller*, 142 S. Ct. 1751 (2022), to seek reimbursement from settlement amounts representing past or future payments for medical care; and update certain outdated terms and phrases throughout TAC Chapter 354, Subchapter J.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §354.2301, Basis and Purpose, replaces "chapter" with "subchapter," replaces "Commission" with "HHSC," corrects a federal law citation, and adds subsection (b), concerning the applicability of Subchapter J, by stating it applies to Medicaid fee-for-service and specifying the sections that apply to Medicaid managed care.

The proposed amendment to §354.2302, Definitions, replaces "chapter" with "subchapter" in the introductory sentence, replaces "the Commission" with "HHSC" in the proposed amendment of the definition of "Applicant," and adds definitions for the following proposed new terms: "Capitation payment," "Coinsurance," "Copayment," "Deductible," "Designee," "HHSC," "Managed care organization (MCO)," "Medicaid," and "Medicaid Benefits." The proposed definition of "Dual Eligible" is amended to define it as "a recipient who has received, or is eligible to receive, benefits under both the Medicare and Medicaid programs." The proposed amendment to the definition of "Dual Eligible" removes "for purposes of this section, a dually eligible recipient is one who has received, or is eligible to receive, benefits under both the Medicare and Medicaid programs." Additionally, the proposed amendment to "Dual Eligible" renumbers it from twelve to seven. The proposed amendment to the definition of "Commissioner" adds "Executive" before the word "Commissioner," replaces "&" with "and," and is renumbered from two to eight. The proposed amendment to the definition of "Provider" replaces "the Commission or its designee" with "HHSC" and is renumbered from four to thirteen. The proposed amendment to the definition of "Recipient" removes "who has been certified as eligible to receive medical assistance from the" and "program by the Commission or other agency of the state" and adds "receiving benefits under" and "or CHIP." Also, "Recipient" is renumbered from five to fourteen. The proposed amendment to "State Plan" renumbers the term from six to fifteen. The proposed definition of "Third party health insurer" is amended to align it with the definition in Texas Human Resources Code §32.0424(e) and renumbers the term from nine to sixteen. The proposed amendment adds "resource" after the existing defined term of "Third party," and adds "entity," "program," and "including a third party health insurer, that" to the proposed amended definition of "Third party resource," and is renumbered from seven to seventeen. The proposed amendment renumbers the term "Title IV-D agency" from ten to eighteen. The proposed amendment deletes existing terms

and definitions for "Commission," "Third party claim," and "Plan administrator."

The proposed amendment to §354.2311, Applicant and Recipient Assignment of Rights, replaces "the Commission" with "HHSC," adds "any" before "payment," replaces the phrase "for medical care from any third party health insurer or third party" with "from a third party resource," replaces "the Commission's" and "The Commission's" with "HHSC's," adds "resource" after "third party" and removes "health insurer or third party," adds subsection (d), which recognizes HHSC's right to seek reimbursement from settlement amounts representing past or future payments for medical care under *Gallardo v. Marstiller*, 142 S. Ct. 1751 (2022), and renumbers the paragraphs to subsections (a) - (d). Along with these edits, editorial revisions are made to update numbering and references.

The proposed amendment to §354.2313, Duty of Applicant or Recipient to Inform and Cooperate, replaces "the Commission" with "HHSC;" replaces "medical" with "health care items or;" corrects a federal law citation by adding a section symbol; removes "health insurer or third party;" adds "resource" after "third party;" and updates a provision related to providing notice to HHSC by removing "to the telephone number and mailing address listed in Subchapter J Division 4," adding "according to the provisions of," and "subchapter (relating to Notices and Payments)," and removing "chapter for notices and Commission contact." The proposed amendment also corrects a reference to the Code of Federal Regulations by removing "Part 232" and replacing it with "Chapter III," replaces "the Commission's" with "HHSC's," and replaces "medical" with "health care items or." Along with these proposed amendments, grammatical and punctuation edits are also made.

The proposed amendment to §354.2315, Duty of Attorney or Representative of a Recipient, replaces "medical" with the phrase "health care items or;" replaces "the Commission" and "The Commission" with "HHSC;" adds "according," "provisions of," and "subchapter (relating to Notices and Payments)," and removes "chapter" and "for notices and Commission contact" to update the provision related to providing notice to HHSC; adds "resource" after "third party;" replaces "or third party health insurer" by adding "resource" after "third party;" corrects a federal law citation by adding a section symbol; and replaces "chapter" with "subchapter."

The proposed amendment to §354.2321, Provider Billing and Recovery from Third Party Health Insurer, changes the heading by replacing "Health Insurer" with "Resources" after "Third Party." The proposed amendment also replaces "health insurer" with "resource" after "third party," adds "by," removes "including examining the recipient's Medicaid eligibility card for third party resources and," replaces "oral or written inquiry of the recipient" with "attempt to verify with the recipient either orally or in writing," replaces "the Commission" with "HHSC," replaces "title" with "chapter," and removes "Subchapter A, Division 1." Further, the proposed amendment renumbers subsection (e) to add (e)(1) and (e)(2), to specify the different distribution procedures for fee-for-service and managed care when a provider receives payments from a third party resource but is limited to the Medicaid payable amount. The proposed amendment replaces "service" with the phrase "health care items or services." Additionally, the proposed amendment adds a new subsection (i) to prohibit providers from refusing to provide health care items or services to a Medicaid recipient because the recipient has a third party resource that may be liable for payment. The proposed amendment also adds subsections (l) and (m). Subsection (l) establishes a two year deadline after which a payment made by a third party resource to HHSC or a provider on a claim for health care provided to a Medicaid recipient becomes final and describes the circumstances under which the claim is subject to adjustment after the claim becomes final. Subsection (m) provides the procedure and notice requirements for a third party resource seeking to recover an amount it overpaid on a claim for payment for health care provided to a Medicaid recipient. The proposed amendment renumbers subsection (i) to become subsection (j). Along with these edits, editorial revisions include grammatical and formatting edits, correcting punctuation, and updating numbering and references.

The proposed amendment to §354.2322, Provider Billing and Recovery from Other Third Parties, adds "Liable" to the heading before "Third Parties." The proposed amendment also adds the phrase "health care items or" before "services," deletes subsection (a)(1) relating to outdated language about examining a "Medicaid eligibility card," replaces "the Commission" with "HHSC," deletes "Subchapter A, Division 1," replaces "title" with "chapter," replaces "parties" with "party resources," adds "resource" after "third party," adds "require a refund to Medicaid or" after "not," deletes "Subchapter J Division 4," adds "(relating to Notices and Payments)" after "chapter," and adds new subsection (l), which prohibits providers from refusing to provide health care items or services to a Medicaid recipient because the recipient has a third party resource that may be liable for payment. The proposed amendment also replaces "subsection" with "section." Further, the proposed amendment renumbers subsection (a)(2) to become subsection (b). Along with these edits, changes are made to update references to the renumbered subsection and to correct grammar and punctuation.

The proposed amendment to §354.2331, Requests for Information, replaces "the Commission" and "The Commission" with "HHSC," replaces "chapter" with "subchapter," corrects a federal law citation by adding a section symbol, removes "Subchapter J Division 4," and replaces "title" with "subchapter."

The proposed amendment to §354.2332, Distribution of Recoveries, adds the phrase "if cost effective" to subsection (a), replaces "The Commission" and "the Commission" with "HHSC," replaces "the Commission's" with "HHSC's total," replaces "Any" with "and any," replaces "parties" with "party resources," replaces "commissioner" with "Executive Commissioner," removes Subchapter J Division 4, and replaces "title" with "division." Along with these proposed amendments, grammatical edits are also made.

The proposed amendment to §354.2333, Waiver Authority of the Commissioner, replaces "commissioner" with "Executive Commissioner," replaces "parties" with "party resources," and replaces "the Commission's" with "HHSC's."

The proposed amendment to §354.2334, Notices and Payments, replaces "the Commission" with "HHSC," replaces "chapter" with "subchapter," adds "by fax or mail," removes "following address:" and "ATTN:," replaces "Health & Human Services Commission" with "Medicaid claims administrator," replaces "Liability, P.O. Box 13247, Austin, Texas 78711-3247, telephone 1-877-511-8858 or 512-482-3274" with "Liability/Tort division" after "Medicaid Third Party" and adds "Contact and address information for the Texas Medicaid claims administrator, Medicaid Third Party Liability/Tort division, can be found online in the Texas Medicaid Provider and Procedures Manual (TMPPM)."

The proposed amendment to §354.2341, Third Party Health Insurer Information Requirements, changes the heading title to add "Payment and" after "Health Insurer." The proposed amendment also implements changes made to Texas Human Resources Code §32.0424 in SB 1342. The proposed amendment adds subsection (a), which requires a third party resource to accept HHSC's right of recovery and assignment to the state of an individual or entity's right to payment for a Medicaid health care item or service provided by the Medicaid program. The proposed amendment adds subsection (b), which sets a two-year deadline after which a payment made by a third party resource to HHSC or a provider on a claim for health care provided to a Medicaid recipient becomes final and describes the circumstances under which the claim is subject to adjustment after the claim becomes final. The proposed amendment deletes existing subsections (b) and (c) because those subsections were based on Texas Human Resources Code §32.042, which SB 1342 repealed. The proposed amendment requires a third party health insurer to: (i) upon request, provide certain insurance coverage information to HHSC on persons who may be, or may have been, covered by coverage issued by the health insurer; (ii) with the exception of certain hospital or Medicare benefits or specific insurance plans, accept authorization from HHSC that an item or service is covered by Medicaid as if that authorization is a prior authorization made by the third party health insurer; and (iii) respond within 60 days to an inquiry from HHSC regarding a claim for payment for health care submitted to a third party health insurer. Further, with the exception of certain hospitals, Medicare benefits, or specific insurance plans, the proposed amendment prohibits a third party health insurer from denying a timely claim from HHSC for failure to obtain prior authorization. The proposed amendment adds subsection (g), which prohibits a third party resource from denying a timely claim submitted by HHSC when the denial is based solely on the date of submission of the claim or the type or format of the claim form. The proposed amendment adds subsection (h), which describes HHSC's right to appeal a third party resource's denial of a claim for payment when such claim is denied based on reasons listed in subsection (g). Finally, the proposed amendments renumber subsection (a) to subsection (c) and subsection (b)(8) becomes subsection (d).

The proposed amendment to §354.2343, Administrative Penalties for Failure to Provide Information, replaces "the Commission" and "The Commission" with "HHSC," replaces "The Commission's" with "HHSC's," and provides that HHSC may impose administrative penalties on an insurer who fails to provide information requested by HHSC under §354.2341 within 180 days from the date of the request. The proposed amendment also removes subsections (a)(1) - (3). Grammatical edits are also made.

The proposed amendment to §354.2344, Notice and Appeal of Administrative Penalty, replaces "the Commission" and "The Commission" with "HHSC," removes "will," "letter," and "[f]ormal." The proposed amendment also adds "Texas" before "Government." The proposed amendment also corrects a TAC rule citation by replacing "1" with the correct Chapter reference of "357, Subchapter I" and adding "Under the Administrative Procedure Act" after "Hearings" for the HHSC hearing rules. The proposed amendment also changes the numbering of the section by changing parts of subsection (a) to become subsection (b). Editorial edits include grammatical and punctuation changes, renumbering, and formatting changes.

The proposed amendment to §354.2354, Billing Medicare Intermediaries, replaces "The Commission" with "HHSC."

The proposed amendment to §354.2355, Long Term Care Providers, adds the phrase "health care items or" before "services" and replaces "the Commission" with "HHSC." Editorial edits include grammatical and formatting changes.

The proposed amendment to §354.2356, Provider Requirements to Bill Third Party Health Coverage, replaces "Third Party or Third Party Health Insurer" with "third party resource." The proposed amendment requires a health care service provider to seek reimbursement from a third party resource before billing Medicaid, except for Medicaid programs and services that are required to be paid first prior to billing the third party resource. Proposed new subsection (b) prohibits providers from billing Medicaid recipients for copayments, deductibles, or coinsurance for Medicaid-covered services and describes the procedure and circumstances under which providers must bill Medicaid for reimbursement of the copayment, deductible, or coinsurance.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules do not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will not create a new rule;

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

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities.

These rules are related to the Medicaid program and the payment for services, which is not the responsibility of small or micro-businesses or rural municipalities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons; are necessary to receive a source of federal funds or comply with federal law; and are necessary to implement legislation

that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Diane Salisbury, Texas Health and Human Services (HHS) Office of Inspector General (OIG) Chief of Data Reviews, has determined that for each year of the first five years the rules are in effect, the public benefit will further strengthen Medicaid Third Party Liability (TPL) processes by requiring health insurers and other liable third parties to be in compliance with federal and state TPL requirements.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the proposed amendments strengthen the state's ability to recover on Medicaid claims after a third party resource has been identified by, for example, (i) requiring a third party resource to respond within 60 days to a state's inquiry regarding a claim and (ii) prohibiting a third party from denying a claim on procedural requirements. There are no system impacts or other costs associated with these changes.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHS Office of Inspector General - Chief Counsel Division, P.O. Box 85200, Austin, Texas 78708, or street address 4601 W. Guadalupe St., Austin, Texas 78751-3146; or by email to IG_Rules_Comments_Inbox@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R034" in the subject line.

DIVISION 1. GENERAL PROVISIONS

1 TAC §354.2301, §354.2302

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2301. Basis and Purpose.

(a) This subchapter [~~chapter~~] implements the requirements of Texas Health & Human Services Commission (HHSC) [~~(Commission)~~] under federal and state law to:

(1) set forth the requirements of Medicaid applicants and recipients, and representatives of applicants and recipients regarding assignment, identification, and cooperation with HHSC [~~the Commission~~] in establishing third party liability and recovery;

(2) set forth the rights, restrictions, and limitations of providers to third party recovery; and

(3) establish the priority of distributions of third party recoveries, including distributions into a trust established under the provisions of the Social Security Act §1917(d)(4) (codified at 42 U.S.C. §1396p(d)(4)) [~~U.S.C 1396p(d)(4))~~].

(b) This subchapter applies:

(1) to Medicaid fee-for-service (FFS); and

(2) except for §354.2322(e) - (g) of this subchapter (relating to Provider Billing and Recovery from Other Liable Third Parties), §354.2331 of this subchapter (relating to Requests for Information), §354.2332 of this subchapter (relating to Distribution of Recoveries), and §354.2333 of this subchapter (relating to Waiver Authority of the Executive Commissioner), to Medicaid managed care.

§354.2302. Definitions.

The following words and terms, when used in this subchapter [~~chapter~~], have the following meanings unless the context clearly indicates otherwise.

(1) Applicant--An individual, or the parent or legal guardian of an individual, who has applied to HHSC [~~the Commission~~] or another agency of the state for medical assistance from the Medicaid program.

(2) Capitation payment--A fixed predetermined fee paid to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.

(3) Coinsurance--A term used to describe the percentage of money an individual is responsible for paying toward health care items or services covered by a health insurer.

(4) Copayment--A set amount of money an individual is required to pay for health care items or services covered by a health insurer.

(5) Deductible--The amount of money an individual is required to pay for health care items or services before the individual's health insurer begins paying for health care items or services.

(6) Designee--An entity to which HHSC has delegated certain functions. A designee may include:

(A) an HHSC contractor;

(B) a health and human services agency; or

(C) a managed care organization (MCO) that contracts with HHSC under Medicaid or CHIP.

(7) Dual Eligible--A recipient who has received, or is eligible to receive, benefits under both the Medicare and Medicaid programs.

(8) [~~(2)~~] Executive Commissioner--The Executive Commissioner of [~~the~~] Texas Health and [~~&~~] Human Services Commission.

(9) HHSC--The Texas Health and Human Services Commission, or its designee.

(10) Managed care organization (MCO)--A dental MCO or a health care MCO.

(11) Medicaid--The medical assistance program authorized by Title XIX of the Social Security Act, including Medicaid waiver programs.

(12) Medicaid benefits--Includes a range of health care and related services or items provided to certain groups of Medicaid recipients depending on the type of coverage needed and where the individual lives.

[~~(3) Commission--The Texas Health & Human Services Commission.~~]

(13) [~~(4)~~] Provider--Any individual or entity enrolled with the Medicaid program to provide services to Medicaid recipients for which claims for payment are submitted to HHSC [~~the Commission or its designee~~].

(14) [~~(5)~~] Recipient--A person receiving benefits under [~~who has been certified as eligible to receive medical assistance from the~~] Medicaid or CHIP [~~program by the Commission or other agency of the state~~].

(15) [~~(6)~~] State Plan--The comprehensive written statement submitted by the single state agency describing the nature and scope of the Medicaid program and giving assurances that the Medicaid program will be administered in compliance with Title XIX requirements and federal regulations.

(16) Third party health insurer--A health insurer or other person or arrangement that is legally responsible by state or federal law or private agreement to pay some or all claims for health care items or services provided to an individual, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, and pharmacy benefit managers.

(17) [~~(7)~~] Third party resource--Any person, entity, or program [~~the insurer of a person~~], including a third party health insurer, that [~~who~~] is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Plan.

[~~(8) Third party claim--A demand or right of action, which a Medicaid recipient may assert against a third party or third party health insurer.~~]

[~~(9) Third party health insurer--Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts); any for profit or nonprofit prepaid plan offering either medical services or full or partial payment for medical services; and any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.~~]

(18) [~~(10)~~] Title IV-D agency--The Office of the Attorney General, the agency in the State of Texas with the responsibility for administering or supervising the administration of the State Plan for child support enforcement under Title IV-D of the Social Security Act.

[~~(11) Plan administrator--A third-party administrator, prescription drug payer or administrator, pharmacy benefit manager, or a dental payer or administrator.~~]

[~~(12) Dual Eligible--For purposes of this section, a dually eligible recipient is one who has received, or is eligible to receive, benefits under both the Medicare and Medicaid programs.~~]

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 30, 2023.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 221-7320

DIVISION 2. APPLICANT AND RECIPIENT REQUIREMENTS

1 TAC §§354.2311, 354.2313, 354.2315

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally

funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2311. Applicant and Recipient Assignment of Rights.

(a) As a condition for eligibility, each applicant for or recipient of Medicaid benefits assigns to HHSC [~~the Commission~~] his or her rights, or the rights of any other individual eligible for Medicaid benefits under the State Plan for whom he or she can legally make an assignment, to medical support and any payment from a third party resource [~~for medical care from any third party health insurer or third party~~].

(b) [~~(1)~~] No separate assignment from the applicant or recipient is required by HHSC [~~the Commission~~] to enforce HHSC's [~~the Commission's~~] right to recover amounts paid by HHSC [~~the Commission~~] for the recipient's medical care.

(c) [~~(2)~~] HHSC's [~~The Commission's~~] right of recovery against a third party resource [~~health insurer or third party~~] is limited to the amount paid by HHSC [~~the Commission~~] on all claims submitted for Medicaid-covered services by Medicaid providers for a recipient's medical care.

(d) HHSC's right of recovery against a third party resource includes the ability to seek reimbursement from settlement amounts representing past or future payments for medical care.

§354.2313. Duty of Applicant or Recipient to Inform and Cooperate.

(a) An applicant or recipient of Medicaid benefits has a duty and responsibility to inform HHSC [~~the Commission~~] or other State agency, at the time of application, during the period of eligibility, or at any time after receiving services from the Medicaid program, of the following:

(1) any pending or unsettled claim for injuries for which a claim for health care items or [~~medical~~] services has or will be submitted to the Medicaid program for payment;

(2) the name and address of any attorney the applicant or recipient hires to represent the applicant or recipient in any claim for injuries for which a claim for health care items or [~~medical~~] services has or will be submitted to the Medicaid program for payment;

(3) any court or administrative order requiring any person to make medical support payments to the recipient or the Title IV-D agency; this duty and responsibility does not apply to any woman defined in the §1905(n)(1) (poverty level pregnant women) (codified at 42 U.S.C. §1396d(n)(1)) [~~U.S.C 1396d(n)(1))~~];

(4) the identity of the father of any child who is an applicant or recipient of Medicaid benefits, and to cooperate with the Title IV-D Agency in establishing paternity and medical support payments for the child;

(5) any third party resource [~~health insurer or third party~~] who is or may be responsible for paying for or providing health coverage to the applicant or recipient, including the name and relationship of the insured, the name of the policyholder, the policy number, the dates coverage is in effect, the date of occurrence of any accident or injury and any other information required by HHSC [~~the Commission~~] or the third party resource [~~health insurer or third party~~] to file a claim or identify the recipient as an insured or covered person; and

(6) any other resource that is or becomes available to provide or pay for health care items or [~~medical~~] services covered by the Medicaid program.

(b) An applicant or recipient, or an attorney or other person who represents or acts on behalf of an applicant or recipient, must notify and provide information regarding the existence or potential existence of any of the resources listed in subsection (a) of this section. The applicant must provide the information at the time of application, and the recipient must provide notice and information within 60 days of learning of or discovering the existence of the resource, or at the time of re-certification, whichever is sooner. Notice may be provided to HHSC [~~the Commission~~] either by telephone or by mail according to the provisions of [~~to the telephone number and mailing address listed in Subchapter J Division 4~~] §354.2334 of this subchapter (relating to Notices and Payments) [~~chapter for notices and Commission contact~~].

(c) An applicant or recipient will have his or her application for benefits denied, and a recipient will have his or her benefits terminated if the applicant or recipient fails or refuses to assign his or her own rights and [~~and/or~~] those of any other individual for whom they can legally make an assignment, or fails or refuses to cooperate with HHSC [~~the Commission~~] as required by subsection (a) of this section, unless cooperation is waived under the procedures specified at 45 Code of Federal Regulations, Chapter III [~~Part 232~~] for child support enforcement, or HHSC's [~~the Commission's~~] procedures for waiving cooperation for any other individual.

(d) The existence of an unsettled claim for damages for personal injuries will not be used by HHSC [~~the Commission~~] to deny or discontinue health care items or [~~medical~~] services under the Medicaid program.

§354.2315. Duty of Attorney or Representative of a Recipient.

(a) An attorney or other person who represents or acts on behalf of a recipient in a third party claim or action for damages for personal injuries, regardless of whether a legal action has been filed, for which health care items or [~~medical~~] services are provided and paid for by Medicaid must send written notice of representation to HHSC [~~the Commission~~]. The written notice must be signed by the attorney or representative of the recipient and sent according to the provisions of [~~address listed in Subchapter J Division 4~~] §354.2334 of this subchapter

[~~chapter~~] (relating to Notices and Payments)[~~for notices and Commission contact~~]. The written notice must be submitted within 45 days from the date the attorney or representative undertakes representation of the recipient, or from the date a potential third party resource is identified. The written notice must include the following information, if known at the time of initial filing:

(1) the name and address and identifying information of the recipient (either the date of birth and the Social Security number, or the date of birth and the Medicaid identification number);

(2) the name and address of any third party resource [~~or third party health insurer~~] against whom a third party claim is or may be asserted for injuries to the Medicaid applicant or recipient;

(3) the name and address of any health care provider who has asserted a claim for payment provided to the Medicaid applicant or recipient for health care items or [~~medical~~] services provided to the Medicaid applicant or recipient for which a third party resource may be liable for payment, whether or not the claim may have been submitted to or paid by HHSC [~~the Commission~~]; and

(4) if any of the information described in subsection (a) of this section is unknown at the time the initial notice is filed, this should be indicated on the notice, and revised if and when the information becomes known.

(b) An authorization to release information relating to the recipient directly to the attorney or representative may be included as a part of the notice and must be signed by the recipient. A notice containing an authorization for release of information will be considered valid until revoked in writing by the recipient, and no separate authorization will be required of the recipient or the attorney or the representative at the time of a request for information.

(c) Any settlement, trust, judgment, order or distribution of proceeds which is required to be disclosed to HHSC [~~the Commission~~] to carry out the purpose of this subchapter [~~chapter~~] is protected from further disclosure by HHSC [~~the Commission~~] or its agents under the provisions of the Social Security Act[~~,~~] §1902(a)(7) (codified at 42 U.S.C. §1396a(a)(7)) [~~U.S.C 1396a(a)(7)), relating to restrictions on information disclosure~~)].

(d) HHSC [~~The Commission~~] must be paid all amounts owed under this subchapter [~~chapter~~] prior to placing any proceeds from a third party resource into a trust created under the provisions of the Social Security Act §1917(d)(4) (codified at 42 U.S.C. §1396p(d)(4)) [~~U.S.C 1396p(d)(4))~~], unless HHSC [~~the Commission~~] agrees otherwise.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 30, 2023.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 221-7320

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DIVISION 3. PROVIDER REQUIREMENTS

1 TAC §354.2321, §354.2322

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2321. Provider Billing and Recovery From Third Party Resources [~~Health Insurer~~].

(a) Providers must make a good faith effort to determine whether a recipient is or may be insured by a third party resource [~~health insurer~~] at the time services are provided, by [~~including examining the recipient's Medicaid eligibility card for third party resources and~~] making a reasonable attempt to verify with the recipient either orally or in [~~or written inquiry of the recipient~~].

(b) If a third party resource [~~health insurer~~] is identified, providers are required to bill the third party resource [~~health insurer~~] before submitting a claim for payment to HHSC [~~the Commission~~] under the provisions of [~~Subchapter A, Division 1~~]§354.1003 of this chapter [~~title~~] (relating to Time Limits for Submitted Claims) unless otherwise directed by HHSC [~~the Commission~~].

(c) Providers who identify a third party resource, within 12 months from the date of service, and wish to submit a claim for payment to a third party resource [~~health insurer~~] after a claim for payment has been submitted and paid by HHSC [~~the Commission~~], must refund any amounts paid by Medicaid prior to submitting a claim for payment to the third party resource [~~insurer~~].

(d) Providers are limited to the Medicaid payable amount and the provider is required to accept the amount paid by HHSC [~~the Commission~~] as payment in full if:

(1) a claim for payment is submitted to and paid by HHSC [~~the Commission~~]; and

(2) the provider failed to inform HHSC [~~the Commission~~] at the time the claim was filed, or any time thereafter, that a third party resource [~~health insurer~~] was also billed for the same service.

(e) Payments made by a third party resource [~~health insurer~~] to a provider who is limited to the Medicaid payable amount under subsection (d) of this section must be forwarded to HHSC [~~the Commission~~] for distribution as follows:

(1) for fee-for-service (FFS), according to the provisions of [~~Subchapter J Division 4~~] §354.2334 of this subchapter [~~chapter~~] (relating to Notices and Payments); or[~~.~~]

(2) for Medicaid managed care, according to provisions as outlined in the provider's contract with an MCO.

(f) If the amount paid by a third party resource [~~health insurer~~] is less than the amount payable for the service by Medicaid, HHSC [~~the Commission~~] may be billed for the difference between the amount paid by the third party resource [~~health insurer~~] and the Medicaid payable amount, if a claim was timely filed with HHSC [~~the Commission~~] under the provisions of [~~Subchapter A, Division 1~~] §354.1003 of this chapter [~~title~~].

(g) Any provider who accepts Medicaid payment as payment in full for health care items or services and retains any amount in excess of the Medicaid payable amount from a third party resource and conceals or fails to account to HHSC [~~the Commission~~] for the third party amount, resulting in excessive or duplicate payment for the same health care items or services [~~service~~], may be referred for investigation and prosecution for violations of state or [~~and/or~~] federal Medicaid or false claims laws, or both.

(h) Providers are prohibited from submitting a bill, or other written demand for payment or collection of debt for any Medicaid-covered service from an individual who the provider knows or should know is a Medicaid eligible recipient or from the representative of a recipient, regardless of whether a claim for payment for the service is submitted to HHSC [~~the Commission~~]. This section does not prohibit a provider from submitting reasonable inquiries or requests for information to a recipient, or representative of a recipient to assist the provider in identifying a third party resource [~~insurer~~]. However, any inquiry which would lead a reasonable person to believe that the provider was making a demand for payment, or attempting to collect an unpaid debt, will bring the provider within the limitations and prohibitions as follows.[~~:~~]

(1) If a provider attempts to recover any amount from a recipient for any Medicaid-covered service, HHSC [~~the Commission~~] may provide for a reduction of an amount otherwise payable to the provider in addition to referring the provider for investigation and prosecution for violations of state or [~~and/or~~] federal Medicaid or false claims laws, or both.

(2) The amount of the reduction may be up to three times the amount the provider sought in excess of the Medicaid payable amount.

(i) Providers are prohibited from refusing to provide health care items or services to a Medicaid recipient because the recipient has a third party resource that may potentially be liable for payment of health care items or services.

(j) Eventual recovery, repayment or recoupment of money by HHSC [~~the Commission~~] or the recipient will not release or preclude referral by HHSC [~~the Commission~~] for investigation, prosecution or liability under any civil or criminal law which would otherwise apply to the unlawful conduct.

(k) [~~(j)~~] HHSC [~~The Commission~~] will not accept any claim for payment under this section [~~subsection~~] submitted after 18 months from the date of service, regardless of whether an informational claim has been timely filed.

(l) A payment made by a third party resource to HHSC or a provider on a claim for payment of a health care item or service provided to a Medicaid recipient is final on the date that is two years after the third party payment was made. After a claim is final, the claim is subject to adjustment only if an action for recovery of an overpayment was commenced under subsection (b) of this section before the date the claim became final and the recovery is agreed to by HHSC under subsection (c) of this section.

(m) If a third party resource determines that it overpaid a claim for payment, the third party resource may seek to recover all or part of the overpayment by filing a notice of its intent to seek recovery with HHSC in writing before the date the payment is final. The notice must specify all of the following:

(1) the full name of the Medicaid recipient who received the health care item or service that is the subject of the claim;

(2) the date on which the health care item or service was provided;

(3) the amount allegedly overpaid and the amount the third party resource seeks to recover;

(4) the claim number and any other number HHSC has assigned to the claim;

(5) the third party resource's rationale for seeking recovery;

(6) the date the third party resource made the payment and the method of payment used;

(7) if payment was made by check, the check number; and

(8) whether the third party resource would prefer to receive payment from HHSC, or prefer HHSC to offset the amount from a future payment.

§354.2322. Provider Billing and Recovery from Other Liable Third Parties.

(a) Providers must make a good faith effort to determine, at the time health care items or services are delivered or at any time thereafter, whether the health care items or services being provided to the recipient are a result of injuries caused by a person who is or may be liable for payment for the health care items or services.

[~~(1) The good faith effort required by this section may be satisfied by examination and verification of the recipient's Medicaid eligibility card for third party resources and/or making reasonable oral or written inquiry of the recipient at the time services are provided.~~]

(b) [~~(2)~~] Providers must submit information relating to the existence or possible existence of third party liability obtained from the recipient or legal representative of the recipient at the time a claim is submitted to HHSC [~~the Commission~~] for payment, or at any time thereafter, or when an informational claim is submitted under the provisions of [~~Subchapter A, Division 1~~]§354.1003 of this chapter [~~title~~] (relating to Time Limits for Submitted Claims).

(c) [~~(b)~~] Providers are required to pursue recovery from third party resources [~~parties~~] whose liability has been established or is

undisputed, before submitting a claim for payment to HHSC [~~the Commission~~] unless otherwise directed by HHSC [~~the Commission~~].

(d) [~~(c)~~] Providers who identify a third party resource, within 12 months from the date of service, and wish to submit a bill, or other written demand for payment or collection of debt to a third party resource after a claim for payment has been submitted and paid by HHSC [~~the Commission~~], must: refund any amounts paid by Medicaid prior to submitting a bill or other written demand for payment or collection of debt to the third party resource for payment, and; comply with the provisions of subsection (e) [~~(d)~~] of this section. This section does not require a refund to Medicaid or prohibit a provider from filing a statutory provider lien [~~or require a refund to Medicaid~~]prior to submitting reasonable requests for information to a third party resource or a representative of a recipient to assess the likelihood of recovery from a third party resource.

(e) [~~(d)~~] Providers may retain a payment from a third party resource in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

(1) the provider submits an informational claim to HHSC [~~the Commission~~] within the claim filing deadline contained in [~~Subchapter A, Division 1~~] §354.1003 of this chapter [~~title~~] indicating the identity of the third party resource from whom recovery is being pursued;

(2) the provider gives notice to the recipient, or the attorney or representative of the recipient, that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party resource, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the recipient or a representative of the recipient for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party resource or Medicaid;

(3) the provider establishes its right to payment separate of any amounts claimed and established by the recipient; and

(4) the provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the recipient or award obtained by or on behalf of the recipient, or there is an agreement between the recipient or attorney or representative of the recipient and the provider, that specifies the amount which will be paid to the provider after a settlement or award is obtained by the recipient.

(f) [~~(e)~~] Providers who have filed informational claims with HHSC [~~the Commission~~] but have not made a recovery from a third party resource within 18 months from the date of service must make a choice before the end of the 18th month from the date of service to:

(1) continue to pursue a claim against the third party resource for payment and forego the right to submit a claim for payment to Medicaid; or

(2) convert the informational claim to a claim for payment from HHSC [~~the Commission~~] and receive payment from HHSC [~~the Commission~~] as payment in full for all Medicaid-covered services.

(g) [~~(f)~~] Providers who pursue a third party resource for payment and who subsequently fail to recover from the third party resource within 18 months from the date of service, or recover less than the Medicaid payable amount within 18 months from the date of service, may submit a claim for payment to HHSC [~~the Commission~~] for the difference between the amount recovered and the Medicaid payable amount, only if the requirements of subsections (d) and (e) [~~subsection (c) and/or (d)~~] of this section are met.

(h) [~~(g)~~] Providers are limited to the Medicaid payable amount and the provider is required to accept the amount paid by HHSC as [~~the Commission~~] payment in full if a claim for payment is submitted and paid by HHSC [~~the Commission~~]:

(1) before a third party resource claim is paid; and

(2) the provider failed to comply with each of the requirements under subsections (d) and (e) [~~subsection (c) and/or (d)~~] of this section.

(i) [~~(h)~~] Except as provided by subsection (d) [~~(c)~~] of this section, payments made by third party resources [~~parties~~] to a provider, after the provider has been paid by HHSC [~~the Commission~~], must be forwarded by the provider to HHSC [~~the Commission~~] for distribution according to the provisions of [~~Subchapter J Division~~ 4]§354.2334 of this chapter (relating to Notices and Payments).

(j) [~~(i)~~] Any provider who accepts Medicaid payment as payment in full for health care items or services and retains any amount in excess of the Medicaid payable amount from a third party resource and conceals or fails to account to HHSC [~~the Commission~~] for the third party resource amount, resulting in excessive or duplicate payment for the same health care item or service may be referred for investigation and prosecution for violations of state or [~~and/or~~] federal Medicaid or false claims laws, or both.

(k) [~~(j)~~] Providers are prohibited from submitting a bill, or other written demand for payment or collection of debt for any Medicaid-covered service from an individual who the provider knows or should know is a Medicaid eligible recipient or from the legal representative of a recipient, regardless of whether a claim for payment for the service is submitted to HHSC [~~the Commission~~]. This section does not prohibit a provider from submitting reasonable requests for information to a recipient, or representative of a recipient, to assist the provider in identifying a third party resource. However, any inquiry which would lead a reasonable person to believe that the provider was making a demand for payment, or attempting to collect an unpaid debt, will bring the provider within the limitations and prohibitions as follows.[~~:~~]

(1) If a provider attempts to recover any amount from a recipient for a Medicaid covered service, HHSC [~~the Commission~~] may provide for a reduction of an amount otherwise payable to the provider in addition to referring the provider for investigation and prosecution for violations of state or [~~and/or~~] federal Medicaid or false claims laws, or both.

(2) The amount of the reduction may be up to three times the amount the provider sought in excess of the Medicaid payable amount.

[~~(3) In addition to the amount of any reduction in paragraphs (1) and (2) of this subsection, the provider may be referred for investigation and prosecution for violations of state and federal Medicaid or false claims laws.~~]

(l) Providers are prohibited from refusing to provide health care items or services to a Medicaid recipient because the recipient has a third party resource that may potentially be liable for payment of the health care items or services.

(m) [~~(k)~~] HHSC [~~The Commission~~] will not accept and cannot pay any claim for payment under this section [~~subsection~~] submitted after 18 months from the date of service, regardless of whether an informational claim has been timely filed.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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DIVISION 4. DUTIES OF THE COMMISSION

1 TAC §§354.2331 - 354.2334

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2331. Requests for Information.

(a) HHSC [~~The Commission~~] will provide assistance and cooperation to recipients, attorneys and representatives of recipients who seek recovery on behalf of HHSC [~~the Commission~~] for amounts owed to HHSC [~~the Commission~~] under this subchapter [~~chapter~~]. HHSC [~~The Commission~~] will provide information, evidence and documents required to settle and receive judgment for the amounts owed HHSC [~~the Commission~~] and provide appropriate and necessary releases and authorizations to settle and distribute amounts owed to HHSC [~~the Commission~~] under this subchapter [~~chapter~~].

(b) HHSC [~~The Commission~~] is required to safeguard the best interests of the recipient under the provisions of Social Security Act §1902(a)(19) (codified at 42 U.S.C. §1396a(a)(19)) [~~U.S.C 1396a(a)(19))~~].

(c) HHSC [~~The Commission~~] is required to provide safeguards which restrict the use and disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the Medicaid program under the provisions of Social Security Act §1902(a)(7) (codified at 42 U.S.C. §1396a(a)(7)) [~~U.S.C 1396a(a)(7))~~].

(d) Requests for information relating to third party recoveries under this subchapter [~~chapter~~] must fall within the requirements of subsections (a) and (b) of this section.

(e) A recipient or an attorney or representative of a recipient may request information relating to claims submitted or paid or payable by HHSC [~~the Commission~~], and records within the custody and control of HHSC [~~the Commission~~], as they relate to this subchapter [~~chapter~~] if:

(1) the request is signed by the recipient or a person with legal authority to act on behalf of the recipient; or

(2) the attorney or representative making the request has filed a notice which complies with the requirements of [~~Subchapter J Division 4~~]§354.2315 of this subchapter [~~title~~] (relating to Duty of Attorney or Representative of a Recipient).

(f) HHSC [~~The Commission~~] will respond to all requests for information within 10 business days from receipt of the request. HHSC [~~The Commission~~] will produce records and provide information to a person making a request under this section only if all requirements of this subsection are met. HHSC [~~The Commission~~] will provide the requested information, if all requirements of this subsection are met, within 15 business days from receipt of the request.

(g) HHSC [~~The Commission~~] has no duty to produce records or to provide information, which does not meet the requirements of this subsection, or which would disclose information which HHSC [~~the Commission~~] is prohibited from disclosing by state or federal law.

§354.2332. Distribution of Recoveries.

(a) HHSC [~~The Commission~~] will distribute third party recoveries, if cost effective, as follows:

(1) HHSC [~~the Commission~~] will receive an amount equal to HHSC's total [~~the Commission's~~] Medicaid expenditures for the recipient, or another individual eligible for Medicaid benefits under the State Plan for whom he or she can legally make an assignment to medical support and payment;

(2) the federal government will receive the federal share of the Medicaid expenditures, minus any incentive payment authorized by federal law; and

(3) the recipient will receive any remaining amount and any [~~. Any~~] amount distributed to the recipient is income or resources for purposes of establishing eligibility for Medicaid benefits.

(b) HHSC [~~The Commission~~] may pay reasonable and necessary attorney fees of fifteen percent (15%) of the entire amount recovered on behalf of HHSC [~~the Commission~~], and reasonable expenses, to a person authorized to recover amounts from third party resources [~~parties~~], other than a person contracted by HHSC [~~the Commission~~] to

recover on behalf of HHSC [~~the Commission~~], if the recovery is made in compliance with these rules.

(c) HHSC [~~The Commission~~] may pay prorated expenses not to exceed ten percent (10%) of the entire amount recovered on behalf of HHSC [~~the Commission~~] if attorney fees are allowed under subsection (b) of this section.

(d) No attorney fees will be paid if the recovery made on behalf of the Medicaid program is waived in whole or in part by the Executive Commissioner [~~commissioner~~] under the provisions of [~~Subchapter J Division 4~~]§354.2333 of this division [~~title~~] (relating to Waiver Authority of the Executive Commissioner).

(e) The amount recovered on behalf of HHSC [~~the Commission~~], for which attorney fees are authorized under this section, must be deducted from the total amount of the recovery before attorney fees and expenses are deducted under the terms of the recipient's contract.

(f) HHSC [~~The Commission~~] may pay reasonable and necessary attorney fees and expenses to a person contracted by HHSC [~~the Commission~~] to recover amounts from third party resources [~~parties~~] on behalf of the Medicaid program.

§354.2333. Waiver Authority of the Executive Commissioner.

(a) The Executive Commissioner [~~commissioner~~] has the authority to waive all or part of the state's right to recover from liable third party resources [~~parties~~] when the Executive Commissioner [~~commissioner~~] finds that enforcement of the state's right of recovery would tend to defeat the purpose of public assistance.

(b) The Executive Commissioner [~~commissioner~~] has the authority to waive all or part of the federal matching share of HHSC's [~~the Commission's~~] right to recovery from liable third party resources [~~parties~~] only if the cost of recovery exceeds the amount, which could be recovered.

§354.2334. Notices and Payments.

Notices and payments required to be submitted to HHSC [~~the Commission~~] under this subchapter [~~chapter~~] must be submitted by fax or mail to the [~~following address:~~] Texas Medicaid claims administrator [~~Health & Human Services Commission~~], [~~ATTN:~~] Medicaid Third Party Liability/Tort division [~~Liability, P.O. Box 13247, Austin, TX 78711-3247, telephone 1-877-511-8858 or 512-482-3274~~]. Contact and address information for the Texas Medicaid claims administrator, Medicaid Third Party Liability/Tort division, can be found online in the Texas Medicaid Provider and Procedures Manual (TMPPM).

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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DIVISION 5. HEALTH INSURER REQUIREMENTS

1 TAC §§354.2341, 354.2343, 354.2344

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2341. Third Party Health Insurer Payment and Information Requirements.

(a) A third party resource must accept HHSC's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the third party resource for a health care item or service provided by the Medicaid program.

(b) A payment made by a third party resource to HHSC or a provider on a claim for payment of a health care item or service provided to a Medicaid recipient is final on the date that is two years after the third party payment was made. After a claim is final, the claim is subject to adjustment only if an action for recovery of an overpayment was commenced under §354.2321(b) of this subchapter (relating to Provider Billing and Recovery From Third Party Resources) before the date the claim became final and the recovery is agreed to by HHSC under §354.2321(c) of this subchapter.

(c) Third party health [~~(a) Health~~] insurers must maintain and provide to HHSC, on request, information HHSC deems necessary to determine [~~a file system that contains the following information for each policyholder or subscriber covered by the insurer~~]:

(1) the period during which an individual entitled to medical assistance, the individual's spouse, or the individual's dependents may be, or may have been, covered by coverage issued by the health insurer [~~name, address, social security number, and date of birth of each subscriber or policyholder and each dependant of each policyholder or subscriber~~];

(2) the nature of the coverage [~~name, address, including claim submission address, of the health insurer~~]; and

(3) the name, address, and identifying number of the health plan under which the individual may be, or may have been, covered [~~mailing address of the employer~~].

[~~(b) The Commission and health insurers from whom the Commission requests information must enter into written agreements for the exchange of health insurance information relating to certified Medicaid recipients. The written agreements must contain the following mandatory terms and provisions:~~]

[~~(1) the Commission agrees to reimburse an insurer for the necessary and reasonable costs incurred in providing information requested under this subchapter;~~]

[~~(2) the Commission provides the insurer with Medicaid data tapes which contain identifying information of individuals whom the Commission certifies are applicants or recipients of services under Medicaid, or are legally responsible for an applicant or recipient of Medicaid services;~~]

[~~(3) the information requested from the insurer is specifically identified and limited to information necessary to determine whether health benefits have been or should be claimed and paid under the health insurance policy or plan for medical care or services received by an individual for whom Medicaid services would otherwise be available;~~]

[~~(4) the agreement states the time the Commission will request the data match and submit the Medicaid data tape to the insurer, and the manner in which the data match is to be conducted, and the time and the place where the information requested is to be produced to the Commission, and a method of verification of receipt by the Commission;~~]

[~~(5) the agreement limits the Commission to not more than one data match every six months;~~]

[~~(6) the agreement contains a confidentiality agreement which prohibits the health insurer from using the information received from the Commission for any purpose other than to data match insurer information against the Medicaid data tapes and prohibits any disclosure, reproduction or retention of the information for any purpose not directly related to the purpose of carrying out the requirements of the agreement;~~]

[~~(7) the agreement contains a confidentiality agreement which prohibits the Commission from using the information received from the health insurer for any purpose other than to identify Medicaid applicants or recipients, and persons legally responsible for a Medicaid applicant or recipient, who have or may have health insurance coverage through the health insurer and prohibits the Commission from further disclosure or use of the information except as required or authorized by state or federal law; and~~]

(d) [~~(8)~~] Not [~~the agreement must contain a provision which requires the insurer to comply with a request for information not~~] later than the 60th day after [~~following~~] the date a third party resource receives an inquiry from HHSC regarding a claim for payment for any health care item or service submitted to the third party resource within three years of the date the health care item or service was provided, the third party resource must respond to the inquiry [~~the request is made by the Commission~~].

[~~(c) These sections apply to plan administrators in the same manner and to the same extent as an insurer if the plan administrator has the information necessary to comply with the Commission's request for a data match.~~]

(e) A third party health insurer must accept authorization provided by HHSC that a health care item or service is covered by Medicaid as if that authorization is a prior authorization made by the third party health insurer for a health care item or service provided to an individual entitled to Medicaid that was previously paid for by HHSC and or which the third party health insurer is responsible for payment.

(f) Subsection (e) of this section does not apply to:

(1) hospital insurance benefits or supplementary insurance benefits under Part A or B of Title XVIII of the Social Security Act (codified at 42 U.S.C. §1395c et seq. or 1395j et seq.);

(2) a health care prepayment plan under Section 1833(a)(1)(A), Social Security Act (codified at 42 U.S.C. §1395l(a)(1)(A));

(3) a Medicare Advantage plan under Part C of Title XVIII of the Social Security Act (codified at 42 U.S.C. §1395w-21 et seq.);

(4) a prescription drug plan as a prescription drug plan sponsor under Part D of Title XVIII of the Social Security Act (codified at 42 U.S.C. §1395w-101 et seq.); or

(5) a reasonable cost reimbursement plan under Section 1876, Social Security Act (codified at 42 U.S.C. §1395mm).

(g) A third party resource may not deny a claim submitted by HHSC for which payment was made under the Medicaid program solely on the basis of the date of submission of the claim, the type or format of the claim form, or for a responsible third party resource, other than a third party resource described in subsection (f)(1) - (5) of this section, a failure to obtain prior authorization for the health care item or service for which the claim is being submitted, if:

(1) the claim is submitted by HHSC not later than the third anniversary of the date the health care item or service was provided; and

(2) any action by HHSC to enforce the State's rights with respect to the claim is commenced not later than the sixth anniversary of the date HHSC submits the claim.

(h) If a third party resource denies a claim for payment submitted by HHSC for reasons outlined in subsection (g) of this section, HHSC may appeal the claim without any limitation on the number of appeals.

§354.2343. Administrative Penalties for Failure to Provide Information.

(a) HHSC [~~The Commission~~] may impose administrative penalties on an insurer who fails to provide information requested by HHSC as required by §354.2341(c) of this division (relating to Third Party Health Insurer Payment and Information Requirements) within 180 days from the date of the request.[:]

[~~(1) does not comply with a request for data match information under a written agreement with the Commission as required by the written agreement; and~~]

[~~(2) more than 180 days have passed since the date the request was made by the Commission; or~~]

[(3) refuses to enter into a written agreement with the Commission to provide information requested by the Commission as required by Subchapter J Division 5 §354.2341(b) of this title (relating to Third Party Insurers Information Requirements).]

(b) If the insurer does not provide the requested information, the administrative penalty will be assessed on a daily basis for each day of non-compliance beginning on the day following the 180th day HHSC [the Commission] made a request for information[,] and continuing until the information is received by HHSC [the Commission].

(1) HHSC's [The Commission's] request for information may be made by any method that [, which] provides verification of receipt.

(2) The 180th day will be calculated from the date HHSC [the Commission] obtains written or electronic verification of receipt by the insurer.

(c) The amount of the administrative penalty may not exceed $10,000 per day for each day of non-compliance. The amount of the administrative penalty will be based on:

(1) the seriousness of the non-compliance, including the nature, circumstances, extent, and gravity of the non-compliance;

(2) the economic harm caused by the non-compliance;

(3) the history of previous non-compliance;

(4) the amount necessary to deter future non-compliance;

(5) efforts made by the insurer to correct the non-compliance; and

(6) other factors presented by the insurer or HHSC [the Commission] which affect the amount and the appropriateness of the administrative penalty.

§354.2344. Notice and Appeal of Administrative Penalty.

(a) HHSC [The Commission] will send the insurer a Notice of Administrative Penalty at least 30 days prior to the date that administrative penalties [will] begin to accrue.

(b) The notice will contain the following information:

(1) the date on which administrative penalties [will] begin to accrue if the information requested by HHSC [the Commission] is not received on or before that date; and

(2) the amount of the administrative penalty which will be assessed for each day of non-compliance after the date indicated on the notice [letter].

(c) [(b)] If the insurer does not submit the information on or before the date on which administrative penalties begin to accrue, penalties will be assessed as stated in the notice [letter].

(d) [(c)] An insurer may request a hearing in writing within 20 days of receiving written notice from HHSC [the Commission] of administrative penalty.

(e) [(d)] If a hearing is requested, the hearing is a contested case under the Administrative Procedure Act, Texas Government Code[,] Chapter 2001, and HHSC's [the Commission's] formal hearing rules in Chapter 357, Subchapter I [1] of this title (relating to [Formal] Hearings Under the Administrative Procedure Act).

(f) [(e)] If an insurer fails to submit a request for hearing within 20 days from the date of the notice [letter], or fails to appear at a scheduled hearing, the right to a hearing is waived and the amount of penalties assessed per day of non-compliance is final.

(g) [(f)] The order of administrative penalty will be reported to the attorney general for collection.

(h) [(g)] The enforcement of the penalty may be stayed during the time the order is under judicial review if the insurer pays the penalty assessed as of the date of the order to the clerk of the court or files a supersedeas bond with the court in the amount of the penalty. An insurer who cannot afford to pay the penalty or file the bond may stay the enforcement by filing an affidavit in the manner required by the Texas Rules of Civil Procedure for a party who cannot afford to file security for costs, subject to the right of HHSC[the Commission] to contest the affidavit as provided by the Texas Rules of Civil Procedure.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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DIVISION 6. BILLING AND PAYMENT GUIDELINES

1 TAC §§354.2354 - 354.2356

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; Texas Government Code §531.102(a), which grants HHS OIG the responsibility for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and which provides HHS OIG with the authority to obtain any information or technology necessary to enable it to meet its responsibilities; Texas Government Code §531.102(a-2), which requires the Executive Commissioner of HHSC to work in consultation with the Office of the Inspector General to adopt rules necessary to implement a power or duty of the office; Texas Government Code §531.102(x), which requires the Executive Commissioner of HHSC, in consultation with the office, to adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas, to administer Medicaid funds, and to adopt rules necessary for the proper and efficient regulations of the Medicaid program; Texas Government Code §531.1131(e), which requires the

Executive Commissioner of HHSC to adopt rules necessary to implement Section 531.1131, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by Section 531.1131; and Texas Human Resources Code §32.039, which provides authority to assess administrative penalties and damages and provides due process for persons potentially subject to damages and penalties.

The proposed amendments affect Texas Government Code §531.0055 and Texas Human Resources Code §32.0421 and §32.0424.

§354.2354. Billing Medicare Intermediaries.

HHSC [~~The Commission~~] shall pursue reimbursement of Medicaid expenditures from each fiscal intermediary who makes a payment to a service provider on behalf of the Medicare program, including a reimbursement for a payment made to a home health services provider or nursing facility for services rendered to a dually eligible individual.

§354.2355. Long Term Care Providers.

(a) A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare certified must:

(1) seek reimbursement from Medicare before billing the Medicaid program [~~Program~~] for health care items or services provided to an individual who is eligible to receive similar services under the Medicare program; and[~~.~~]

(2) as directed by HHSC [~~the Commission~~], appeal Medicare claim denials for payment.

(b) A nursing facility, home health services provider, or any other similar long-term care services provider that is Medicare certified is not required to seek reimbursement from Medicare before billing the Medicaid program [~~Program~~] for a person who is:

(1) Medicare eligible; and

(2) has been determined as not being homebound.

(c) For health care items or services in subsection (a) of this section, a payment or denial remittance from Medicare is required prior to Medicaid considering payment.

§354.2356. Provider Requirements to Bill Third Party Health Coverage.

(a) To the extent allowed by federal law, a health care service provider must seek reimbursement from any third party resource [~~Third Party or Third Party Health Insurer~~] that the provider knows about or should know about before billing Medicaid, except for Medicaid programs and services that are required to be paid first prior to billing the third party resource [~~billing the medical assistance program~~].

(b) Providers cannot bill Medicaid recipients for copayments, deductibles, or coinsurance for Medicaid-covered services. If a recipient's third party resource does not cover a copayment, deductible, or coinsurance, the provider must bill Medicaid for reimbursement of the copayment, deductible, or coinsurance, as follows.

(1) Deductible or coinsurance: Include the explanation of benefits from the third party resource with the claim showing the payment amount was applied directly to the recipient's deductible or coinsurance.

(2) Copayment: Include the copayment code on the claim form in order to be eligible for reimbursement.

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TITLE 7. BANKING AND SECURITIES

PART 6. CREDIT UNION DEPARTMENT

CHAPTER 97. COMMISSION POLICIES AND ADMINISTRATIVE RULES

SUBCHAPTER B. FEES

7 TAC §97.113

The Credit Union Commission (the Commission) proposes amendments to 7 TAC, Chapter 97, Section 97.113 concerning fees and charges, waiver of fees and semi-annual assessments.

Specifically, the rule changes will:

- fund necessary additional security and operating costs,

- allow the commissioner to reduce, not simply waive, operating fees for individual credit unions,

- align the annual operating fee matrix and methodology with other financial institutions' operating fees methodology, and

- realign the asset size brackets to reflect current asset growth of regulated credit unions.

Texas Finance Code, Section 15.402 (c), authorizes the Commission to establish reasonable and necessary fees for the administration of the Credit Union Department.

Proposed amendments to paragraph (b) include changes to the fee schedule as follows:

1. Changes the base operating fee for the first $200,000 in assets to the first $3 million in assets.

2. Changes the base assessment amount from $200 to $1,450.

3. Deletes the category of $200 thousand to $1 million.

4. Changes the category of $1 million to less than $10 million to $3 million to less than $10 million.

5. Decreases the rate from a base of $1,500 to $1,450 and decreases the percentage assessed from .00034 to .00025 of assets on assets between $3 million and $10 million.

6. Deletes two specific categories from $10 million to $25 million and $25 million to $50 million.

7. Changes the category of $50 million to $100 million to $10 million to $100 million.

8. Decreases the base amount of the $10 million to $100 million category from $4,560 to $3,200.

9. Fixes the percentage assessment on assets between $10 and $100 million from a range of .00014 to .00019 to a new rate of .000165.

10. Decreases the base assessment for assets between $100 million and $500 million from $20,410 to $18,050.

11. Increases the percentage assessed on assets between $100 million and $500 million from .00008 to .00010.

12. Increases the base assessment for assets between $500 million and $1 billion from $52,410 to $58,050.

13. Increases the percentage assessed on assets between $500 million and $1 billion from .000072 to .000082.

14. Increases the base assessment for assets between $1 billion and $2 billion from $88,410 to $99,050.

15. Increases the percentage assessed on assets between $1 billion and $2 billion from .000069 to .000078.

16. Changes the category of $2 billion and over to $2 billion but less than $6.8 billion.

17. Increases the base amount on the $2 billion and over category from $157,410 to $177,050 (an increase of $19,640).

18. Adds a category of $6.8 billion and over of assets.

19. Sets a base amount for over $6.8 billion in assets of $474,650.

20. Reduces the percentage assessed on assets over $6.8 billion from .000062 to .000040.

Proposed amendments to (c), adds the ability of the Commissioner to reduce the operating fee of an individual credit union, in addition to being able to waive the fee.

STATE AND LOCAL GOVERNMENTS

Michael S. Riepen, Commissioner, has determined that for the first five-year period that the rule changes are in effect there will be no fiscal implications for state and local government as a result of enforcing or administering the rule changes.

STATEMENT OF PUBLIC COST AND BENEFITS

Mr. Riepen has also determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the proposed amendments because it will provide for investment by the Department in technology, training, data security, addressing financial risks and addressing operational risks.

SMALL AND MICRO BUSINESSES AND RURAL COMMUNITIES

Mr. Riepen has also determined that for each year of the first five years the rule changes are in effect, there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. This will increase regulatory costs to credit unions with assets larger than $238 million and two credit unions under $1 million in assets. Allowing the commissioner to reduce fees in addition to waiving them provides flexibility in mitigating any impact to an institution. The maximum $19,640 proposed fee increase for the larger credit unions is of an amount that is considered immaterial to the profitable operations of these institutions.

GOVERNMENT GROWTH IMPACT STATEMENT

- Except as may be described below to the contrary, for each year of the first five years that the rules will be in effect, the rules will not:

- Create or eliminate a government program;

- Require the creation of new employee positions or the elimination of existing employee positions;

- Require an increase or decrease in future legislative appropriations to the agency;

- Create new regulations;

- Expand, limit, or repeal an existing regulation;

- Increase or decrease the number of individuals subject to the rule's applicability; or

- Positively or adversely affect this state's economy.

NEED FOR DEPARTMENT OPERATING FLEXIBILITY

Adjustments to the operating fee will provide for nominal, but much needed, funds for operations flexibility. This is needed for strategic expenditures related to:

- Investment in cybersecurity related to the systems utilized by the Credit Union Department.

- Investment in technology upgrades.

- Creation of a position for a full-time training examiner and a Subject Matter Expert related to more complex, and/or problematic CU operations.

- Investment in an internal audit and internal controls.

- Implementation of a succession plan related to future retirements in key positions.

- Additional flexibility to fund unexpected operating costs.

PARITY WITH REGARD TO OTHER DEPOSITORY INSTITUTIONS

Changes to the operating fee schedule will provide for greater parity with other depository institutions who currently charge higher incremental rates at most asset levels. The Texas Finance Code, Section 15.402(b)(3) provides for in adopting rules "the commission shall consider the need to (3) preserve and protect the competitive parity of credit unions with regard to other depository institutions consistent with the safety and soundness (c) requires that "The commission by rule shall establish reasonable and necessary fees for the administration of this chapter and Subtitle D, Title 3." (The Texas Credit Union Act).

COMMENTS

Written comments on the proposed amendments may be submitted to Michael S. Riepen, Commissioner, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699 or by email to CUDMail@cud.texas.gov. To allow the Commission sufficient time to fully address all the comments it receives, all comments must be received on or before 5:00 p.m. on the 31st day after the date the proposal is published in the *Texas Register.*

AUTHORITY

The rule changes are proposed under Texas Finance Code, Section 15.402, which authorizes the Commission to adopt reason-

able rules for administering Texas Finance Code Title 2, Chapter 15 and Title 3, Subtitle D.

The statutory provision authorizing the proposed amendments is Texas Finance Code, Section 15.402 (c), regarding establishing reasonable and necessary fees for the administration of the Credit Union Department.

§97.113. Fees and Charges.

(a) Remittance of fees.

(1) Each credit union authorized to do business under the Act shall remit to the department an annual operating fee. The fee shall be paid in semi-annual installments, billed effective September 1 and March 1 of each year. The final installment may be adjusted as provided by subsection (d) of this section. Installments received after September 30 or March 30 of each year will be subject to a monthly 10% late fee unless waived by the commissioner for good cause.

(2) Credit unions that exit the Texas credit union system on or before August 31 or February 28 of a given year, will not be subject to the semi-annual assessment for the period beginning September 1 or March 1, respectively. Only those credit unions leaving the state credit union system prior to the close of business on those dates avoid paying the semi-annual assessment for the period beginning September 1 or March 1, as applicable.

(b) Calculation of operating fees. The schedule provided in this section shall serve as the basis for calculating operating fees. The base date shall be June 30 of the year in which operating fees are calculated. The asset base may be reduced by the amount of reverse-repurchase balances extant on the June 30 base date. The commissioner is authorized to increase the fee schedule once each year as needed to match revenue with appropriations. An increase greater than 5% shall require prior approval of the commission. The commissioner shall notify the commission of any such adjustment at the first meeting of the commission following the determination of the fee schedule.
Figure: 7 TAC §97.113(b)
[~~Figure: 7 TAC §97.113(b)~~]

(c) Waiver or reduction of operating fees. The commissioner is authorized to waive or reduce the operating fee for an individual credit union when good cause exists. The commissioner shall document the reason(s) for each waiver or reduction of operating fees and report such waiver or reduction to the commission at its next meeting.

(d) Adjustment of an installment. The commissioner in the exercise of discretion may, after review and consideration of actual revenues to date and projected revenues for the remainder of the fiscal year, lower the amount of the final installment due from credit unions.

(e) Supplemental examination fees.

(1) If the commissioner or deputy commissioner schedules a special examination in addition to the regular examination, the credit union is subject to a supplemental charge to cover the cost of time and expenses incurred in the examination.

(2) The credit union shall pay a supplemental fee of $50 for each hour of time expended on the examination. The commissioner may waive the supplemental fee or reduce the fee, individually or collectively, as he deems appropriate. Such waiver or reduction shall be in writing and signed by the commissioner. The department shall fully explain the time and charges for each special examination to the president or designated official in charge of operations of a credit union.

(f) Foreign credit union branches. Credit unions operating branch offices in Texas as authorized by §91.210 of this title (relating to Foreign Credit Unions) shall pay an annual operating fee of $500 per branch office.

(g) Credit union conversion fee. A credit union organized under the laws of the United States or of another State that converts to a credit union organized under the laws of this State shall remit to the department an annual operating fee within 30 days after the issuance of a charter by the commissioner. The schedule provided in subsection (b) of this section shall serve as the basis for calculating the operating fee. All provisions set forth in subsection (b) of this section shall apply to converting credit unions with the following exceptions:

(1) Should the effective date of the conversion fall on or after October 31, the base date shall be the calendar quarter end immediately preceding the issuance date of a charter by the commissioner.

(2) The amount of the operating fee calculated under this section will be prorated based upon the number of full months remaining until September 1. For example, should the effective date of the conversion be January 31, the converting credit union will remit seven-twelfths of the amount of the operating fee calculated using December 31 base date.

(3) Any fee received more than 30 days after the issuance of a charter will be subject to a monthly 10% late fee unless waived by the commissioner for good cause.

(h) Mergers/Consolidations. In the event a credit union in existence as of June 30 merges or consolidates with another credit union and the merger/consolidation is completed on or before August 31, the surviving credit union's asset base, for purposes of calculating the operating fee prescribed in subsection (b) of this section, will be increased by the amount of the merging credit union's total assets as of the June 30 base date.

(i) Special assessment. The commission may approve a special assessment to cover material expenditures, such as major facility repairs and improvements and other extraordinary expenses.

(j) Foreign credit union fee for field of membership expansion. A foreign credit union applying to expand its field of membership in Texas shall pay a fee of $200. This fee shall be paid at the time of filing to cover the cost of processing the application. In addition, the applicant shall pay any cost incurred by the department in connection with a hearing conducted at the request of the applicant.

(k) Foreign credit union examination fees.

(1) If the commissioner schedules an examination of a foreign credit union, the credit union is subject to supplemental charges to cover the cost of time and expenses incurred in the examination.

(2) The foreign credit union shall pay a fee of $50 for each hour of time expended by each examiner on the examination. The commissioner may waive the examination fee or reduce the fee as he deems appropriate.

(3) The foreign credit union shall also reimburse the department for actual travel expenses incurred in connection with the examination, including mileage, public transportation, food, and lodging in addition to the fee set forth in paragraph (2) of this subsection. The commissioner may waive this charge at his discretion.

(l) Contract Services. In addition, the commissioner may charge, or otherwise cause to be paid by, a credit union, a foreign credit union or related entities the actual cost incurred by the department for an examination or a review of all or part of the operations or activities of a credit union, a foreign credit union or related entity that is performed under a personal services contract entered into between the department and third parties.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304078
Michael S. Riepen
Commissioner
Credit Union Department
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 837-9236

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TITLE 16. ECONOMIC REGULATION

PART 8. TEXAS RACING COMMISSION

CHAPTER 311. OTHER LICENSES

SUBCHAPTER A. LICENSING PROVISIONS

DIVISION 1. OCCUPATIONAL LICENSES

16 TAC §311.2

The Texas Racing Commission (TXRC) proposes amendments to an existing rule in Texas Administrative Code, Title 16, Part 8, Chapter 311, Subchapter A, Division 1, Occupational Licenses, §311.2, Application Procedure, concerning the occupational licensing application procedures. This amendment is referred to as a "proposed rule amendment." The purpose of this rule amendment is to address the changes in the Texas Racing Act made during the 88th Legislative Session. Effective September 1, 2023, the Texas Occupations Code § 2025.260, Temporary Licenses was repealed, and the statute was amended to conform with licensing standards found in Chapter 53, Texas Occupations Code, which, among other standards applies the requirements for a criminal background check before a license is issued. The proposed rule changes bring the agency into compliance with its statute and allows the agency to conform with the provisions of Texas Occupations Code § 2025.251-262.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §311.2 to update the language to allow for online license submissions as well as provide notice that applicants must go through a qualification process including a criminal background check before they are licensed.

GOVERNMENT GROWTH IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rules will not affect the local economy, so the Commission is not required to prepare a local employment impact statement under Government Code § 2001.022.

For each year of the first five years the proposed rules will be in effect, Amy F. Cook, Executive Director has determined the following:

The proposed rule amendment does not create or eliminate a government program.

Implementation of the proposed rule amendment does not require the creation of new employee positions or the elimination of existing employee positions.

Implementation of the proposed rule amendment does not require an increase or decrease in future agency legislative appropriations.

The proposed rule amendment does not require an increase or decrease in fees paid to the agency.

The proposed rule amendment does not create a new regulation.

The proposed rule amendment does expand, limit, or repeal an existing regulation.

The proposed rules do not increase or decrease the number of individuals subject to the proposed rule amendment's applicability.

The proposed rule amendment does not positively or adversely affect this state's economy.

ECONOMIC IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of an Economic Impact Statement as detailed under Texas Government Code § 2006.002, is not required.

REGULATORY FLEXIBILITY ANALYSIS

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of a Regulatory Flexibility Analysis as detailed under Texas Government Code § 2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

Amy F. Cook, Executive Director, has determined that no private real property interests are affected by the proposed rule amendments, and the proposed rule amendments do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rule amendments do not constitute a taking or require a takings impact assessment under Texas Government Code § 2007.043.

LOCAL EMPLOYMENT IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed amendments are not expected to have any fiscal implications for state or local government as outlined in Texas Government Code § 2001.024(A)(6).

COST-BENEFIT ANALYSIS

Amy F. Cook, Executive Director has determined that the proposed rule amendments are expected to reduce the overall costs of the licensing process by encouraging licensees to become licensed before a horse is entered in a race (typically a week before the race is scheduled) rather than waiting until the horse has been entered and causing the horse to be removed from the race because the owner failed to meet the requirement for a criminal background check (which typically take 10 business days) and the availability of agency staff to accept, review and process the new or renewed license (which can from 21-60 days).

FISCAL NOTE ANALYSIS

Amy F. Cook, Executive Director has determined that no significant fiscal impact is associated with the proposed rule change.

PUBLIC COMMENTS

All comments or questions regarding the proposed amendment may be submitted in writing within 30 days following publication of this notice in the *Texas Register,* via webpage comment form at https://www.txrc.texas.gov/texas-rules-of-racing or through the agency customer service desk at customer.service@txrc.texas.gov, or by telephone at (512) 833-6699.

STATUTORY AUTHORITY

The amendments are proposed under Tex. Occ. Code § 2023.004, which authorizes the Commission to adopt rules to administer the Act.

No other statute, code, or article is affected by the proposed amendments.

§311.2. Application Procedure.

(a) General Requirements. To request a license from the Commission, a person must apply to the Commission on forms prescribed by the executive director [~~secretary~~].

(b) Application Submission [~~Site~~].

(1) [~~Except as provided in paragraphs (2) and (3) of this subsection, an~~] An applicant for an occupational license must file the appropriate application form and related documents at the licensing office at a licensed racetrack or through an online process established by the executive director. All applications must be submitted to the agency at least thirty-one days before the licensee engages in an activity that requires an occupational license under 16 TAC § 311.1.

~~[(2) An applicant for the following occupational license types may file the appropriate application form and related documents by mail to the main office of the Commission in Austin; kennel owner, kennel owner/owner, kennel owner/owner/trainer, kennel owner/trainer, owner, owner/trainer, trainer, multiple owner/stable/farm registration, training facility employee, and training facility general manager/CEO.]~~

~~[(3) An applicant for an occupational license that is available through the Texas OnLine portal may submit the required application information through the Texas OnLine portal.]~~

(2) [~~(c)~~] Examinations. The Commission may require the applicant for an occupational license to demonstrate the applicant's knowledge, qualifications, and proficiency for the license applied for by an examination prescribed by the Commission.

(c) [~~(d)~~] Issuance of License.

(1) The stewards or racing judges may review any application for an occupational license and deny a license if the stewards or racing judges determine:

(A) grounds for denial of the license exist under §311.6 of this title (relating to Denial, Suspension, and Revocation of Licenses); or

(B) if the applicant or a member of the applicant's family or household currently holds a Commission license, after considering the nature of the licenses sought or held by the applicant, issuing a license to the applicant would create a conflict of interest that might affect the integrity of pari-mutuel racing.

(2) An occupational licensee may not act in any capacity other than that for which he or she is licensed.

(3) The stewards or racing judges may issue a license subject to the applicant satisfying one or more conditions, as specified by the stewards, or racing judges, which reasonably relate to the applicant's qualifications or fitness to perform the duties of the license sought.

(d) [~~(e)~~] License Badge.

(1) The Commission shall issue a certificate identification card in the form of a license badge to each individual licensed under this subchapter.

(2) The badge must bear the seal of the Commission.

(3) The badge must contain:

(A) the licensee's full name;

(B) the licensee's photograph;

(C) the category of license;

(D) the month and year in which the license expires;

(E) a color code that designates whether the licensee has access to the stable or kennel area; and

(F) the license number assigned by the Commission.

(4) If a badge issued under this section is lost or stolen, the licensee shall immediately notify the Commission and may apply for a duplicate badge with the same terms as the original badge. To apply for a duplicate badge, the licensee must:

(A) file a sworn affidavit stating that the badge was lost, stolen, or destroyed;

(B) surrender any remaining portion of the badge; and

(C) pay a duplicate badge fee in an amount set by the Commission.

(e) [~~(f)~~] License provisions for military service members, military spouses, and military veterans.

(1) The terms "military service member," "military spouse," and "military veteran" shall have the same meaning as those terms are defined in Texas Occupations Code, Chapter 55.

(2) Credit for Military Service. Military service members and military veterans will receive credit toward any experience requirements for a license as appropriate for the particular license type and the specific experience of the military service member or veteran.

(3) Credit for holding a current license issued by another jurisdiction. Military service members, military spouses, and military veterans who hold a current license issued by another jurisdiction that has licensing requirements that are substantially equivalent to the license in this state will receive credit toward any experience requirements for a license as appropriate for the particular license type.

(4) Supporting documentation must be submitted with the license application.

(5) The executive director may waive any prerequisite to obtaining a license for an applicant who is a military service member, military veteran, or military spouse, after reviewing the applicant's credentials.

(6) Expedited license procedure. As soon as practicable after a military service member, military veteran, or military spouse files an application for a license, the commission will process the application and issue the license to an applicant who qualifies under this section.

(7) License application and examination fees will be waived for the initial application of an applicant who qualifies under this subsection.

(8) Military spouse acting under out-of-state license. A military spouse who holds a racing license issued by another jurisdiction and who wishes to participate in racing in Texas under that license shall submit to the Commission the information required by Section 55.0041 of the Texas Occupations Code. Upon receipt of such information, the Commission shall determine whether the requirements of Section 55.0041 are satisfied and notify the military spouse that the person is authorized to act under that section if it confirms, through communication with the other jurisdiction or through other means, that:

(A) the jurisdiction that issued the license on which the military spouse is relying to act in Texas has substantially equivalent license requirements; and

(B) the military spouse is licensed in good standing in the other jurisdiction.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304087
Amy F. Cook
Executive Director
Texas Racing Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 833-6699

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SUBCHAPTER B. SPECIFIC LICENSES

16 TAC §311.101

The Texas Racing Commission (TXRC) proposes rule amendments and a repeal of selected language in Texas Administrative Code, Title 16, Part 8, Chapter 311, Subchapter B, §311.101 concerning specific licensing provisions for horse owners. This amendment is referred to as a "proposed rule amendment." The purpose of this rule amendment is to address the changes in the Texas Racing Act made during the 88th Legislative Session. Effective September 1, 2023, the Texas Occupations Code § 2025.260, Temporary Licenses was repealed, and the statute was amended to conform with licensing standards found in Chapter 53, Texas Occupations Code, which, among other standards applies the requirements for a criminal background check before a license is issued. The proposed rule changes bring the agency into compliance with its statute and allows the agency to conform with the provisions of Texas Occupations Code § 2025.251-262.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §311.101 to update the language to conform with the updated version of the Texas Racing Act, specifically, the provisions of Texas Occupations Code § 2025.251-262.

GOVERNMENT GROWTH IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rules will not affect the local economy, so the Commission is not required to prepare a local employment impact statement under Government Code § 2001.022.

For each year of the first five years the proposed rules will be in effect, Amy F. Cook, Executive Director has determined the following:

The proposed rule amendment does not create or eliminate a government program.

Implementation of the proposed rule amendment does not require the creation of new employee positions or the elimination of existing employee positions.

Implementation of the proposed rule amendment does not require an increase or decrease in future agency legislative appropriations.

The proposed rule amendment does not require an increase or decrease in fees paid to the agency.

The proposed rule amendment does not create a new regulation.

The proposed rule amendment does expand, limit, or repeal an existing regulation.

The proposed rules do not increase or decrease the number of individuals subject to the proposed rule amendment's applicability.

The proposed rule amendment does not positively or adversely affect this state's economy.

ECONOMIC IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of an Economic Impact Statement as detailed under Texas Government Code § 2006.002, is not required.

REGULATORY FLEXIBILITY ANALYSIS

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of a Regulatory Flexibility Analysis as detailed under Texas Government Code § 2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

Amy F. Cook, Executive Director, has determined that no private real property interests are affected by the proposed rule amendments, and the proposed rule amendments do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rule amendments do not constitute a taking or require a takings impact assessment under Texas Government Code § 2007.043.

LOCAL EMPLOYMENT IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments are not expected to have any fiscal implications for state or local government as outlined in Texas Government Code § 2001.024(A)(6).

COST-BENEFIT ANALYSIS

Amy F. Cook, Executive Director has determined that the proposed rule amendments are expected to reduce the overall costs of the licensing process by encouraging licensees to become li-

censed before a horse is entered in a race (typically a week before the race is scheduled) rather than waiting until the horse has been entered and causing the horse to be removed from the race because the owner failed to meet the requirement for a criminal background check (which typically take 10 business days) and the availability of agency staff to accept, review and process the new or renewed license (which can from 21-60 days).

FISCAL NOTE ANALYSIS

Amy F. Cook, Executive Director has determined that no significant fiscal impact is associated with the proposed rule change.

PUBLIC COMMENTS

All comments or questions regarding the proposed amendment may be submitted in writing within 30 days following publication of this notice in the *Texas Register,* via webpage comment form at https://www.txrc.texas.gov/texas-rules-of-racing or through the agency customer service desk at customer.service@txrc.texas.gov, or by telephone at (512) 833-6699.

STATUTORY AUTHORITY

The amendments are proposed under Tex. Occ. Code § 2023.004, which authorizes the Commission to adopt rules to administer the Act.

No other statute, code, or article is affected by the proposed amendments.

§311.101. Horse Owners.

(a) General Provisions.

(1) The owner of a horse, as listed on the animal's registration paper, must obtain an owner's license from the Commission. Except as otherwise provided by §313.301(a)(2) of this title (relating to Officials and Rules of Horse Racing), a person may not be licensed as an owner if the person is not the owner of record of a properly registered horse that the person intends to race in Texas. A person who meets the qualifications for a trainer's or assistant trainer's license may also be licensed as an owner if the person intends to be the owner of record of a properly registered horse during the time of licensure. Except as otherwise provided by this subsection, the owner or designated trainer acting on behalf of the owner, must be licensed before making a request to enter a horse eligible under 16 TAC §313.103. [~~one hour prior to the post time of the first race of the day in which the owner intends to race the animal.~~]

(2) If the owner is not an individual, each individual who is a director, officer, or partner of the owner or who has an ownership interest in the horse of 5.0% or more must be licensed by the Commission.

(3) If the owner is not an individual, the owner must provide to the Commission:

(A) a sworn statement by the chief executive officer of the owner or by one of the partners of the owner that the officer or partner represents the owner and is responsible for the horse;

(B) a statement that the owner is authorized by law to do business in Texas; and

(C) a list of the names and addresses of all individuals having an ownership interest in the horse.

(4) If the owner is not an individual, the ownership entity must:

(A) designate a representative; or

(B) file an authorized agent form with the Commission and pay the prescribed fee.

(5) If the registered owner of a horse is a minor, a financial responsibility form approved by the executive director [~~secretary~~] must be signed by the parent or guardian of the owner assuming financial responsibility for the debts incurred for the training and racing of the horse.

(b) Stable Names.

(1) An owner that wants to participate in racing using a stable name must register with the Commission by filing an application on a form prescribed by the executive director [~~secretary~~] and paying the prescribed fee. A person may not use the real name of an owner of a race animal as a stable name. A stable name which has already been registered with the Commission may not be registered by another owner.

(2) Registering a stable name with the Commission does not affect a person's obligation to file or register a fictitious name as provided by the laws of Texas.

(3) An application to register a stable name must disclose the real names of all interests participating in the stable and the percentage of ownership interest of each, including the interest owned by a corporation, general partnership, limited partnership, trust, estate or individual.

(4) A stable name may be changed by registering a new stable name. A stable name may be abandoned by giving written notice to the Commission. A change of 5.0% or more in ownership of a stable registered under a stable name shall be immediately reported to the Commission.

(5) A licensee who has registered a stable name under this section may not use the licensee's real name for racing purposes except on approval of the stewards.

(c) Change of Ownership.

(1) If the owner of an interest in a horse housed on an association's grounds transfers that interest to another person, both parties to the transaction shall give written notice of the transfer to the stewards officiating for that association. Notice under this section must be submitted to the appropriate officials not later than 24 hours after the agreement to transfer the interest is made.

(2) A licensee of the Commission may not transfer an ownership interest in a horse to avoid disqualification of the horse.

(d) Change of Trainer. An owner may change the trainer of his or her horse registered at a licensed race meeting provided:

(1) the request to change trainers is submitted for approval to the stewards on a form provided by the association and approved by the executive director [~~stewards~~];

(2) the trainer from whom the horse is being transferred signs the form releasing custody of the horse;

(3) the trainer to whom the horse is being transferred signs the form accepting responsibility for the horses; and

(4) the stewards approve the transfer.

(e) Owner/Trainer. A person licensed as an owner/trainer who is training horses at a racetrack may not have any horse owned by the owner/trainer under the care, custody, or control of another trainer at that racetrack.

(f) Restrictions on Racing. An owner may not enter a horse or cause a horse to be entered in a race at a racetrack if:

(1) the owner or trainer is employed by the racetrack association in a management or supervisory position that is capable of affecting the conduct of races or pari-mutuel wagering at the racetrack; or

(2) the owner or trainer is involved in any way with the sale or publication of tip sheets on association grounds.

~~[(g) Emergency License.]~~

~~[(1) If an owner is unable to complete an application for an owner's license because of absence or illness, the licensed trainer desiring to enter a horse in a race may apply for an emergency owner's license on behalf of the absent owner.]~~

~~[(2) The trainer applying for an emergency owner's license on behalf of an absent owner must submit a written statement with the license application specifying the reasons the owner is unable to complete the application.]~~

~~[(3) The trainer applying for an emergency owner's license must submit at least the following information: the owner's full name, home or business address, and telephone number. At the time of application, the appropriate licensing fee must be paid to the Commission. Failure to provide all of the foregoing information is grounds for denial of an emergency owner's license.]~~

~~[(4) If an owner submits an incomplete application for an owner's license, the application will remain in pending status until:]~~

~~[(A) the owner submits any additional information required to process the application;]~~

~~[(B) the application expires in accordance with the term of the applied-for license; or]~~

~~[(C) a horse is entered in the owner's name or in the name of a multiple owner of which the owner is a member, in which case the pending license will be presumed to be a request for an emergency license.]~~

~~[(5) A license issued under this section expires on the 21st day after the date the emergency owner's license is issued. An owner may obtain only one emergency license per year. An emergency license cannot be issued if the owner failed to complete the prior licensing process.]~~

~~[(6) An owner granted an emergency license is prohibited from withdrawing any funds from his/her horseman's bookkeeper account until the owner complies with all licensing procedures provided by subsection (a) of this section.]~~

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304088
Amy F. Cook
Executive Director
Texas Racing Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 833-6699

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CHAPTER 313. OFFICIALS AND RULES OF HORSE RACING

SUBCHAPTER E. TRAINING FACILITIES

16 TAC §313.501

The Texas Racing Commission (TXRC) proposes amendments to an existing rule in Texas Administrative Code, Title 16, Part 8, Chapter 313, Subchapter E, Training Facilities §313.501, Training Facility License, concerning the training facility licensing requirements and costs. This amendment is referred to as a "proposed rule amendment." The purpose of this rule amendment is to reduce training facility licensing costs to offset any costs required by rule amendments to §313.504 and §313.505, which require increased safety protocols for equine and human athletes participating in Texas horseracing.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §313.501(a) to reduce training facility licensing costs, and §313.501(d) to allow licensed Class 1 racetracks to operate as a training facility without going through an additional licensing process.

GOVERNMENT GROWTH IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rules will not affect the local economy, so the Commission is not required to prepare a local employment impact statement under Government Code § 2001.022.

For each year of the first five years the proposed rules will be in effect, Amy F. Cook, Executive Director has determined the following:

The proposed rule amendment does not create or eliminate a government program.

Implementation of the proposed rule amendment does not require the creation of new employee positions or the elimination of existing employee positions.

Implementation of the proposed rule amendment does not require an increase or decrease in future agency legislative appropriations.

The proposed rule amendment does not require an increase or decrease in fees paid to the agency.

The proposed rule amendment does not create a new regulation.

The proposed rule amendment does expand, limit, or repeal an existing regulation.

The proposed rules do not increase or decrease the number of individuals subject to the proposed rule amendment's applicability.

The proposed rule amendment does not positively or adversely affect this state's economy.

ECONOMIC IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of an Economic Impact Statement as detailed under Texas Government Code § 2006.002, is not required.

REGULATORY FLEXIBILITY ANALYSIS

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of a Regulatory Flexibility Analysis as

detailed under Texas Government Code § 2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

Amy F. Cook, Executive Director, has determined that no private real property interests are affected by the proposed rule amendments, and the proposed rule amendments do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rule amendments do not constitute a taking or require a takings impact assessment under Texas Government Code § 2007.043.

LOCAL EMPLOYMENT IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments are not expected to have any fiscal implications for state or local government as outlined in Texas Government Code § 2001.024(A)(6).

COST-BENEFIT ANALYSIS

Amy F. Cook, Executive Director has determined that the proposed rule amendments are expected to reduce the overall number of injuries to equine and human athletes. The agency removed the cost of the training facility license fee ($1800.00) to provide resources to pay for the additional cost as well as extended the period for which the license is effective. In addition, Class I racetracks, upon request and without further application may now be licensed as training facilities.

FISCAL NOTE ANALYSIS

Amy F. Cook, Executive Director has determined that no significant fiscal impact is associated with the proposed rule change.

PUBLIC COMMENTS

All comments or questions regarding the proposed amendment may be submitted in writing within 30 days following publication of this notice in the *Texas Register,* via webpage comment form at https://www.txrc.texas.gov/texas-rules-of-racing or through the agency customer service desk at customer.service@txrc.texas.gov, or by telephone at (512) 833-6699.

STATUTORY AUTHORITY

The amendments are proposed under Tex. Occ. Code § 2023.004, which authorizes the Commission to adopt rules to administer the Act.

No other statute, code, or article is affected by the proposed amendments.

§313.501. Training Facility License.

(a) A training facility must be licensed by the Executive Director [~~Commission~~] in accordance with this section to provide official workouts. Except as otherwise provided by this subchapter, an official workout obtained at a training facility licensed under this section satisfies the workout requirements of §313.103 of this title (relating to Eligibility Requirements).

(b) A training facility license expires two years [~~one year~~] after the last day of the month in which the license was issued. [~~An applicant for a training facility license must submit with the application documents the license fee of $1,800.~~]

(c) A training facility license is personal to the licensee and may not be transferred.

(d) A Class 1 racetrack licensed by the Commission may also operate a training facility without an additional license requirement if the racetrack association operating the Class 1 racetrack submits a request for training facility dates with its annual race date application form and the request is approved by the Executive Director.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304089
Amy F. Cook
Executive Director
Texas Racing Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 833-6699

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16 TAC §313.504

The Texas Racing Commission (TXRC) proposes rule amendments of selected language in Texas Administrative Code, Title 16, Part 8, Chapter 313, Subchapter E, Training Facilities, §313.504, Operational Requirements. This amendment is referred to as a "proposed rule amendment." The purpose of this rule amendment is to implement increased safety protocols for Texas horseracing. As of November 1, 2023, there have been nine (9) equine catastrophic breakdowns during live racing events, and eight (8) additional breakdowns during training events that have also resulted in head and collarbone injuries to jockeys and exercise riders. The proposed rule changes require Mobile Intensive Care Unit capabilities for human athletes and two functional Equine Ambulances with veterinary staffing for equine athletes to respond to serious injuries.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §313.504(d) to require a comparable level of emergency response capabilities to address serious injuries that are currently required at licensed racetracks during live racing at training facilities when the activities performed, including schooling races, official works and exercise riding are performed in preparation for a live racing event. The requirement for an e-wagering plan to address the prohibition on wagering at training facilities is including §313.504(d). Additional language changes update the term "executive secretary" to "executive director" for consistency throughout the Texas Rules of Racing.

GROWTH IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rules will not affect the local economy, so the Commission is not required to prepare a local employment impact statement under Government Code § 2001.022.

For each year of the first five years the proposed rules will be in effect, Amy F. Cook, Executive Director has determined the following:

The proposed rule amendment does not create or eliminate a government program.

Implementation of the proposed rule amendment does not require the creation of new employee positions or the elimination of existing employee positions.

Implementation of the proposed rule amendment does not require an increase or decrease in future agency legislative appropriations.

The proposed rule amendment does not require an increase or decrease in fees paid to the agency.

The proposed rule amendment does not create a new regulation.

The proposed rule amendment does expand, limit, or repeal an existing regulation.

The proposed rules do not increase or decrease the number of individuals subject to the proposed rule amendment's applicability.

The proposed rule amendment does not positively or adversely affect this state's economy.

ECONOMIC IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of an Economic Impact Statement as detailed under Texas Government Code § 2006.002, is not required.

REGULATORY FLEXIBILITY ANALYSIS

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of a Regulatory Flexibility Analysis as detailed under Texas Government Code § 2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

Amy F. Cook, Executive Director, has determined that no private real property interests are affected by the proposed rule amendments, and the proposed rule amendments do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rule amendments do not constitute a taking or require a takings impact assessment under Texas Government Code § 2007.043.

LOCAL EMPLOYMENT IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule repeal and rule amendments are not expected to have any fiscal implications for state or local government as outlined in Texas Government Code § 2001.024(A)(6).

COST-BENEFIT ANALYSIS

Amy F. Cook, Executive Director has determined that the proposed rule amendments are expected to reduce the overall number of injuries to equine and human athletes. The agency removed the cost of the training facility license fee ($1800.00) in a related rule amendment to §313.501 to provide resources to pay for the additional cost as well as extended the period for which the license is effective. In addition, Class I racetracks, upon request and without further application may now be licensed as training facilities.

FISCAL NOTE ANALYSIS

Amy F. Cook, Executive Director has determined that no significant fiscal impact is associated with the proposed rule change.

PUBLIC COMMENTS

All comments or questions regarding the proposed amendment may be submitted in writing within 30 days following publication of this notice in the *Texas Register,* via webpage comment form at https://www.txrc.texas.gov/texas-rules-of-racing or through the agency customer service desk at customer.service@txrc.texas.gov, or by telephone at (512) 833-6699.

STATUTORY AUTHORITY

The amendments are proposed under Tex. Occ. Code § 2023.004, which authorizes the Commission to adopt rules to administer the Act.

No other statute, code, or article is affected by the proposed amendments.

§313.504. Operational Requirements.

(a) The primary business of a training facility must be the training of racehorses. The training facility must be available to provide official workouts on a schedule approved by the executive director [~~secretary~~], but at least three days per week.

(b) A training facility licensee shall prohibit any wagering at the facility and shall promptly eject any person who is found to be wagering. All training facilities located at licensed racetracks shall have an e-wagering plan approved by the Executive Director, as set out in Sec. 321.603, before the first date of an approved official work schedule.

(c) A training facility licensee shall ensure that veterinary services and facilities are available to the training facility in close enough proximity to permit a response time of one hour or less. The veterinary services and facilities are subject to the approval of the executive director [~~secretary~~].

(d) A training facility licensee shall comply with the requirements of Sec. 309.117, First Aid and Sec. 309.254, Equine Ambulance, during the period where the racetrack association allows occupational licensees to conduct official works or exercise horses on the racetrack.

(e) [~~(d)~~] A training facility licensee shall maintain records regarding the management and operation of the training facility and the records are subject to inspection by the executive director [~~secretary~~]. A training facility licensee shall cooperate fully with and shall promptly provide any information requested by the Executive Director in the regulation of training facilities. [~~the Commission, the executive secretary, and the Department of Public Safety in the regulation of training facilities and shall promptly provide any information requested by the Commission, the executive secretary, or the Department of Public Safety.~~]

(f) [~~(e)~~] A training facility licensee shall post in a condition book approved by the executive director with any conditions imposed by the racetrack association along with [~~prominent place~~] a list of the dates and times that official workouts may be obtained.

(g) [~~(f)~~] A training facility licensee shall comply with all the requirements of this subchapter. Failure to continuously comply with those requirements is grounds for disciplinary action by the executive director [~~Commission~~], including suspension or revocation of the training facility license.

(h) [~~(g)~~] The facilities and operations of a licensed training facility are subject to inspection and verification by the executive director [~~secretary~~] at any time. If the executive director [~~secretary~~] determines that inappropriate or unsafe conditions exist at the training facility or that the integrity of workouts obtained at the facility are in question, the executive director [~~secretary~~] may immediately notify the pari-mutuel racetracks in this state that workouts obtained at the facility may not be accepted as official workouts. The executive director [~~secretary~~] shall notify the general manager or chief executive officer of the li-

censed training facility of the executive director [~~secretary's~~] findings and specifically describe the corrective action necessary to make the facility's workouts official, to rectify the inappropriate condition, or to make the conditions safe. The training facility may take the necessary corrective action or request a hearing with the Commission on the executive director [~~secretary's~~] findings.

(i) [~~(h)~~] A training facility licensee may not, unless otherwise approved by the executive director:

(1) conduct a race at its facility; or

(2) allow its facility to be used for a race.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304090
Amy F. Cook
Executive Director
Texas Racing Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 833-6699

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16 TAC §313.505

The Texas Racing Commission (TXRC) proposes rule amendments of selected language in Texas Administrative Code, Title 16, Part 8, Chapter 313, Subchapter E, Training Facilities, §313.505, Workout Requirements. The purpose of this rule amendment is to implement increased safety protocols for Texas horseracing. As of November 1, 2023, there have been nine (9) equine catastrophic breakdowns during live racing events, and eight (8) additional breakdowns during training events that have also resulted in head and collarbone injuries to jockeys and exercise riders. The proposed rule changes require the addition of three (3) staff members to monitor track conditions and activities during official works as well as related rule amendments in §313.504 to provide Mobile Intensive Care Unit capabilities for human athletes and two functional Equine Ambulances with veterinary staffing to respond to serious injuries. These standards are in place for live racing events but are not currently required for training events.

SECTION-BY-SECTION SUMMARY

The proposed rule amends §313.505 require the addition of three (3) staff members to monitor track conditions and activities during official works as an increased safety measure.

GOVERNMENT GROWTH IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rules will not affect the local economy, so the Commission is not required to prepare a local employment impact statement under Government Code § 2001.022.

For each year of the first five years the proposed rules will be in effect, Amy F. Cook, Executive Director has determined the following:

The proposed rule amendment does not create or eliminate a government program.

Implementation of the proposed rule amendment does not require the creation of new employee positions or the elimination of existing employee positions.

Implementation of the proposed rule amendment does not require an increase or decrease in future agency legislative appropriations.

The proposed rule amendment does not require an increase or decrease in fees paid to the agency.

The proposed rule amendment does not create a new regulation.

The proposed rule amendment does expand, limit, or repeal an existing regulation.

The proposed rules do not increase or decrease the number of individuals subject to the proposed rule amendment's applicability.

The proposed rule amendment does not positively or adversely affect this state's economy.

ECONOMIC IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of an Economic Impact Statement as detailed under Texas Government Code § 2006.002, is not required.

REGULATORY FLEXIBILITY ANALYSIS

Amy F. Cook, Executive Director, has determined that the proposed rule amendments will have no adverse economic effect on small businesses, micro-businesses, or rural communities, therefore preparation of a Regulatory Flexibility Analysis as detailed under Texas Government Code § 2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

Amy F. Cook, Executive Director, has determined that no private real property interests are affected by the proposed rule amendments, and the proposed rule amendments do not restrict, limit, or impose a burden on an owner's rights to his or her private real property that would otherwise exist in the absence of government action. As a result, the proposed rule amendments do not constitute a taking or require a takings impact assessment under Texas Government Code § 2007.043.

LOCAL EMPLOYMENT IMPACT STATEMENT

Amy F. Cook, Executive Director, has determined that the proposed rule repeal and rule amendments are not expected to have any fiscal implications for state or local government as outlined in Texas Government Code § 2001.024(A)(6).

COST-BENEFIT ANALYSIS

Amy F. Cook, Executive Director has determined that the proposed rule amendments are expected to reduce the overall number of injuries to equine and human athletes. The agency removed the cost of the training facility license fee ($1800.00) in a related rule amendment to §313.501 to provide resources to pay for the additional cost of staffing during official works and exercising periods as well as extended the period for which the license is effective.

FISCAL NOTE ANALYSIS

Amy F. Cook, Executive Director has determined that no significant fiscal impact is associated with the proposed rule change.

PUBLIC COMMENTS

All comments or questions regarding the proposed amendment may be submitted in writing within 30 days following publication of this notice in the *Texas Register,* via webpage comment form at https://www.txrc.texas.gov/texas-rules-of-racing or through the agency customer service desk at customer.service@txrc.texas.gov, or by telephone at (512) 833-6699.

STATUTORY AUTHORITY

The amendments are proposed under Tex. Occ. Code § 2023.004, which authorizes the Commission to adopt rules to administer the Act.

No other statute, code, or article is affected by the proposed amendments.

§313.505. Workout Requirements.

(a) All official workouts must be supervised by the following officials, who must be licensed and approved by the executive director [~~secretary~~]:

(1) a timer/clocker;

(2) a horse identifier; and

(3) a starter, and an assistant starter;[~~,~~]

(4) two outriders to address track safety issues.

(b) The person riding a horse in an official workout must hold a valid Commission license as a jockey, apprentice jockey, or exercise rider, or as the trainer or assistant trainer of the horse.

(c) The horse identifier shall identify each horse before each official workout. The original registration papers for each horse that is to work, or a copy that satisfies the horse identifier, must be submitted to the horse identifier before the horse's initial workout at the facility to permit the identifier to record the horse's color, gender, markings, and tattoo number, if applicable. The horse identifier shall inspect all documents of ownership, registration, or breeding necessary to ensure the proper identification of the horse. The identification procedures used at the training facility are subject to the approval of the executive director. [~~secretary. The individual serving as the horse identifier may serve as timer or starter also, with the approval of the executive secretary. The timer may not serve as the starter.~~]

(d) A training race conducted at a licensed pari-mutuel racetrack may be used as an official workout. The distance of an official workout must be at least:

(1) 220 yards for a quarter horse;

(2) two furlongs, for a two-year old thoroughbred; and

(3) three furlongs, for a thoroughbred three years of age or older.

(e) A workout must be timed on a stopwatch that is accurate to within .01 of a second. Times for quarter horses shall be rounded to tenths of one second and times for thoroughbred horses shall be rounded to fifths of one second.

(f) An individual may not ride a horse in an official workout unless the individual is wearing a properly fastened helmet of a type approved by the executive director. [~~secretary.~~]

(g) Each official workout must be recorded on a form prescribed by the executive director [~~secretary~~]. Not later than 24 hours after the day of an official workout, a training facility shall transmit the results of the workout to:

(1) the official past performance publisher;

(2) the executive director [~~Commission~~]; and

(3) each pari-mutuel horse racetrack in this state that is:

(A) conducting a live race meeting for the same breed of horse as the horse that was worked; or

(B) will, in 45 days or less after the date of the workout, commence a live race meeting for the same breed of horse as the horse that was worked.

(h) A horse may not have more than one official workout on a calendar day.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on October 31, 2023.

TRD-202304091
Amy F. Cook
Executive Director
Texas Racing Commission
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 833-6699

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TITLE 22. EXAMINING BOARDS

PART 30. TEXAS STATE BOARD OF EXAMINERS OF PROFESSIONAL COUNSELORS

CHAPTER 681. PROFESSIONAL COUNSELORS

SUBCHAPTER C. APPLICATION AND LICENSING

22 TAC §681.72

The Texas Behavioral Health Executive Council proposes amendments to §681.72, relating to Required Application Materials.

Overview and Explanation of the Proposed Rule. The proposed amendments delete the requirement that an applicant must receive a passing score on either the NCE or NCMHCE within five years of the date of application. The licensure exams for other types of behavioral health licensees, such as psychologists and marriage and family therapists, do not have a time limit or expiration for their examination scores. Therefore, this five year expiration for a passing scores is being proposed to be deleted.

Fiscal Note. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or

administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

Public Benefit. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to licensees, applicants, and the general public because the proposed rule will provide greater clarity and consistency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

Probable Economic Costs. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

Small Business, Micro-Business, and Rural Community Impact Statement. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

Regulatory Flexibility Analysis for Small and Micro-Businesses and Rural Communities. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

Local Employment Impact Statement. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

Requirement for Rules Increasing Costs to Regulated Persons. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

Government Growth Impact Statement. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

Takings Impact Assessment. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

Request for Public Comments. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the Texas Register.

Applicable Legislation. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

Statutory Authority. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §503.2015 of the Tex. Occ. Code the Texas State Board of Examiners of Professional Counselors previously voted and, by a majority, approved to propose this rule to the Executive Council. The rule is specifically authorized by §503.2015 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also proposes this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 503 and 507 of the Texas Occupations Code and may propose this rule.

Lastly, the Executive Council proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§681.72. Required Application Materials.

(a) To apply for LPC Associate, the applicant must submit:

(1) the Council's application form;

(2) all applicable fees;

(3) official examination results from the National Board of Certified Counselors verifying a passing score on the National Counselor Exam (NCE) or National Clinical Mental Health Counselor Exam (NCMHCE); [~~issued no more than five (5) years before the date the application was received;~~]

(4) completion certificate for the Texas jurisprudence exam dated no more than six months before the date the application was received;

(5) an official graduate transcript(s);

(6) a practicum/graduate intern documentation form;

(7) a supervisory agreement form; and

(8) The holder of a current license in good standing issued by another jurisdiction equivalent to the Texas LPC Associate license must submit official verification of his or her license, including official verification of any supervised experience recognized by the issuing jurisdiction. If supervised experience cannot be verified by the issuing jurisdiction, the Council may consider a supervised experience documentation form with verification of the supervisor's credentials.

(b) To apply for LPC as the holder of a current Texas LPC Associate license, the applicant must submit:

(1) the Council's application form;

(2) all applicable fees;

(3) completion certificate for the jurisprudence exam dated no more than six months before the date the application for LPC was received;

(4) the Council's supervised experience documentation form; and

(5) other information or forms as requested by the Council.

(c) To apply for LPC as the holder of a current license equivalent to a Texas LPC license issued by another jurisdiction, the applicant's license must be in good standing and must submit:

(1) all of the items listed in subsection (a)(1)-(5) of this section;

(2) official verification of the license, including official verification of any supervised experience recognized by the issuing jurisdiction; and

(3) other information or forms as requested by the Council.

~~[(4) The five-year expiration of the NCE or NCMHCE score does not apply to an applicant who has held a license issued by a United States jurisdiction in good standing for at least two (2) years before the date the application for LPC was received.]~~

(d) To apply for supervisor status, an LPC must:

(1) have held the LPC license in good standing for at least 60 months;

(2) submit an application and all applicable fees; and

(3) submit a completion certificate for an acceptable supervisor training. An acceptable supervisor training is:

(A) a doctoral level course in the supervision of professional counseling or mental health services which was taken for credit at an accredited school and documented on an official transcript; the qualifying doctoral level course may have been completed no more than five (5) years before the date the application for supervisor status was received; or

(B) a 40-clock-hour supervision course as set forth in §681.147 of this title (relating to 40-ClockHour Supervisor Training Course); the qualifying 40-clock-hour supervision course may have been completed no more than two (2) years before the date the application for supervisor status was received.

(e) An applicant who holds a current LPC license in good standing issued by another jurisdiction must be substantially equivalent to Texas licensure requirements.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304079
Darrel D. Spinks
Executive Director
Texas State Board of Examiners of Professional Counselors
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 305-7706

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PART 34. TEXAS STATE BOARD OF SOCIAL WORKER EXAMINERS

CHAPTER 781. SOCIAL WORKER LICENSURE

SUBCHAPTER B. RULES OF PRACTICE

22 TAC §781.323

The Texas Behavioral Health Executive Council proposes amendments to §781.323, relating to Technology in Social Work Practice.

Overview and Explanation of the Proposed Rule. The proposed amendments provide clarification regarding telehealth practice.

Fiscal Note. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

Public Benefit. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to licensees, applicants, and the general public because the proposed rule will provide greater clarity and consistency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

Probable Economic Costs. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

Small Business, Micro-Business, and Rural Community Impact Statement. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

Regulatory Flexibility Analysis for Small and Micro-Businesses and Rural Communities. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

Local Employment Impact Statement. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

Requirement for Rules Increasing Costs to Regulated Persons. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

Government Growth Impact Statement. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

Takings Impact Assessment. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

Request for Public Comments. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register.*

Applicable Legislation. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

Statutory Authority. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §505.2015 of the Tex. Occ. Code the Texas State Board of Social Worker Examiners previously voted and, by a majority, approved to propose this rule to the Executive Council. The rule is specifically authorized by §505.2015 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also proposes this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 505 and 507 of the Texas Occupations Code and may propose this rule.

Lastly, the Executive Council proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§781.323. Technology in Social Work Practice.

When social workers use technology to provide services, they are subject to all rules and statutes, including this chapter and Occupations Code, Chapter 505, as if providing face to face services. Licensees who provide professional services to clients or supervision to supervisees outside the State of Texas must comply with the laws and rules of Texas and of the out-of-state authority which govern the practice of social work. Electronic practice may be utilized by licensees, but it must meet the same standards of practice as licensees who practice face to face services.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

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Darrel D. Spinks
Executive Director
Texas State Board of Social Worker Examiners
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 305-7706

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SUBCHAPTER C. APPLICATION AND LICENSING

22 TAC §781.412

The Texas Behavioral Health Executive Council proposes amendments to §781.412, relating to Examination Requirement.

OVERVIEW AND EXPLANATION OF THE PROPOSED RULE. The proposed amendments will eliminate the requirement that an applicant must receive a passing score on the ASWB national examination within two years prior to the initial or upgrade application. The rule as proposed will still require a passing score before the date of application, but examination scores older than two years will no longer expire for licensure purposes. The licensure exams for other types of behavioral health licensees, such

as psychologists and marriage and family therapists, do not have a time limit or expiration for their examination scores. Therefore, this two year expiration for a passing scores is being proposed to be deleted.

FISCAL NOTE. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

PUBLIC BENEFIT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to licensees, applicants, and the general public because the proposed rule will provide greater clarity and consistency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

PROBABLE ECONOMIC COSTS. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT STATEMENT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO-BUSINESSES AND RURAL COMMUNITIES. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

LOCAL EMPLOYMENT IMPACT STATEMENT. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

REQUIREMENT FOR RULES INCREASING COSTS TO REGULATED PERSONS. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

GOVERNMENT GROWTH IMPACT STATEMENT. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

TAKINGS IMPACT ASSESSMENT. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register.*

APPLICABLE LEGISLATION. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

STATUTORY AUTHORITY. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

In accordance with §505.2015 of the Tex. Occ. Code the Texas State Board of Social Worker Examiners previously voted and, by a majority, approved to propose this rule to the Executive Council. The rule is specifically authorized by §505.2015 of the Tex. Occ. Code which states the Board shall propose to the Executive Council rules regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice; continuing education requirements for license holders; and a schedule of sanctions for violations of this chapter or rules adopted under this chapter.

The Executive Council also proposes this rule in compliance with §507.153 of the Tex. Occ. Code. The Executive Council may not propose and adopt a rule regarding the qualifications necessary to obtain a license; the scope of practice, standards of care, and ethical practice for a profession; continuing education requirements; or a schedule of sanctions unless the rule has been proposed by the applicable board for the profession. In this instance, the underlying board has proposed this rule to the Executive Council. Therefore, the Executive Council has complied with Chapters 505 and 507 of the Texas Occupations Code and may propose this rule.

Lastly, the Executive Council proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§781.412. Examination Requirement.

(a) An applicant for licensure or specialty recognition must pass an examination designated by the Council.

(b) Applicants must have received a passing score on the ASWB national examination prior to the date of the application. [~~within the two-year period preceding the date of the initial or upgrade application. The Council will not accept an exam score received more than two years prior to the date of the initial or upgrade application.~~]

(c) The Council may waive the examination for an applicant with a valid certificate or license from another state if the certificate or license was issued before January 1, 1986, if petitioned in writing.

(d) On the basis of a verified report from ASWB that an applicant has cheated on the examination, the application shall be denied.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

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Darrel D. Spinks
Executive Director
Texas State Board of Social Worker Examiners
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For further information, please call: (512) 305-7706

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PART 41. TEXAS BEHAVIORAL HEALTH EXECUTIVE COUNCIL

CHAPTER 882. APPLICATIONS AND LICENSING

SUBCHAPTER B. LICENSE

22 TAC §882.23

The Texas Behavioral Health Executive Council proposes amendments to §882.23, relating to License Required to Practice.

Overview and Explanation of the Proposed Rule. The proposed amendments are intended to clarify when an individual is conducting a professional service in Texas, which is regulated by the Executive Council.

Fiscal Note. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

Public Benefit. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to applicants, licensees, and the general public because the proposed rule will provide greater clarity, consistency, and efficiency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

Probable Economic Costs. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

Small Business, Micro-Business, and Rural Community Impact Statement. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

Regulatory Flexibility Analysis for Small and Micro-Businesses and Rural Communities. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

Local Employment Impact Statement. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

Requirement for Rules Increasing Costs to Regulated Persons. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

Government Growth Impact Statement. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

Takings Impact Assessment. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register.*

Applicable Legislation. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

Statutory Authority. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§882.23. License Required to Practice.

(a) A person may not engage in or represent that the person is engaged in the practice of marriage and family therapy, professional counseling, psychology, or social work within this state, unless the person is licensed or otherwise authorized to practice by law.

(b) A person is engaged in the practice of marriage and family therapy within this state if any of the criteria set out in §502.002(6) of the Occupations Code occurs while a client is located [~~either in whole or in part~~] in this state.

(c) A person is engaged in the practice of professional counseling within this state if any of the criteria set out in §503.003(a) of the Occupations Code occurs while a client is located [~~either in whole or in part~~] in this state.

(d) A person is engaged in the practice of psychology within this state if any of the criteria set out in §501.003(b) of the Occupations Code occurs while a client is located [~~either in whole or in part~~] in this state.

(e) A person is engaged in the practice of social work within this state if any of the criteria set out in §505.0025 of the Occupations Code occurs while a client is located [~~either in whole or in part~~] in this state.

(f) In accordance with §113.002 of the Occupations Code, a licensee of the Executive Council may provide a mental health service, that is within the scope of the license, through the use of a telehealth service to a client who is located outside of this state, subject to any applicable regulation of the jurisdiction in which that client is located. Such conduct does not constitute the practice of marriage and family therapy, professional counseling, psychology, or social work in this state.

(g) For the purposes of this rule, the term "client" means:

(1) a recipient of marriage and family therapy, professional counseling, psychology, or social work services within the context of a professional relationship, including a child, adolescent, adult, couple, family, group, organization, community, or other populations, or other entities receiving services;

(2) an individual or entity requesting the services (e.g., an employer, a state, tribal, or federal court, an attorney acting on behalf of his or her client, an office or agency within local, state, or federal government) and the recipient of those services (e.g., the subject of an evaluation, assessment, or interview);

(3) an organization such as a business, charitable, or governmental entity that receives services directed primarily to the organization, rather than to individuals associated with the organization;

(4) minors and wards in guardianships, as well as their legal guardians; and

(5) any related term for the recipient of services, such as a patient, evaluee, examinee, interviewee, participant, or any other similar term.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

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Darrel D. Spinks
Executive Director
Texas Behavioral Health Executive Council
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 305-7706

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22 TAC §882.28

The Texas Behavioral Health Executive Council proposes new §882.28, relating to Update to Degree on a License.

Overview and Explanation of the Proposed Rule. The proposed new rule implements a process to update the degree listed on a license.

Fiscal Note. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

Public Benefit. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to applicants, licensees, and the general public because the proposed rule will provide greater clarity, consistency, and efficiency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

Probable Economic Costs. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

Small Business, Micro-Business, and Rural Community Impact Statement. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

Regulatory Flexibility Analysis for Small and Micro-Businesses and Rural Communities. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

Local Employment Impact Statement. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

Requirement for Rules Increasing Costs to Regulated Persons. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

Government Growth Impact Statement. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

Takings Impact Assessment. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register*.

Applicable Legislation. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

Statutory Authority. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§882.28. Update to Degree on a License.

(a) A licensee may update a sub-doctoral degree listed on his or her official license to a doctoral degree if the licensee submits a complete application and transcript, pays the required fee, and provides any other information or supportive documentation deemed relevant by the Council.

(b) Licensees must submit an official transcript in accordance with §882.2 of this chapter indicating the date the doctoral degree was awarded or conferred. Foreign doctoral degrees must be evaluated in accordance with §882.11 of this chapter.

(c) A doctoral degree must meet the minimum degree requirements for the applicable license.

(d) An application to update the degree on a license is not an application for licensure, and therefore is not subject to any appeal or review under §882.3 of this chapter or Chapter 2001 of the Government Code. Further, the staff review and processing of an application under this rule is not subject to the processing times referenced in §882.9 of this chapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

TRD-202304071
Darrel D. Spinks
Executive Director
Texas Behavioral Health Executive Council
Earliest possible date of adoption: December 17, 2023
For further information, please call: (512) 305-7706

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CHAPTER 883. RENEWALS
SUBCHAPTER A. GENERAL PROVISIONS

22 TAC §883.1

The Texas Behavioral Health Executive Council proposes amendments to §883.1, relating to Renewal of a License.

OVERVIEW AND EXPLANATION OF THE PROPOSED RULE. The proposed amendments require licensees selected for audit during renewal to obtain and submit a National Practitioner Data Base self-query. Current Council rule §882.2 requires new applicants to submit an NPDB self-query with their application, but currently there is no Council rule that requires licensees to submit an NPDB self-query. In a recent audit conducted by the State Auditor's Office, the lack of any required NPDB self-query for licensure renewal was identified as an area of concern for the licensing functions of the Council. Section 507.258 of the Occupations Code requires the Council to establish a process to search a national practitioner database to determine whether another state has taken any disciplinary or other legal action against an applicant or license holder before issuing an initial or renewal license. Therefore, these rule amendments have been proposed to address this identified area of concern, and to further implement §507.258 of the Occupations Code.

FISCAL NOTE. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to

the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

PUBLIC BENEFIT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to applicants, licensees, and the general public because the proposed rule will provide greater clarity, consistency, and efficiency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

PROBABLE ECONOMIC COSTS. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT STATEMENT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO-BUSINESSES AND RURAL COMMUNITIES. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

LOCAL EMPLOYMENT IMPACT STATEMENT. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

REQUIREMENT FOR RULES INCREASING COSTS TO REGULATED PERSONS. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

GOVERNMENT GROWTH IMPACT STATEMENT. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

TAKINGS IMPACT ASSESSMENT. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register*.

APPLICABLE LEGISLATION. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

STATUTORY AUTHORITY. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

Lastly, the Executive Council proposes this rule pursuant to the authority found in §507.258 of the Tex. Occ. Code which requires the Executive Council to establish a process to search a national practitioner database to determine whether another state has taken any disciplinary or other legal action against an applicant or license holder before issuing an initial or renewal license.

No other code, articles or statutes are affected by this section.

§883.1. Renewal of a License.

(a) All licenses subject to the jurisdiction of the Council are renewable on a biennial basis and must be renewed online.

(b) Renewals are due on the last day of the license holder's birth month, but may be completed up to 60 days in advance.

(c) Renewal Conditions:

(1) Licensees must pay all applicable renewal and late fees, indicate compliance with any continuing education requirements, and comply with any other requests for information or requirements contained within the online renewal system as a prerequisite for renewal of a license. This paragraph is effective for licenses with expiration dates prior to November 30, 2021.

(2) Licensees must pay all applicable renewal or late renewal fees, indicate compliance with any continuing education requirements, and comply with any other requests for information or requirements contained within the online renewal systems as a prerequisite for renewal of a license. This paragraph is effective for licenses with expiration dates on or after November 30, 2021.

(d) In addition to the requirements of subsection (c) of this section, licensees must also show compliance with each of the following as a condition of renewal:

(1) provide or update the standardized set of information about their training and practices required by §105.003 of the Health and Safety Code; [~~and~~]

(2) affirm or demonstrate successful completion of a training course on human trafficking prevention described by §116.002 of the Occupations Code; and[.]

(3) if chosen for an audit under §882.50 of this title, licensees are required to submit a self-query report from the National Practitioner Data Bank in the same manner required by §882.2 of this title.

(e) Licensed psychologists must update their online profile information when renewing their license.

(f) A license may not be renewed until a licensee has complied with the requirements of this rule.

(g) A licensee who falsely reports compliance with continuing education requirements on his or her renewal form or who practices with a license renewed under false pretenses will be subject to disciplinary action.

(h) Licensees will be sent notification of their approaching renewal date at least 30 days before their renewal date. This notification will be sent to the licensee's main address via first class mail. Responsibility for renewing a license rests exclusively with the licensee, and the failure of the licensee to receive the reminder notification from the Council shall not operate to excuse a licensee's failure to timely renew a license or any unlawful practice with a subsequent delinquent license.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on November 6, 2023.

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Darrel D. Spinks
Executive Director
Texas Behavioral Health Executive Council
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For further information, please call: (512) 305-7706

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CHAPTER 884. COMPLAINTS AND ENFORCEMENT

SUBCHAPTER A. FILING A COMPLAINT

22 TAC §884.1

The Texas Behavioral Health Executive Council proposes amendments to §884.1, relating to Timeliness of Complaints.

OVERVIEW AND EXPLANATION OF THE PROPOSED RULE. The proposed amendments provide notice and clarity that the rule of limitations for the timeliness of a complaint does not apply to applications for reinstatement.

FISCAL NOTE. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

PUBLIC BENEFIT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to applicants, licensees, and the general public because the proposed rule will provide greater clarity, consistency, and efficiency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

PROBABLE ECONOMIC COSTS. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT STATEMENT. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO-BUSINESSES AND RURAL COMMUNITIES. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

LOCAL EMPLOYMENT IMPACT STATEMENT. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

REQUIREMENT FOR RULES INCREASING COSTS TO REGULATED PERSONS. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

GOVERNMENT GROWTH IMPACT STATEMENT. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

TAKINGS IMPACT ASSESSMENT. Mr. Spinks has determined that there are no private real property interests affected by the

proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register.*

APPLICABLE LEGISLATION. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

STATUTORY AUTHORITY. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

No other code, articles or statutes are affected by this section.

§884.1. Timeliness of Complaints.

(a) A complaint not involving sexual misconduct will be considered timely if brought within five years of the date of the termination of professional services.

(b) A complaint alleging sexual misconduct will be considered timely if brought within seven years after the date of termination of services or within five years of the patient, client or recipient of services reaching the age of majority, whichever is greater.

(c) A complaint arising out of a matter required to be reported to the Council pursuant to rule §884.32 of this chapter, will be considered timely if brought within five years of the date the matter is reported to the Council. Limitations shall not begin to run for any such complaint until the matter is reported in accordance with Council rules.

(d) This rule does not apply to a complaint closed as a result of the expiration of a license and subsequently reopened or initiated anew by the Council in connection with an application for reinstatement under §882.22 of this chapter.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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Darrel D. Spinks
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CHAPTER 885. FEES

22 TAC §885.1

The Texas Behavioral Health Executive Council proposes amendments to §885.1, relating to Executive Council Fees.

Overview and Explanation of the Proposed Rule. The proposed amendments provide additional notice to applicants and licensees of the potential disciplinary action that may result from attempting to refund fees paid to the Council. Additionally, a new rule has been proposed, §882.28, regarding updates to degrees on licenses, so a new fee of $54.00 has been proposed for these types of applications.

Fiscal Note. Darrel D. Spinks, Executive Director of the Executive Council, has determined that for the first five-year period the proposed rule is in effect, there will be no additional estimated cost, reduction in costs, or loss or increase in revenue to the state or local governments as a result of enforcing or administering the rule. Additionally, Mr. Spinks has determined that enforcing or administering the rule does not have foreseeable implications relating to the costs or revenues of state or local government.

Public Benefit. Mr. Spinks has determined for the first five-year period the proposed rule is in effect there will be a benefit to applicants, licensees, and the general public because the proposed rule will provide greater clarity, consistency, and efficiency in the Executive Council's rules. Mr. Spinks has also determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be to help the Executive Council protect the public.

Probable Economic Costs. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no additional economic costs to persons required to comply with this rule.

Small Business, Micro-Business, and Rural Community Impact Statement. Mr. Spinks has determined for the first five-year period the proposed rule is in effect, there will be no adverse effect on small businesses, micro-businesses, or rural communities.

Regulatory Flexibility Analysis for Small and Micro-Businesses and Rural Communities. Mr. Spinks has determined that the proposed rule will have no adverse economic effect on small businesses, micro-businesses, or rural communities. Thus, the Executive Council is not required to prepare a regulatory flexibility analysis pursuant to §2006.002 of the Tex. Gov't Code.

Local Employment Impact Statement. Mr. Spinks has determined that the proposed rule will have no impact on local employment or a local economy. Thus, the Executive Council is not required to prepare a local employment impact statement pursuant to §2001.022 of the Tex. Gov't Code.

Requirement for Rules Increasing Costs to Regulated Persons. The proposed rule does not impose any new or additional costs to regulated persons, state agencies, special districts, or local governments; therefore, pursuant to §2001.0045 of the Tex. Gov't Code, no repeal or amendment of another rule is

required to offset any increased costs. Additionally, no repeal or amendment of another rule is required because the proposed rule is necessary to protect the health, safety, and welfare of the residents of this state and because regulatory costs imposed by the Executive Council on licensees is not expected to increase.

Government Growth Impact Statement. For the first five-year period the proposed rule is in effect, the Executive Council estimates that the proposed rule will have no effect on government growth. The proposed rule does not create or eliminate a government program; it does not require the creation or elimination of employee positions; it does not require the increase or decrease in future legislative appropriations to this agency; it does not require an increase or decrease in fees paid to the agency; it does not create a new regulation; it does not expand an existing regulation; it does not increase or decrease the number of individuals subject to the rule's applicability; and it does not positively or adversely affect the state's economy.

Takings Impact Assessment. Mr. Spinks has determined that there are no private real property interests affected by the proposed rule. Thus, the Executive Council is not required to prepare a takings impact assessment pursuant to §2007.043 of the Tex. Gov't Code.

REQUEST FOR PUBLIC COMMENTS. Comments on the proposed rule may be submitted by mail to Brenda Skiff, Executive Assistant, Texas Behavioral Health Executive Council, 1801 Congress Ave., Ste. 7.300, Austin, Texas 78701 or via https://www.bhec.texas.gov/proposed-rule-changes-and-the-rulemaking-process/index.html. The deadline for receipt of comments is 5:00 p.m., Central Time, on December 17, 2023, which is at least 30 days from the date of publication of this proposal in the *Texas Register.*

Applicable Legislation. This rule is proposed pursuant to the specific legal authority granted to the Executive Council by H.B. 1501, 86th Leg., R.S. (2019).

Statutory Authority. The rule is proposed under Tex. Occ. Code, Title 3, Subtitle I, Chapter 507, which provides the Texas Behavioral Health Executive Council with the authority to make all rules, not inconsistent with the Constitution and Laws of this State, which are reasonably necessary for the proper performance of its duties and regulations of proceedings before it.

Additionally, the Executive Council proposes this rule pursuant to the authority found in §507.152 of the Tex. Occ. Code which vests the Executive Council with the authority to adopt rules necessary to perform its duties and implement Chapter 507 of the Tex. Occ. Code.

The Executive Council also proposes this rule under the authority found in §2001.004 of the Tex. Gov't Code which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures.

Lastly, the Executive Council proposes this rule amendment pursuant to the authority found in §507.154 of the Tex. Occ. Code which authorizes the Executive Council to set fees necessary to cover the costs of administering Chapters 501, 502, 503, 505, and 507 of the Tex. Occ. Code.

No other code, articles or statutes are affected by this section.

§885.1. Executive Council Fees.

(a) General provisions.

(1) All fees are nonrefundable, nontransferable, and cannot be waived except as otherwise permitted by law. Any attempt to cancel, initiate a chargeback, or seek recovery of fees paid to the Council may result in the opening of a complaint against a licensee or applicant.

(2) Fees required to be submitted online to the Council must be paid by debit or credit card. All other fees paid to the Council must be in the form of a personal check, cashier's check, or money order.

(3) For applications and renewals the Council is required to collect fees to fund the Office of Patient Protection (OPP) in accordance with Texas Occupations Code §101.307, relating to the Health Professions Council.

(4) For applications, examinations, and renewals the Council is required to collect subscription or convenience fees to recover costs associated with processing through Texas.gov.

(5) All examination fees are to be paid to the Council's designee.

(b) The Executive Council adopts the following chart of fees:

(1) Fees effective through August 31, 2023.

Figure: 22 TAC §885.1(b)(1)

[~~Figure: 22 TAC §885.1(b)(1)~~]

(2) Fees effective on September 1, 2023.

Figure: 22 TAC §885.1(b)(2)

[~~Figure: 22 TAC §885.1(b)(2)~~]

(c) Late fees. (Not applicable to Inactive Status)

(1) If the person's license has been expired (i.e., delinquent) for 90 days or less, the person may renew the license by paying to the Council a fee in an amount equal to one and one-half times the base renewal fee.

(2) If the person's license has been expired (i.e., delinquent) for more than 90 days but less than one year, the person may renew the license by paying to the Council a fee in an amount equal to two times the base renewal fee.

(3) If the person's license has been expired (i.e., delinquent) for one year or more, the person may not renew the license; however, the person may apply for reinstatement of the license.

(d) Open Records Fees. In accordance with §552.262 of the Government Code, the Council adopts by reference the rules developed by the Office of the Attorney General in 1 TAC Part 3, Chapter 70 (relating to Cost of Copies of Public Information) for use by each governmental body in determining charges under Government Code, Chapter 552 (Public Information) Subchapter F (Charges for Providing Copies of Public Information).

(e) Military Exemption for Fees. All licensing and examination base rate fees payable to the Council are waived for the following individuals:

(1) military service members and military veterans, as those terms are defined by Chapter 55, Occupations Code, whose military service, training, or education substantially meets all licensure requirements; and

(2) military service members, military veterans, and military spouses, as those terms are defined by Chapter 55, Occupations Code, who hold a current license issued by another jurisdiction that has licensing requirements that are substantially equivalent to the requirements of this state.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

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