ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

1 TAC §353.1302

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

The amendment of §353.1302 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6670). This rule will be republished.

BACKGROUND AND PURPOSE

HHSC sought and received approval from the Centers for Medicare and Medicaid Services (CMS) to create the Quality Incentive Payment Program (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.

The amendment modifies the eligibility criteria for non-state government-owned nursing facilities. Beginning in state fiscal year 2025, the eligibility criteria related to the nursing facility 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 non-state government-owned nursing facility 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 amendment also requires a non-state government-owned nursing facility eligible to participate in QIPP due to an active partnership, to produce certain documentation in connection with the enrollment application that demonstrates an active partnership between the nursing facility and the governmental entity exists. The amendment to the active partnership criteria enables HHSC to confirm non-state government-owned nursing facility eligibility at the time of program enrollment.

Beginning in state fiscal year 2026, QIPP-enrolled nursing facilities 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 amendment also modifies 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 amendment to the funding allocations simplifies the allocation formulas and provides 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 (1 TAC) §353.1304.

HHSC made other minor clarifying or grammatical edits to improve the readability of the rule text.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received comments regarding the proposed rule from approximately 100 commenters, including Barton Valley Rehabilitation and Healthcare Center; Beacon Harbor Healthcare & Rehabilitation; Beacon Hill; Bel Air at Teravista; Borger Healthcare Center; Bridgecrest Rehabilitation Suites; Brownfield Rehabilitation & Care Center; Canton Oaks; Cass Valley Healthcare Center with Nexion Health; Childress Healthcare Center; Coleman Healthcare; Colonial Manor Nursing; Colonnades at Refection Bay by Cantex Continuing Care Network; Coronado at Stone Oak by Cantex Continuing Care Network; Coronado Healthcare Center/Senior Living Properties; Crest View Court by Cantex Continuing Care Network; Crestwood Health and Rehabilitation Center; Cross Timbers Rehabilitation & Healthcare Center; Ensign Services; Fort Bend Healthcare Center by Cantex Continuing Care Network; Grand Terrace Rehabilitation and Healthcare - The Heart of Mc Allen; Green Valley Healthcare and Rehabilitation Center; Gulf Shores Rehabilitation and Healthcare Center; Haskell Healthcare Center; Hillside Heights Rehabilitation Suites in Amarillo; Holly Mead by Cantex Continuing Care Network; Jacksonville Healthcare Center; Keystone Care; Lake Hills Healthcare Center; Las Brisas Rehabilitation & Wellness Suites; Laurel Court; Legend Oaks Healthcare and Rehab of Gladewater; Lily Springs Rehabilitation and Healthcare Center; Lone Star Ranch Rehabilitation and Healthcare Center; Los Arcos del Norte Nursing & Rehab; M Chest Pharmacy; McAllen Transitional Care Center; Meadowbrook Care Center; Mill Creek; Nexion Health Management, Inc; Fundamental; Oak Manor of Com-

merce Nursing and Rehab; Oakwood Manor Nursing Home; Palma Real Transitions Care Center; Paradigm Healthcare, LLC; Park Valley Inn Health Center; Prairie Estates by Cantex Continuing Care Network; Renaissance Care Center; Retama Manor; San Remo by Cantex Continuing Care Network; Sandy Lake Rehab & Care Center-Coppell; Senior Living Properties; Solera at Weston Houston; Solutions Healthcare; Sorrento by Cantex Continuing Care Network; Spend Management SLP Operations; State Long-Term Care Ombudsman; Sterling Hills Rehab & Healthcare; Sterling Oaks Rehabilitation; Sundance Inn Health Center; Terrell HeathCare; Texas Health Care Association; Texas Hospital Association; Texas Medical Association; Texas Organization of Rural and Community Hospitals; The Bradford at Brookside by Cantex Continuing Care Network; The Courtyards at Pasadena; The Crescent Transitional Care; The Independent Coalition of Nursing Home Providers ("Coalition "); The Madison on March by Cantex Continuing Care Network; The Manor At Seagoville; The Villa of Mountain View by Cantex Continuing Care Network; The Villages of Dallas; Trinity Nursing & Rehab of Granbury; Truman W. Smith Children's Care Center; Villa Haven Health and Rehabilitation; Whispering Springs Rehabilitation and Healthcare Center; Windmere at Westover Hills; Wood Memorial in Mineola - Senior Living Properties; and Woodville Health and Rehab Center. A summary of comments relating to the rule and HHSC's responses follows.

Comment: One commenter expressed appreciation for the amendment to the non-state government-owned nursing facilities eligibility requirement, including the same or contiguous county requirement. The commenter stated that a non-state government owner who is in the same community as a nursing facility will have a greater interest in the operations of that facility and will better understand the community that the facility serves. The commenter expressed concerns that the eligibility requirement related to the same or contiguous county would apply to a management company of a non-state government-owned nursing facility.

Response: HHSC acknowledges the comment and appreciates the support of the amendment. To clarify, HHSC confirms the non-state government-owned nursing facility eligibility requirement related to the same county or contiguous counties applies to the nursing facility and the non-state governmental entity taking ownership of the facility. The location of a management company cannot be utilized to meet the eligibility requirement. No revisions were made in response to this comment.

Comment: One commenter expressed appreciation for the active participation requirements that are a part of the non-state government-owned nursing facility eligibility requirements. The commenter stated that active partnerships improve oversight, collaboration, and problem-solving between nursing facility owners and operators, which will lead to improved outcomes for residents.

Response: HHSC acknowledges the comment and appreciates the support of the amendment. No revisions were made in response to this comment.

Comment: Several commenters requested the addition of the word "or" between the first and second non-state government-owned nursing facility eligibility criteria. Commenters shared the addition of the word "or" would ensure a clear understanding that a nursing facility that is owned by a non-state governmental entity for no less than four years prior to the first day of the program period would be eligible to participate in QIPP, and would not require a demonstrative active partnership.

Response: HHSC disagrees that the text of the rule requires clarification and declines to revise the rule in response to the comment. The suggested change is not grammatically necessary. HHSC confirms that if a nursing facility is owned by the same non-state governmental entity for four or more years, that nursing facility does not have to satisfy the active partnership requirement described in the rule to be eligible to participate in the QIPP.

Comment: One commenter suggested that HHSC consider an exception to ineligible private facilities to meet the active partnership requirements. The commenter stated private facilities generally do not learn whether they will be eligible to participate until after the application date. The commenter further shared that if a private facility is not eligible to participate, the private facility will not have an opportunity to partner with a non-state government-owned facility unless the facility is located within the same county as the non-state government-owned facility due to the amended eligibility criteria for non-state government-owned facilities.

Response: HHSC acknowledges the comment and declines to revise the rule in response to the comment. While the QIPP program contains provisions regarding changes of ownership for participation in QIPP, the rule does not limit a facility's ability to enter into a CHOW in accordance with their business practices and needs. The limitations related to CHOWs in the QIPP rules intended to enable HHSC to have reasonable certainty in financial modeling used to establish capitation rates for the managed care organizations. Because QIPP is a quality-improvement program, HHSC has imposed additional requirements in QIPP to ensure that the owners of facilities are engaged in promoting the improved quality for the Medicaid beneficiaries that reside in their facilities. As such, HHSC does not make decisions regarding these timelines to facilitate decision-making by a current nursing facility owner to sell their facility for the seeming sole purpose of maintaining eligibility for QIPP. HHSC encourages providers to serve Medicaid beneficiaries and reminds providers that participation as a private facility requires the facility to "have a percentage of Medicaid NF days of service that is greater than or equal to 65 percent."

Comment: Multiple commenters recommended that nursing facilities and non-state governmental entities be given more time to undergo a CHOW and demonstrate active partnership activities in relation to state fiscal year 2025 QIPP program eligibility requirements. Commenters sought clarification regarding CHOW deadlines and the requirement of non-state government-owned nursing facilities that are eligible to participate in QIPP due to an active partnership to provide documentation of activities that demonstrate an active partnership has 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. One commenter suggested that HHSC delete the requirement for the documentation of activities.

Response: HHSC acknowledges the comment and declines to revise the rule in response to this comment. HHSC confirms a nursing facility's QIPP eligibility at the time of enrollment. To confirm eligibility, a non-state government-owned nursing facility eligible to participate in QIPP based on an active partnership between the nursing facility and the governmental entity that owns the nursing facility must be able to provide documentation of activities that demonstrate an active partnership for HHSC to confirm the nursing facility's eligibility. There is not a specific CHOW

deadline related to the demonstration of an active partnership. The governmental entity that owns the nursing facility and the nursing facility will be required to demonstrate the active partnership as outlined in the amendment.

Comment: Several commenters requested that, for state fiscal year 2026, the timeframe for which as active partnership must be demonstrated at enrollment be changed from nine months to six months. Commenters shared that the program period starts six months after the date of application, therefore demonstrating active partnership activities six months before the date of application effectively provides one year of active partnership before the start of the program period.

Response: HHSC acknowledges the comment and declines to revise the rule in response to this comment. HHSC confirms a nursing facility's QIPP eligibility at the time of enrollment. To confirm eligibility, a non-state government-owned nursing facility eligible to participate in QIPP based on an active partnership between the NF and the governmental entity that owns the NF must be able to provide documentation of activities that demonstrate an active partnership as well as a detailed plan for maintaining the partnership in the months following the application date through the end of the program period. The active partnership activities include monthly, quarterly, and annual activities. Before the proposal to amend §353.1302 was published, a workgroup was convened that consisted of industry representatives to discuss and receive feedback on the QIPP program. The workgroup's feedback was evaluated and incorporated into the rule amendment, including the feedback requiring between six and twelve months of active partnership activities at the time of enrollment. HHSC preferred twelve months, but agreed to require nine months due to our understanding that twelve months was not the preference of workgroup participants.

Comment: One commenter requested that HHSC exempt non-nursing facilities that are owned by a non-state governmental entity as of the effective date amendment from the application of the amendment. The commenter shared that nursing facilities that have been owned by a non-state governmental entity for fewer than four years at the time of rule implementation and do not comply with the geographic requirement would be ineligible for QIPP for one or more program years.

Response: HHSC acknowledges the comment and declines to revise the rule in response to this comment. The eligibility requirements for non-state government-owned nursing facilities require the nursing facility to 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; to be owned by the non-state governmental entity for no less than four years before the first day of the program period; or to be able to provide documentation of activities that demonstrate an active partnership has occurred in the prior two months (for state fiscal year 2025) and in the prior nine months (for state fiscal year 2026) 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.

HHSC anticipates that if a non-state government-owned nursing facility is more than 150 miles away from the non-state governmental entity that owns the facility and is not in the same county as that entity or a county contiguous to the county in which the non-state governmental entity is located, the nursing facility would be eligible to participate in QIPP based on an active partnership between the facility and the non-state governmental entity that owns the facility. The amendment pertaining to the state fiscal year 2025 eligibility criteria requires the submission of documents for only two months of activities before enrollment, and nine months in state fiscal year 2026.

Comment: Multiple commenters recommended that if an enrolled nursing facility undergoes a CHOW that changes the class of the facility from privately-owned to non-state government-owned during the program period, the enrolled nursing facility be permitted to participate in the program for the remainder of the program period, but only as a privately-owned facility eligible to receive payments for Component Two and Component Three. The commenters shared that a nursing facility that participates in QIPP as a privately-owned facility may be forced to not participate in QIPP for a year if they drop below the 65 percent eligibility criteria or temporarily not participate in QIPP if they undergo a CHOW with a non-state governmental entity in order to continue to participate in QIPP.

Response: HHSC acknowledges the comment and declines to make the suggested change. A nursing facility must maintain its eligibility to participate in QIPP for an entire program period. If a nursing facility no longer meets the eligibility requirements under which the facility enrolled in QIPP, the facility is no longer eligible to participate in QIPP. Allowing a nursing facility to participate in or continue to participate in QIPP based on a different classification than the nursing facility's actual operational classification contradicts the program requirements and could introduce significant financial risk into to the program.

Comment: One commenter recommended that the Component One payment continue to be paid monthly, rather than the quarterly basis. The commenter shared cashflow concerns with the non-state government-owned nursing facilities that are eligible to receive Component One payments based on achievement of Component One metrics.

Response: HHSC acknowledges the comment and declines to make the suggested change. The amendment regarding the frequency of payments aligns with the proposed state fiscal year 2025 quality metrics. Pursuant to 1 TAC §353.1304, HHSC published proposed state fiscal year 2025 QIPP quality metrics on December 1, 2023, held a public hearing regarding the proposed metrics, and stakeholders were able to submit comments regarding those metrics through December 15, 2023.

Comment: Several commenters requested that QIPP Component Four be combined with QIPP Component One metrics creating an enhanced Component One equal to 60 percent of the total program value for the program period. The commenters also requested the enhanced Component One would maintain the proposed achievement of 1 metric would earn 90 percent and achievement of 2 metrics earns 100 percent of the total dollars included in the new "combined" Component. The commenters shared that this request would simplify the program implementation, improve administrative efficiency, and better focus those participating public nursing homes for improved quality performance.

Response: HHSC disagrees with the suggested changes and declines to revise the rule in response to the comment. The amendment to 1 TAC §353.1302 aligns with the proposed state fiscal year 2025 quality metrics. Pursuant to 1 TAC §353.1304, HHSC published proposed state fiscal year 2025 QIPP quality metrics on December 1, 2023, held a public hearing regarding the proposed metrics, and allowed stakeholders to submit comments regarding those metrics through December 15, 2023.

Comment: Several commenters requested to change the allocation across quality metrics for Components Two, Three, and Four from each quality metric being equally weighted to align with the allocation for Component One. The allocation would change so achievement in one metric earns 90 percent and achievement in two metrics earns 100 percent of the total dollars included in the component. Commenters indicated that the suggested change would incentivize participants who are already high achievers in one metric to continue to improve their quality in other metrics, knowing that failure to meet the continuous improvement requirement in one metric could negatively impact program performance.

Response: HHSC acknowledges the comment. HHSC declines to revise the rule in response to the comment as the comment related to Components Three and Four. With regards to Component Two, HHSC revised the allocation of funds within the component so that in state fiscal year 2025, achievement in 1 metric earns 70 percent and achievement in 2 metrics earns 100 percent of total dollars included in the component; in state fiscal year 2026, achievement in 1 metric earns 60 percent, achievement in 2 metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and in state fiscal year 2027 and subsequent state fiscal years, each quality metric will be allocated an equal portion of the total dollars included in the component.

Comment: Multiple commenters recommended the non-dispersed funds remain within each Component and only be distributed to qualifying nursing facilities that achieved metrics within the same Component.

Response: HHSC acknowledges the comment and declines to make the suggested change. The non-dispersed funds pool is the total funds paid through the capitation rate to the managed care organizations, less the total funds earned by facilities. The total funds paid through the capitation rate are not separated or allocated by component amounts. Revising the methodology to distribute non-dispersed funds by component would require HHSC to base the calculation on an estimate of funds paid by component instead of the actual capitation payment and could inject unacceptable risks into the program. HHSC, however, did make changes to the way in which non-disbursed funds are distributed in response to other comments received.

Comment: One commenter expressed appreciation for the addition of the staffing component and recommended the component should be increased to at least 25 percent of the total program value.

Response: HHSC acknowledges the comment and the importance of staffing and appreciates the support of the comment, but HHSC declines to make the suggested change. The amendment aligns with the proposed state fiscal year 2025 quality metrics. Pursuant to 1 TAC §353.1304, HHSC published proposed state fiscal year 2025 QIPP quality metrics on December 1, 2023, HHSC held a public hearing regarding the proposed metrics, and allowed stakeholders to submit comments regarding those metrics through December 15, 2023. The QIPP proposed state fiscal year 2025 quality metrics for Component Two pertain to staffing. Component Two is amended to be equal to 20 percent of the total program value for the program period in the amendment. Additionally, changes were made to the distribution of non-disbursed funds that may support facilities that choose to focus on enhancing staffing at the facility.

In addition to the QIPP program, there are additional Medicaid revenues a nursing facility may receive to support staffing. The other Medicaid revenues include the Medicaid base rate, which was increased on September 1, 2023, pursuant to the 2024-25 General Appropriations Act (GAA), Article II, Rider 24, which provides "appropriations for reimbursement rate increases that will increase the wages and benefits of direct care staff." Furthermore, a nursing facility may choose to participate in the Direct Care Staff Enhancement program (rate enhancement). Rate enhancement participating providers receive additional funding to their Medicaid base rates and agree to use that funding on compensation for direct care staff compensation.

Comment: Multiple commenters recommended modifications specific to the QIPP Components or metrics. The comments pertained to increasing Component One metrics from five metrics to eight metrics; moving to a trailing four-quarter average for performance targets; the new calculation methodology for the Nursing Facility Specific Relative Improvement Target; and the performance requirements set at the national mean.

Response: HHSC acknowledges these comments. The comments are not relevant to the amendment because they are outside the scope of the rule being amended. Pursuant to 1 TAC 353.1304, HHSC published proposed state fiscal year 2025 QIPP quality metrics on December 1, 2023, held a public hearing regarding the proposed metrics, and stakeholders were able to submit comments regarding those metrics through December 15, 2023.

A minor editorial change is made to subsection (b)(7). The word "Period" is made lowercase. Also, a period is added at the end of subsection (h)(1)(E).

STATUTORY AUTHORITY

The amendment is authorized by 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.

§353.1302. 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 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.

(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, 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 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:

(i) For the program periods beginning on or before September 1, 2020, but on or after September 1, 2019, 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 beginning on or before September 1, 2023, but on or after September 1, 2021, 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 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:

(i) For the program periods beginning on or before September 1, 2020, but on or before September 1, 2019, 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 beginning on or before September 1, 2023, but on or after September 1, 2021, 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 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.

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

(C) 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) Non-Disbursed Funds.

(A) For program periods that begin on or before September 1, 2023, 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.

(B) For program periods that begin on or after September 1, 2024, funds that are non-disbursed due to failure of one or more NFs to meet performance requirements will be distributed across QIPP NFs who have demonstrated achievement of a measure established in accordance with §353.1304 of this subchapter and designated by HHSC as the measure on which distribution of non-disbursed funds will be based. Funds distributed under this subparagraph will be allocated to each achieving NF based upon each NF's proportion of total earned QIPP funds from Components One, Two, Three, and Four combined compared to the total amount paid to achieving NFs from all components.

(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 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 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 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 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 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 (C) and (D) of this paragraph, each quality metric will be allocated an equal portion of the total dollars included in the component.

(iii) For purposes of the calculations described in subparagraph (B) of this paragraph:

(I) for program periods beginning on September 1, 2024, achievement in 1 metric earns 70 percent and achievement in 2 metrics earns 100 percent of total dollars included in the component;

(II) for program periods beginning on September 1, 2025, achievement in 1 metric earns 60 percent, achievement in 2 metrics earns 85 percent, and achievement in 3 metrics earns 100 percent of total dollars included in the component; and

(III) for program periods beginning on or after September 1, 2026, 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 or from non-state 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) 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. 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 adoption and found it to be a valid exercise of the agency's legal authority.

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TRD-202400072
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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Proposal publication date: November 17, 2023
For further information, please call: (737) 867-7817

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1 TAC §353.1306, §353.1307

The Texas Health and Human Services Commission (HHSC), adopts an amendment 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.

Section 353.1306 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6676). This rule will be republished.

Section 353.1307 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6676). This rule will be republished.

BACKGROUND AND JUSTIFICATION

HHSC adopts modifications to the Comprehensive Hospital Increase Reimbursement Program (CHIRP), 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 & 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 has not made 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 the program can continue to advance the quality goal or objective the program is intended to impact.

The adopted amendments create a new 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 the 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 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). The Average Commercial Incentive Award (ACIA) will be paid using a scorecard that directs managed care organizations (MCOs) 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 adopted amendments will meet the need for continued 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 (Texas 1115 Waiver) and will lead to continued quality improvements in the healthcare delivery system in Texas.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received comments regarding the proposed rules from 18 organizations, including Medical Center Health System; Midland Memorial Hospital; Teaching Hospitals of Texas; Children's Hospital Association of Texas; Texas Organization of Rural and Community Hospitals; Baylor Scott & White; HCA Healthcare; Memorial Hermann; Tenet Health; Texas Health Resources; Christus Health; Texas Association of Behavioral Health Systems; Oceans Healthcare; Universal Health Services; Texas Essential Healthcare Partnerships; Texas Hospital Association; Steward Health Care System; and Texas Association of Voluntary Hospitals. A summary of comments relating 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 and HHSC's responses follows.

Regarding §353.1306, concerning the Comprehensive Hospital Increase Reimbursement Program for program periods on or after September 1, 2021:

Allocation Methodology

Comment: A commenter provided a suggestion to allocate funds for the APHRIQA component by accounting for, by hospital class, uninsured costs in addition to any Medicaid long fall. The commenter also provided a suggested methodology for this funding allocation.

Response: HHSC acknowledges the comment. The comment is not relevant to the rule because the comment describes a preference for how HHSC will determine the allocation of funding available to providers across CHIRP components and is, therefore, outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided suggestions to allocate the minimum amount necessary for the APHRIQA component to achieve HHSC's policy goals.

Response: HHSC acknowledges the comment. The comment is not relevant to the rule because the comment relates to the allocation methodology of fund allocations to be used for the APHRIQA component and is, therefore, outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: A comment was received in support of the Proposed Rule text that allows HHSC discretion to set percentage reductions to the ACIA and UHRIP components (that form the basis of the APHRIQA allocation) on a Service Delivery Area (SDA)-class basis to the extent that HHSC agrees to implement a model that sets percentage reductions in line with holistic considerations of hospital contributions to the Medicaid program. Based on this model, reductions are made by applying a mandatory reduction to a class's CHIRP allocation when its Medicaid payments exceed its Medicaid and uninsured charity care costs; and imposing a payment floor equal to a percent of the uninsured charity care costs incurred by a class to incentivize hospitals to continue providing care.

Response: HHSC acknowledges the comment. The portion of the comment detailing specific allocation methodology for fund allocations is not relevant because it is outside of the scope of this rule amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters provided comments requesting the removal of the 90 percent of the Average Commercial Reimbursement (ACR) limit and for HHSC to seek approval for CHIRP payments to be no less than 90 percent of the ACR.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC must consider the available budget neutrality room available under the Texas 1115 Waiver, the reasonableness of payments available to providers under CHIRP, and other factors when determining what percentage of ACR will be available under the program. Additionally, the 90 percent of the ACR limitation is the result of extensive negotiations with CMS. No revision to the rule text was made in response to this comment.

Unearned APHRIQA payments redistributions

Comment: A commenter requested that HHSC revise the wording in §353.1306 (h)(2)(C) to always calculate any unearned APHRIQA redistribution at the SDA level, as opposed to calculating any unearned APHRIQA redistribution at the class level within the SDA and the SDA level if applicable under the rule.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. Because the funds for the APHRIQA component are allocated on a class and SDA basis, it is by design that §353.1306 (h)(2)(C) allows hospitals in the same class in the same SDA the first opportunity receive any available unearned APHRIQA redistribution payments based upon their ability to successfully achieve their measures.

Timing

Comment: A comment was received in support of the timing of the rule change and stated that the change is both necessary and important to protect Texas' rural healthcare safety net.

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Comment: Several commenters urged postponement of any alterations to the CHIRP program until the impact of changes is fully understood due to uncertainties in broader Federal and state Medicaid supplemental payment landscapes.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed amendment and the creation of the APHRIQA component is a proactive mechanism to further the goals of the Texas 1115 Waiver as the CHIRP program matures. In addition, the creation of the APHRIQA component is a mechanism for the state to effectively respond to changes in the larger Medicaid supplemental payment landscapes as pay-for-performance and quality initiatives become increasingly important strategies to drive healthcare improvement and innovation on both the Federal and state levels. No revision to the rule text was made in response to this comment.

Comment: A commenter stated that reallocating funds to the APHRIQA component would lead to a reduction in payments that will begin immediately on September 1, 2024, while payments earned for achieving quality will be delayed until after the program year concludes in September 2025, creating significant cash flow challenges for hospitals.

Response: HHSC disagrees with the commenter that the creation of the APHRIQA component is a reduction in payments because the total payments potentially available to providers will not necessarily be changed by the creation of the third component. However, HHSC understands the commenter's concern that, if measure achievement is calculated only once per year, waiting for full payment could create cash flow concerns for certain providers. Therefore, in response to the commenter, HHSC will modify the rule text upon adoption to create an option for a provider to elect, on its enrollment application, to receive two interim payments per program period if measure achievement is calculated only once per year. Each interim payment will be equal in amount to an estimated 20 percent of the provider's potential total APHRIQA payment if the provider were to earn 100 percent of available payments under the APHRIQA component. The interim payments will be reconciled with final payments after measure achievement has been determined. Interim payments are subject to being recouped and are not an indication of presumptive measure achievement.

Funding Risk and Instability

Comment: Several comments were received against the proposed rule changes, stating that the rule changes will lead to unpredictability and instability in the Medicaid program because the proposed rule allows HHSC to make decisions on the percentage for allocation to the program components each year. The commenters also stated that the proposed rule could lower the funds available to providers and lead to program funds being put at risk for children's hospitals that are heavily dependent on Medicaid.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed rule allows HHSC to make decisions on the percentage for allocation to the program components each year so HHSC can ensure that funding allocation advances the goals of the Texas 1115 Waiver and protects the overall stability of the healthcare system of Texas. The proposed rule does not inherently lower the amount of funds available to providers but rather creates a new pay-for-performance component to incentivize quality improvement and improved health outcomes for Medicaid recipients in Texas. Additionally, HHSC must consider the available budget neutrality room available under the Texas 1115 Waiver, the reasonableness of payments available to providers under CHIRP, and other factors when determining what percentage of ACR will be available under the program. No changes to the rule text were made in response to this comment.

IMD Exclusion

Comment: Several commenters requested that institutions for mental diseases (IMDs) be officially excluded from the APHRIQA component for future years. Commenters noted that, consistent with federal law, IMDs do not receive CHIRP payments on their entire population of managed Medicaid inpatient claims; and, therefore, commenters state that moving IMDs to the APHRIQA component would further inequities for IMDs.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. As the CHIRP program continues to mature and to ensure that the program continues to advance the quality goals and strategies of Texas Medicaid managed care as required by 42 C.F.R. §438.6(c), HHSC may need to incentivize different classes to achieve program-

matic and quality goals by aligning payments in different program components.

CHIRP Hospital Class Definition

Comment: A commenter requested that HHSC update the CHIRP class definition to create a separate Children's free-standing psychiatric facilities class or to update the Children's class definition to include children's free-standing psychiatric facilities.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC did not propose modifications of class definitions in the rule proposal; and, consequently, other program participants and the public did not have an opportunity to comment on such a change. Therefore, HHSC is unable to consider all potential perspectives on this matter. No revision to the rule text was made in response to this comment.

Disproportionate Share Hospital (DSH) and Uncompensated Care (UC) Condition of Participation

Comment: Several commenters requested clarification for DSH and UC conditions of participation associated with APHRIQA.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment. The current proposed rule text describes the APHRIQA component as a voluntary component, which is true when considering only CHIRP participation. The specifications for participation in the APHRIQA component to meet the DSH and UC programs' conditions of participation are described in Title 1 Texas Administrative Code (1 TAC) §355.8065(e)(9) and §355.8212(c)(1)(F). These references state that it will be required for all non-rural hospitals, except for state-owned hospitals, to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs.

Lump sum payments

Comment: Several commenters requested for all CHIRP components to be paid in lump sums, not just the APHRIQA component, citing ease of tracking and the advantage of easing cash flow burdens for hospitals.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. It is more appropriate for a uniform rate increase to be paid on claims at the time of adjudication.

MCO payment reporting requirements

Comment: Several commenters requested that HHSC require MCOs to report to hospitals the contracted base payment portion of each claim and the UHRIP and ACIA payment on each claim.

Response: HHSC acknowledges the comment. While HHSC supports payment transparency between MCOs and hospitals, the content of reporting between MCOs and hospitals is outside the scope of the rule being amended. No revision to the rule text was made in response to this comment because the comment is outside of the scope of the rule being amended.

Data corrections

Comment: Several commenters requested additional specificity regarding the timelines for data corrections. The commenters state that the rule as amended imposes a deadline for hospitals to request corrections to identified data errors but does not impose a deadline for HHSC to provide calculation files to the providers for verification.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. The proposed rule amendment provides a formal cut-off by which corrections should be submitted. Providers, however, are encouraged to submit corrections as soon as the need for corrections is discovered. The CHIRP calculations, including supporting worksheets, will continue to be made available through the public web postings of CHIRP preprint submissions. Postings include both draft and official CHIRP calculations, as well as Intergovernmental Transfer (IGT) commitment and notification files that will contain information for providers' verifications. The timing of these notifications is described in §353.1306(i).

General Comments

Comment: A commenter addressed a potential incentive program under the authorization of 42 C.F.R. §438.6(b) and made several requests related to a potential program developed under that authority.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because CHIRP is authorized under 42 C.F.R. §438.6(c). The comment discusses an incentive program authorized by 42 C.F.R. §438.6(b), which is outside of the scope of the proposed rules.

Comment: A comment was received against the proposed rule, stating that the rule change would conflict with the intention of the CHIRP program to benchmark Medicaid payments to external sources such as Medicare payments and average commercial rates and to pay providers closer to fair market value of the Medicaid services that hospitals provide.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. CHIRP was 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. The rule as amended furthers the goals and objectives of the state's managed care quality strategy and will lead to continued quality improvements in the healthcare delivery system in Texas.

Comment: A commenter requested that §353.1306(e)(2)(E) be removed as it is no longer applicable in the CHIRP program.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because, while this factor is not currently considered when determining a class's eligibility for rate increases in the program, this historical factor of consideration may be used in the future administration of the program.

Comment: A comment was received in support of the rule text language for §353.1306(g)(3); §353.1306(g)(4); and §353.1306(h), including §353.1306(h)(2)(C).

Response: HHSC appreciates the support for the proposed amendment. No revision to the rule text was made in response to this comment.

Regarding §353.1307, concerning Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program:

Comment: One commenter recommended that HHSC solicit industry feedback on APHRIQA metrics sooner through a mecha-

nism HHSC used for DSRIP under the Texas 1115 Waiver - Bundle Advisory Teams. The Bundle Advisory Teams consisted of clinicians from participating hospitals with operational expertise, which provided feedback on the quality measures to include in the program.

Response: HHSC disagrees and declines to make changes to the rule text in response to this comment. HHSC convened a stakeholder workgroup of representatives from hospitals and hospital associations to assist in selecting quality metrics for CHIRP (specifically APHRIQA), including encouraging participation from clinicians. This workgroup met six times over several months.

Comment: One commenter indicated that HHSC should amend the rules to put specified guardrails or guiding principles in the rules to give hospitals the notice they need to implement programs, policies, and additional steps to meet new or altered quality metrics. They also requested that achievement goals be established in advance to cover a several-year period, providing participating providers with adequate notice of the goal and the ability to put processes in place to achieve the desired outcomes over time.

Response: HHSC acknowledges the comment. Although HHSC does not agree with the comment in the comment in its entirety, HHSC has updated the rules to allow 30 calendar days for public comment. In the future, HHSC will post proposed quality metrics and requirements by August 10 and final quality metrics and requirements by October 1. HHSC has historically engaged stakeholders prior to posting the proposed metrics and quality requirements for public comment and has reviewed historic performance when considering changes to the quality requirements. HHSC intends to continue to engage stakeholders and to review historic performance when selecting metrics and quality requirements.

HHSC declines to make the additional changes to the rules suggested by this commenter. HHSC engaged stakeholders in extensive conversations regarding program design and quality metrics before proposing the rule amendment. The program must be approved on an annual basis under 42 C.F.R. § 438.6(c).

Comment: One commenter opposed HHSC's proposal to shorten the timeframe for hospitals to furnish information to HHSC related to quality metrics and performance requirements from thirty (30) days to twenty (20) days. They stated the shorter timeframe will increase the administrative burden on participating providers.

Response: HHSC acknowledges the comment and maintained the 30 days for requests for additional information or corrections. Hospitals will continue to have 30 days to submit reporting.

Comment: Several commenters expressed concern with the length and timing of the public comment period for CHIRP quality metrics and requirements. The commenters state it is possible that a significant portion of each hospital class's CHIRP payments could be in the APHRIQA component in any future program year. As such, the process used to choose performance metrics is important for all providers. They state that allowing only fifteen (15) business days to assess and comment on the proposed metrics and performance requirements is insufficient. CHIRP hospitals need at least thirty (30) calendar days to meaningfully review HHSC's proposals and provide substantive feedback, especially in light of HHSC's ability to pick new metrics from year to year. Providing a longer process to review and submit feedback is also important, considering the general timing of this process and how it lines up with other Texas programs. The fifteen-day period will presumably overlap with the Thanksgiving holiday when many people are traveling, and it also overlaps with the annual due date for hospitals' DSH/UC Applications. Regardless of when HHSC publishes the annual list of pay-for-performance metrics and performance requirements, hospitals should be afforded at least thirty (30) calendar days to submit comments and participate in a public hearing.

Response: HHSC acknowledges these comments and has updated the rule to allow 30 calendar days for public comment. HHSC will post proposed quality metrics and requirements by August 10 and final quality metrics and requirements by October 1. HHSC has previously been able to engage stakeholders prior to posting the proposed metrics and quality requirements for public comment and HHSC plans to continue this practice when necessary and appropriate.

Comment: A commenter recommended that HHSC work with CMS to allow for meeting benchmark performance levels without requiring improvement over self when high levels of benchmark performance have been met.

Response: HHSC acknowledges the comment. No revision to the rule text was made in response to this comment because the comment on specific program quality metric achievement targets is not directly relevant to the content of the proposed rule amendment.

A minor edit is made to the title of §353.1306. The words "program periods" are capitalized.

STATUTORY AUTHORITY

The amendments are adopted 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.

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

(4) 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) 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) 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) 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) 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) Rural hospital--A hospital that is a rural hospital as defined in §355.8052 of this title.

(10) 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) 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 described in subsections (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. In the application, the hospital must also select whether the hospital elects to receive interim payments described by subsection (h)(2)(D) 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 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 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 described under subsection (h)(1) 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 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 September 1, 2021, 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) 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. 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, and the other hospital has an estimated ACR UPL of $600 and an ACR gap of $500, HHSC will first reduce the gaps by the UHRIP payment of $50 to a gap of $250 and $450, 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 will then direct the MCOs to pay a percentage increase for the first hospital of 71 percent in addition to the 50 percent increase under UHRIP for the first hospital for a total increase of 121 percent above the contracted base rate, and 128 percent in addition to the 50 percent increase under UHRIP for the second hospital for a total increase of 178 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.

(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 final payments for the APHRIQA component will be based on achievement of performance measures established in accordance with §353.1307 of this subchapter.

(A) Except as otherwise provided by subparagraph (D) of this paragraph, 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.

(D) For any performance measures for which achievement is determined on an annual basis, a hospital may elect, on the hospital's enrollment application, to receive two interim payments the amount of each which will be equal to 20 percent of the total estimated value of the hospital's potential APHRIQA payment if the hospital were to earn 100 percent of available payments under the APHRIQA component.

(i) Any interim payments will be reconciled with final payment for APHRIQA after measurement achievement has been determined under §353.1307 of this subchapter. If a hospital's final payment is calculated to be less than the amount that the hospital was paid on an interim basis, the interim payments are subject to recoupment as described by this subparagraph. If a hospital's final payment is calculated to be greater than the amount that the hospital was paid on an interim basis, the hospital's final payment will be an amount equal to the amount the hospital earned for measurement achievement under §353.1307 of this subchapter minus the amount the hospital was paid on an interim basis.

(ii) Prior to the beginning of the program period, for hospitals that make the election described by this subparagraph, HHSC will calculate the total estimated value of the hospital's potential APHRIQA payment if the provider were to earn 100 percent of available payments under the APHRIQA component. MCOs will distribute interim payments described by this subparagraph to enrolled hospitals as directed by HHSC.

(iii) Interim payments made under this subparagraph are not an indication of presumed measurement achievement by a provider under §353.1307 of this subchapter.

(iv) If a provider is notified by HHSC that an interim payment, or any portion of an interim payment, is being recouped under this subparagraph, the provider must return all funds subject to recoupment to the MCO that made the interim payment subject to recoupment within 20 business days of notification by HHSC.

(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) 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) 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) 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 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) and §353.1301(k) of this subchapter.

§353.1307. Quality Metrics for the Comprehensive Hospital Increase Reimbursement Program.

(a) Introduction. This section establishes the quality metrics for the Comprehensive Hospital Increase Reimbursement Program (CHIRP).

(b) Definitions. Terms that are used in this and other sections of this subchapter 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).

(c) Quality metrics. For each program period, HHSC will designate one or more quality metrics 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.

(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) 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) of this section.

(f) Participating Hospital Reporting Frequency.

(1) Participating hospitals will be required to report on quality metrics semiannually unless otherwise specified by the metric.

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

(g) Notice and hearing.

(1) HHSC will publish notice of the proposed metrics and their associated performance requirements no later than August 10 of the calendar year that precedes 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 30 calendar days of publication. There will also be a public hearing within that 30-day period to allow interested persons to present comments on the proposed metrics and performance requirements.

(h) Quality metric publication. Final quality metrics and performance requirements will be provided through the CHIRP quality webpage on HHSC's website on or before October 1 of the calendar year that precedes the first month of the program period.

(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 October 1, HHSC will provide notice of the changes through HHSC's website.

(j) 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 adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 9, 2024.

TRD-202400070
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 29, 2024
Proposal publication date: November 17, 2023
For further information, please call: (512) 487-3480

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1 TAC §353.1309

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §353.1309, relating to Texas Incentives for Physicians and Professional Services. The amendment to §353.1309 is adopted with changes to the proposed text as published in the November 17, 2023, issue of the *Texas Register* (48 TexReg 6683). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the amendment 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 & Medicaid Services (CMS) to create TIPPS for state fiscal year (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 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, therefore, amends and modifies the program rule to reduce administrative complexity and advance the program toward improved quality of services provided to Medicaid clients by participating providers.

Beginning in SFY 2025, the rule amendment will shift the program structure. For SFY 2025, Component One will be 90 percent of the total program value paid as a uniform rate increase at the time of claim adjudication, and Component Two will be 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 the 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 all future years, comprising 10 percent of the total program value, based on a uniform rate increase percentage paid at the 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 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 in subsequent program periods.

HHSC will 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 included other minor clarifying or grammatical revisions to improve the accuracy and readability of the rule text.

COMMENTS

The 31-day comment period ended December 18, 2023.

During this period, HHSC received feedback regarding the proposed rule from nine commenters at seven organizations: The University of North Texas Health Science Center at Fort Worth, Texas Tech University Health Science Center Lubbock, Texas Children's Hospital, The University of Texas Medical Branch, The University of Texas Health Science Center at Houston, Teaching Hospitals of Texas, and Texas A&M University Health Science

Center. A summary of the comments relating to the rule and HHSC's responses follows.

Comment: Multiple commenters suggested that HHSC require Managed Care Organizations (MCOs) to include visibility for TIPPS payments in the processing of adjudicated claims to enable providers to track TIPPS payments from MCOs.

Response: HHSC acknowledges the comment. While HHSC supports transparency between MCOs and providers, the content of contracts between MCOs and providers is outside the scope of the rule being amended. Therefore, it is not relevant to the proposed rule change. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters requested that HHSC clarify whether network status for enrollment purposes will be determined using the National Provider Indicator (NPI) assigned to the parent or umbrella network physician group, the NPI assigned to a clinic location of a network physician group, or another criteria such as documentation from an MCO that the network physician group is in the MCO's network.

Response: HHSC disagrees that the text of the rule requires clarification and declines to revise the rule in response to the comment. HHSC encourages all network physician groups to include all eligible NPIs, including those assigned to a parent or umbrella network group and those assigned to a clinic location, on enrollment applications so that HHSC can most fully evaluate the network status and eligibility of each network physician group. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions regarding NPIs at that time.

Comment: Multiple commenters asked HHSC to calculate TIPPS Component add-on amounts on a level specific to each Service Delivery Area (SDA).

Response: HHSC acknowledges the comment and is taking these suggestions into consideration for future program operations. However, HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment on such a change. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters asked HHSC to clarify the methodology for determining eligibility each program year.

Response: HHSC acknowledges the comment. HHSC encourages all providers to include all eligible NPIs on enrollment applications, including NPIs assigned to a parent or umbrella network physician group and those assigned to a clinic location, so that HHSC can evaluate the network status and eligibility of each provider. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions at that time. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters suggest reconciliation should be based on the number of unique Medicaid clients served by a network physician group and should not be tied to billing NPI where a single, enrolled Medicaid member may be counted multiple times within the same parent or umbrella network physician group. Some commenters recommend that clauses 353.1309(g)(1)(A)(vi) and (vii), as well as 353.1309(g)(2)(B) and (C), be struck accordingly.

Response: HHSC acknowledges the comment and is taking these suggestions into consideration for future program operations. However, HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment on such a change. No revision to the rule text was made in response to this comment.

Comment: One commenter suggested that HHSC implement a formal network status validation process that includes MCOs submitting a point of contact for network status validation, a standard reporting template or other system, and mediation services provided by HHSC.

Response: HHSC acknowledges the comment. Beginning in SFY 2025, the TIPPS enrollment process will include network status validation from both MCOs and providers. HHSC staff will remain available to assist providers with questions regarding network status. No revision to the rule text was made in response to this comment.

Comment: One commenter asked HHSC to require MCOs to track and verify group NPIs instead of individual provider NPIs.

Response: HHSC acknowledges the comment. HHSC encourages all network physician groups to include all eligible NPIs, including those assigned to a parent or umbrella network group and those assigned to a clinic location, on enrollment applications so that HHSC can most fully evaluate the network status and eligibility of each network physician group.

Comment: One commenter expressed concern about moving Components One and Two to uniform rate increases paid at the time a claim is adjudicated, citing a delayed payment timeline for Component Three rate increases in the current TIPPS program. The commenter disagrees with the change and requests that HHSC update contracts between HHSC and MCOs to include payment timelines and penalties for non-compliance.

Response: HHSC acknowledges the comment. HHSC supports the timely adjudication of claims and payment of rate increases. Please refer to Chapter 2 of the Uniform Managed Care Manual for processes and procedures related to claim adjudication. No revision to the rule text was made in response to this comment.

Comment: One commenter asked what codes will be receiving the Component One enhanced payments and whether the uniform enhanced rate has been determined.

Response: HHSC acknowledges the comment. All payable codes to providers, excluding certain services that are outside the scope of TIPPS, will receive a uniform rate increase. Payable taxonomy codes will be published on the Provider Finance Department website for TIPPS (https://pfd.hhs.texas.gov/acute-care/texas-incentives-physicians-and-professional-services) prior to the beginning of each applicable program period. No revision to the rule text was made in response to this comment.

Comment: One commenter requested clarification regarding whether care provided outside of the SDA for which an MCO has a contract with HHSC may qualify for TIPPS reimbursement.

Response: HHSC acknowledges the comment. TIPPS payments are made to in-network providers even if the care delivered is outside of the service delivery area in which the MCO operates. HHSC did not propose modifications related to this topic in the current rule proposal; consequently, other program participants and the public did not have an opportunity to comment

on such a change. Should an MCO and provider disagree regarding whether a claim is reimbursable within the provider/MCO network agreement, the provider and MCO should work through the typical and already established provider/MCO complaint processes. No revision to the rule text was made in response to this comment.

Comment: One commenter supports the proposed elimination of minimum volume requirements for eligibility purposes.

Response: HHSC acknowledges the comment and appreciates the support. No revision to the rule text was made in response to this comment.

Comment: One commenter requests clarification on whether the terms "physician group" or "provider group" have the same meaning.

Response: HHSC acknowledges the comment. HHSC appreciates the suggestion for clarification and is amending "provider group" to read "physician group" in the rule in two instances under Section 353.1309(e)(2), to ensure consistency of terms.

Comment: Multiple commenters believe there is a drafting error in multiple places within the proposed version of the rule, and that HHSC intended to propose: "[P]rogram periods beginning on or before September 1, 2023, but on or after September 1, 2021" instead of "[P]rogram periods beginning on or after September 1, 2023, but on or after September 1, 2021."

Response: HHSC agrees with the suggested edits and made changes to the rule accordingly.

Comment: Multiple commenters ask HHSC to revert to the previous methodology for assigning NPIs to an SDA in which the NPI bills the most claims.

Response: HHSC acknowledges the comment and will evaluate the methodology during the SFY 2025 model preparation. No revision to the rule text was made in response to this comment.

Comment: One commenter asks HHSC to include advanced practice providers in HHSC's list of eligible taxonomy codes for each component of the TIPPS program.

Response: HHSC acknowledges the comment and will evaluate the inclusion of advanced practice providers during the SFY 2025 model preparation. No revision to the rule text was made in response to this comment.

Comment: One commenter requests HHSC to explain if the proposed performance-based Component 2 in SFY 2026 will require a reconciliation or how the agency intends to avoid a reconciliation under the proposed process while also meeting the CMS regulatory requirement for all directed payment programs to be based on the utilization and delivery of services.

Response: HHSC acknowledges the comment. For program periods prior to SFY 2026, HHSC will continue to work with providers as well as CMS on actuarially sound reconciliations and meeting regulatory requirements. The intent of updating this portion of the rule is to eliminate the need for a reconciliation in program years that coincide with, and are subsequent to, SFY 2026. No revision to the rule text was made in response to this comment.

Comment: One commenter wants confirmation on whether HHSC intended for proposed §1309.353(g)(2)(B) and (g)(2)(C) to be at a consistent sub-order as (g)(1)(A)(vi) and (g)(1)(A)(vii), respectively. If so, they ask that HHSC confirm and correct the sub-order, or otherwise explain why identical provisions under Component Two apply to different program years than those under Component One.

Response: HHSC agrees with the suggested changes in the comment and made language updates to the rule text under Section 353.1309(g).

Comment: One commenter asks that the agency remain open to considering separate payment terms for TIPPS if CMS issues favorable regulations or guidance.

Response: HHSC acknowledges the comment and will consider program changes in response to updated CMS guidance, should CMS issue an update. No revision to the rule text was made in response to this comment.

Comment: One commenter supports HHSC's goal of simplifying the program structure.

Response: HHSC acknowledges the comment and appreciates the support. No revision to the rule text was made in response to this comment.

Comment: One commenter recommends that HHSC publish and disseminate the plan codes to enrolled providers once developed and assigned.

Response: HHSC acknowledges the comment. HHSC will disseminate any updates to plan code information to providers once developed and assigned. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters recommend amending "For program periods beginning on or after September 1, 2023, but on or after September 1, 2021" to read, "For program periods beginning on or after September 1, 2021," as those same clauses clearly call out and reference the changes specific to FY25 with the language "periods beginning on or after September 1, 2024." The commenter believes the labeling of the program periods covered under the initial rules is confusing as written and recommends amending "For program periods beginning on or after September 1, 2023, but on or after September 1, 2021" to read, "For program periods beginning on or after September 1, 2021, but prior to September 1, 2024."

Response: HHSC disagrees with the edit language suggested. HHSC made edits that more accurately reflect the rule's intended language, which is being corrected from "on or after September 1, 2023," to "on or before September 1, 2023," throughout the rule text. No revision to the rule text was made in response to this comment.

Comment: One commenter recommends that any minimum window for changes to enrollment information be at least 10 business days instead of 9 calendar days.

Response: HHSC acknowledges the comment and will consider the commenter's suggestion regarding changes to enrollment information for future program operations. No revision to the rule text was made in response to this comment.

Comment: One commenter requests clarification and guidance from HHSC on what "documentation" qualifies as proof of a network agreement. The commenter asked if only fully executed contracts with MCOs are acceptable or if the ability to demonstrate current contract negotiations with an MCO is sufficient for submission and network status credit at the time of TIPPS enrollment.

Response: HHSC acknowledges the comment. Beginning in SFY 2025, the TIPPS enrollment process will include network

status validation from both MCOs and providers. HHSC will verify network status at the time of enrollment, and HHSC staff will be available to answer specific questions at that time. No revision to the rule text was made in response to this comment.

HHSC made minor editorial changes in subsections (b)(5), (b)(7), (d)(2), (d)(10), (e)(7), (f)(1), (g)(1)(A)(i), (g)(1)(A)(vi), (g)(1)(B)(ii), (g)(1)(C)(ii), and (g)(2)(A)(vi), (g)(2)(C)(ii), and (g)(3)(A) to correct grammar and improve readability.

STATUTORY AUTHORITY

The amendment is adopted 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.

§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 MCO, as determined by the national provider identification (NPI) number and Plan Code combination.

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

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

(8) 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.

(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 before September 1, 2023, but on or after September 1, 2021, 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 to be eligible to participate in the 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 before 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 before 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 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 the eligibility status of other physician groups for program periods beginning on or before 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 physician group with multiple locations, based on the SDA in which the majority of a physician 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) 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) 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) Report all quality data denoted as required as a condition of participation in §353.1311(d)(1) of this subchapter.

(7) Failure to meet any conditions of participation described in this subsection will result in the 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 the 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 before September 1, 2023, but on or after September 1, 2021, the total value of Component One will be equal to 65 percent of the total program value.

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

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

(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.

(v) 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 the 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 the 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 the 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 before September 1, 2023, but on or after September 1, 2021, the total value of Component Two will be equal to 25 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.

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

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

(v) 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 the 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 September 1, 2024, Component Two will be equal to 0 percent of the program.

(C) 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 their 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 the 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 from Component One.

(i) For program periods beginning on or before 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 from Component Two.

(i) For program periods beginning on or before 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 adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on January 8, 2024.

TRD-202400063
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 28, 2024
Proposal publication date: November 17, 2023
For further information, please call: (512) 707-6071

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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 7. PESTICIDES

SUBCHAPTER D. USE AND APPLICATION

4 TAC §7.30

The Texas Department of Agriculture (Department) adopts amendments to Texas Administrative Code, Title 4, Part 1, Chapter 7, Subchapter D, §7.30 relating to "Classification of Pesticides." The amendments are adopted without changes to the proposed text, as published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 6983), and will not be republished.

The adopted amendments add new subsection (d) to classify pesticide products containing the active ingredient warfarin as a "state-limited-use" pesticide when used as a feral hog toxicant and to establish related licensure requirements. As a result of classification as a state limited use pesticide, the adopted amendments also ensure proper sales, use, and compliance by trained individuals and address the risk of potential misapplication or distribution resulting in possible secondary exposure to humans or non-target animals.

PUBLIC COMMENT

Pursuant to Sections 76.003(a) and 76.104 of the Texas Agriculture Code (Code), the Department conducted a public hearing to receive public comment on the proposed amendments. Notice of the hearing was provided in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7185). At the hearing, the Department received a comment from a commenter, on behalf of the Texas Farm Bureau, expressing support for the proposed amendments. No other comments were received at the public hearing.

The Department also received no written comments regarding the proposed amendments in response to publication in the *Texas Register.*

The amendments are adopted pursuant to Code, Section 76.003, which allows the Department to adopt a list of state-limited-use pesticides and to regulate their terms and conditions of use; Section 76.004, which allows the Department to adopt rules for carrying out the provisions of Chapter 76, to include rules providing for the distribution of pesticides; and Section 76.104, which allows the Department to adopt rules related to

the use and application of pesticides to include rules related to restricted-use and state-limited-use pesticides and regulated herbicides. The code affected by the adopted amendments is Texas Agriculture Code, Chapter 76.

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

Filed with the Office of the Secretary of State on January 11, 2024.

TRD-202400100
Susan Maldonado
General Counsel
Texas Department of Agriculture
Effective date: January 31, 2024
Proposal publication date: December 1, 2023
For further information, please call: (512) 463-6591

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION
SUBCHAPTER JJ. CIGARETTE, E-CIGARETTE, AND TOBACCO PRODUCTS REGULATION

34 TAC §3.1208

The Comptroller of Public Accounts adopts new §3.1208, concerning prohibited e-cigarette products, without changes to the proposed text as published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7160). The rule will not be republished. The new section implements House Bill 4758, 88th Legislature, 2023, which enacted Health and Safety Code, §161.0876 (Prohibited E-Cigarette Products).

The Texas Legislature has identified concerns that electronic cigarette ("e-cigarette") manufacturers have begun marketing their products to attract youth.

"Various e-cigarette manufacturers package e-cigarette products to appear nearly identical to popular candy, flavored juice boxes, and other edible treats. The similarity in packaging of e-cigarette products to children's snacks is a direct appeal from manufacturers to children, which entices them to consume these dangerous nicotine products. The CDC reports that 69 percent of youth are exposed to e-cigarette advertisement via retail stores, magazines, TV shows, movies, and the Internet. These mediums also use cartoon-like characters and celebrity imagery to appeal to youths. According to the CDC, in the 10-year period from 2011 to 2021, vaping rates among middle and high school student increased from 1.5 percent of youth to nearly 30 percent of youth using e-cigarettes. These deliberate and ongoing efforts considerably impact the consumption rates of e-cigarettes among youth and require swift action. In 2018, the Department of State Health Services determined that e-cigarette use has reached epidemic status among teens." House Comm. on Pub. Health, Bill Analysis, Tex. C.S.H.B. 4758, 88th Leg., R.S. (2023).

The Legislature enacted Health and Safety Code, §161.0876 to reduce youth consumption of e-cigarettes by prohibiting the marketing, advertising, or sale of e-cigarette products in containers designed to appeal to minors. *Id.*

Subsection (a) provides definitions. Paragraph (1) defines "cartoon." Health and Safety Code, §161.0876 uses the term but does not define it. The comptroller derives this definition from the definition of "cartoon" in the Master Settlement Agreement entered into in November 1998 by four United States tobacco manufacturers and the attorneys general of 46 States. The Master Settlement Agreement is available at: https://www.naag.org/wp-content/uploads/2020/09/2019-01-MSA-and-Exhibits-Final.pdf (last visited November 27, 2023).

Paragraph (2) defines "celebrity." See, e.g., David Tan, *Much Ado About Evocation: A Cultural Analysis of "Well-Known-ness" and the Right of Publicity,* 28 Cardozo Arts & Ent. L.J. 317, 340-41 (2010). The definition is consistent with dictionary definitions of the term. For example, the Oxford English Dictionary defines "celebrity" as "{a} well-known or famous person; (now chiefly) *spec.* a person, esp. in entertainment or sport, who attracts interest from the general public and attention from the mass media." Oxford English Dictionary, https://www.oed.com/dictionary/celebrity_n?tab=meaning_and_use (last visited November 27, 2023). Dictionary.com defines "celebrity" to mean "a famous or well-known person." *Dictionary.com,* https://www.dictionary.com/browse/celebrity (last visited November 27, 2023).

Paragraph (3) defines "container" based upon the dictionary definition of the term. For example, Merriam Webster defines "container" as "a receptacle (such as a box or jar) for holding goods." *Merriam-Webster.com,* https://www.merriam-webster.com/dictionary/container (last visited November 27, 2023). Dictionary.com defines "container" as "anything that contains or can contain something, as a carton, box, crate, or can." *Dictionary.com,* https://www.dictionary.com/browse/container (last visited November 27, 2023). The definition is consistent with the description of e-cigarette nicotine containers in Health and Safety Code, §161.0875 (Sale of E-cigarette Nicotine Containers), which provides that an e-cigarette nicotine container must satisfy the child-resistant effectiveness standards under 16 C.F.R. §1700.15(b)(1). Those federal standards, in turn, apply to "special packaging." The definition in paragraph (3) therefore provides that the term "container" includes the packaging of an e-cigarette product.

Paragraph (4) defines "e-cigarette" using the definition given in Health and Safety Code, §161.081(1-a) (Definitions).

Paragraph (5) defines "e-cigarette product" using the definition given in Health and Safety Code, §161.0876(a).

Paragraph (6) defines "food product." Health and Safety Code, §161.0876 uses the term but does not define it. The comptroller derives this definition from the definition of "food and food ingredients" in §3.293 of this title (relating to Food; Food Products; Meals; Food Service).

Paragraph (7) defines "minor" using the definition given in Health and Safety Code, §161.081(1-b).

Paragraph (8) defines "retailer." The definition is based on the definition given in Health and Safety Code, §161.081(4). The qualifier "coin-operated" is removed from the description of vending machines to better track the language in Tax Code, Chapters

154 (Cigarette Tax) and 155 (Cigars and Tobacco Products Tax), and to eliminate any confusion with coin-operated machines, which are regulated under the Occupations Code. In addition, because the comptroller does not permit e-cigarette vending machines, the term "e-cigarette" is deleted as a descriptor of vending machines.

Subsection (b) implements Health and Safety Code, §161.0876(b), which makes it an offense to market, advertise, sell, or cause to be sold an e-cigarette product if the product's container displays images or depictions aimed at minors, and §161.0901, which provides that the comptroller may take disciplinary action against a retailer who commits such an offense. Paragraph (1) provides specific examples of the types of depictions and images identified in §161.0876(b)(1) - (5). For example, Health and Safety Code, §161.0876(b)(1) provides that it is an offense to sell an e-cigarette product if the product's container "depicts a cartoon-like fictional character that mimics a character primarily aimed at entertaining minors." Subparagraph (A) adds that a superhero, video game character, or character from an animated television show may be a cartoon-like fictional character aimed at entertaining minors. Paragraph (2) cross-references §3.1204 of this title (relating to Administrative Remedies for Violations of Health and Safety Code, Chapter 161, Subchapter H or K).

The comptroller did not receive any comments regarding adoption of the amendment.

This section is adopted under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture), which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2 (State Taxation), and taxes, fees, or other charges which the comptroller administers under other law, and under Health and Safety Code, §161.0901 (Disciplinary Action Against Cigarette, E-Cigarette, and Tobacco Product Retailers), which provides the comptroller with the authority to adopt rules to implement the section.

The section implements Health and Safety Code, §161.0876 (Prohibited E-Cigarette Products) and §161.0901 (Disciplinary Action Against Cigarette, E-Cigarette, and Tobacco Product Retailers).

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

Filed with the Office of the Secretary of State on January 11, 2024.

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Jenny Burleson
Director, Tax Policy Division
Comptroller of Public Accounts
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For further information, please call: (512) 475-2220

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CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER I. VALUATION PROCEDURES

34 TAC §9.4038

The Comptroller of Public Accounts adopts new §9.4038, concerning definition of petroleum products, without changes to the proposed text as published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7162). The rule will not be republished. The new section replaces existing §9.4201, concerning definition of petroleum products, which the comptroller is repealing to improve the clarity and organization of Subchapter I. The section is also updated to better reflect the list of products that fall under this definition.

The definition in paragraph (14) is modified from its current form in order to hyphenate "kerosene-type," which is not currently hyphenated. The definitions are also expanded to incorporate the products of ethane, normal butane, isobtutane, and natural gasoline. No other changes are being made to the existing language of §9.4201.

The comptroller provides the definition of petroleum products to assist appraisal districts in the administration and implementation of Tax Code, §11.251 (Tangible Personal Property Exempt). The products defined by this section are not exempt under the "freeport" exemption provided by Tax Code, §11.251 and Texas Constitution, Article VIII, Section 1-j.

The comptroller did not receive any comments regarding adoption of the amendment.

The comptroller adopts the new section under Tax Code, §5.03 (Powers and Duties Generally), which provides the comptroller with the authority to adopt rules establishing minimum standards for the administration and operation of an appraisal district.

The new section implements Tax Code, §11.251 (Tangible Personal Property Exempt).

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

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Victoria North
General Counsel for Fiscal and Agency Affairs
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For further information, please call: (512) 475-2220

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34 TAC §9.4201

The Comptroller of Public Accounts adopts the repeal of §9.4201, concerning definition of petroleum products, without changes to the proposed text as published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7163). The rule will not be republished. The comptroller repeals existing §9.4201 in order to propose the adoption of a replacement §9.4038 to improve the organization of Subchapter I. The repeal of §9.4201 will be effective as of the date the new §9.4038 takes effect.

The comptroller did not receive any comments regarding adoption of the repeal.

The repeal is adopted under Tax Code, §5.03 (Powers and Duties Generally), which provides the comptroller with the authority to adopt rules establishing minimum standards for the administration and operation of an appraisal district.

The repeal implements Tax Code, §11.251 (Tangible Personal Property Exempt).

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

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