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 §353.1309, §353.1311

The Texas Health and Human Services Commission (HHSC) adopts new §353.1309, concerning Texas Incentives for Physicians and Professional Services; and new §353.1311, concerning Quality Metrics for the Texas Incentives for Physician and Professional Services Program. New §353.1309 and §353.1311 are adopted with changes to the proposed text as published in the December 25, 2020, issue of the *Texas Register* (45 TexReg 9367). The text of the rules will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the new rules is to describe the circumstances under which HHSC will direct a Medicaid managed care organization (MCO) to provide a uniform per member per month payment, certain incentive payments, and a uniform percentage rate increase to physician groups in the MCO's network in a participating service delivery area (SDA) for the provision of physician and professional services. The rules also describe the methodology used by HHSC to determine the amounts of the payments or rate increase.

Currently, Texas' Medicaid physician payments, made through either the fee-for-service (FFS) or managed care models, do not always cover all Medicaid allowable costs for physician and professional services. HHSC is adopting these new rules to align with the ongoing efforts to transition from the Delivery System Reform Incentive Payment (DSRIP) program and the Network Access Improvement Program (NAIP).

Healthcare policy experts believe that increasing reimbursements in a value- or incentive-based manner may result in improved health outcomes for clients. HHSC anticipates that the increased payments to certain physician groups will support access to services, promote better health outcomes, and increase focus on improving quality goals that are established as part of the Texas Medicaid program.

In May 2016, the Centers for Medicare and Medicaid Services (CMS) finalized a rule that allows a state to direct expenditures under its contract with an MCO under certain limited circumstances. Under the federal rule, a state may direct an MCO to raise rates for a class of providers of a particular service by a uniform dollar amount or percentage, or as a performance incentive, subject to approval of the contract arrangements by CMS. To obtain approval, the arrangements must be based on the utilization and delivery of services; direct expenditures equally, and using the same terms of performance, for a class of providers of a particular service; advance at least one of the goals and objectives of the state's managed care quality strategy and have an evaluation plan to measure the effectiveness of the arrangements at doing so; not condition provider participation on an intergovernmental transfer (IGT); and not be automatically renewed.

These new rules authorize HHSC to use IGTs from governmental entities or from other state agencies to support capitation payment increases in one or more SDAs. Each MCO within the SDA would be contractually required by the state to increase payments by a per member per month payment, a performance incentive payment, or a uniform percentage for one or more classes of physician groups in the MCO network that provide services within the SDA.

Conceptual Framework

Eligibility:

HHSC determines eligibility for payments by physician group class. The SDA must have at least one governmental entity willing to provide IGT to support increased payments. Also, to be eligible for the reimbursement increase, a physician group must be within a class designated by HHSC to receive the increase.

HHSC will classify physician groups into three groups: health-related institution physician groups, indirect medical education physician groups, and other physician groups. The classifications allow HHSC to direct reimbursement increases where they are most needed and to align with the quality goals of the program. The reimbursement increase will be uniform for all providers within each class; but if HHSC directs rate increases to more than one class within an SDA, the reimbursement increase may vary between classes.

Services subject to rate increase:

HHSC may direct rate increases for all or a subset of physician and professional services based on advancing the goals and objectives of HHSC's managed care quality strategy.

Determination of rate increase:

HHSC will consider several factors in determining the percentage rate increase that will be directed for one or more classes of physician groups within an SDA, including the amount of available funding; the class or classes of physician groups eligible to receive the increase; the type of service subject to the increase; budget neutrality; and the actuarial soundness of the capitation payment needed to support the increase.

Reconciliation and recoupment:

HHSC will follow the methodology described in Texas Administrative Code Title 1 §353.1301 to reconcile the amount of non-federal funds expended under this section and to authorize recoupments of overpayments or disallowed amounts.

COMMENTS

The 31-day comment period ended January 25, 2021.

During this period, HHSC received feedback regarding the proposed rules from thirty (30) commenters: American College of Obstetricians and Gynecologists-District XI (Texas); Amerigroup Texas, Inc.; Baylor College of Medicine; Children's Health System of Texas; Community Health Systems; Coryell Health; Dell Medical School at UT Austin; Discovery Medical Network; Doctors Hospital at Renaissance, Ltd. (DHR Health); Gjerset & Lorenz, LLP; Mitchell County Hospital; Raymondville Pediatrics; Rolling Plains Memorial Hospital; Teaching Hospitals of Texas (THOT); Texas Academy of Family Physicians; Texas Association of Community Health Plans;

Texas Association of Health Plans; Texas Association of Obstetricians and Gynecologists; Texas Chapter of the American College of Physicians Services;

Texas Children's Hospital; Texas Essential Healthcare Partnerships (TEHP); Texas Hospital Association; Texas Medical Association (TMA); Texas Organization of Rural & Community Hospitals (TORCH); Texas Pediatric Society; Travis County Healthcare District, d/b/a Central Health; University Health; University of Texas at Southwestern Medical Center; University of Texas Health Science Center at Houston; and University of Texas Health Science Center at Tyler.

A summary of the comments received and HHSC's responses to the comments follow.

Definitions

Comment: The proposed definition of "Health Related Institution (HRI) physician practice group" in §353.1309(b)(1) says it must be "associated with an institution named in the Texas Education Code §63.002". Several commenters asked HHSC to clarify what is meant by "associated with" for purposes of determining eligibility to participate in this class. For example, the commenters asked "does a written contract between a physician group and an HRI named in the Texas Education Code to provide resident training meet the requirement? Or, is HHSC's intent that only the physician groups owned and operated by the HRI are eligible?"

One commenter said HHSC should revise the definition to ensure that all physician groups owned or operated by, contracted with, or otherwise affiliated or associated with a hospital district created under Chapter 281 of the Texas Health and Safety Code are included in the definition.

Response: HHSC agrees with commenters that additional clarity to the definition would be beneficial and amended the rule in response to these comments. HHSC has updated the definition of HRI physician group at §353.1309(b)(1) to clarify that the term means a physician group owned or operated by the HRI.

Comment: Multiple commenters asked HHSC for clarification on the definition of "Indirect Medical Education (IME) physician practice group" in §353.1309(b)(2). Some of the commenters noted that the inpatient reimbursement rule at 1 TAC §355.8052(d) does not use the term "IME add-on," but instead describes two separate medical education add-ons -- one for urban hospitals and one for children's hospitals. The commenters said the use of the term "IME add-on" leaves room for multiple interpretations of physician practice groups eligible to participate in the program as a member of this class.

Other commenters recommended HHSC amend the definition to clarify that Component Three includes IME physician practice groups and practices affiliated with children's hospitals that receive graduate medical education funding.

Response: HHSC agrees with commenters that additional clarity to the definition would be beneficial and amended the rule in response to these comments. HHSC updated the definition of an IME physician group at §353.1309(b)(2) to clarify that it applies to a hospital receiving either a medical education add-on or a teaching medical education add-on as described in 1 TAC §355.8052.

Comment: Multiple commenters recommended HHSC revise the definition of "Indirect Medical Education (IME) physician practice group" in §353.1309(b)(2) to accommodate various hospital-affiliated physician group structures utilized in Texas by IME hospitals, such as 501(a) organizations. One commenter opposed HHSC removing the requirement that IME physician practice groups assign their billing rights to the IME hospital with whom they contract. The commenter said removing the assignment requirement will open the program up to more providers which will significantly further dilute their potential benefit.

Response: HHSC declines to revise the rule as recommended. Eligibility for the IME physician group will be based upon the billing provider's national provider identification (NPI) number only. The various hospital-affiliated physician group structures noted by the commenters may be eligible to participate under Component Three if they can meet the requirements of the "Other" physician group class and if the participation requirements are met.

Comment: Three commenters requested the definition "IME physician practice group" also clarify that the threshold for eligibility of a physician group will be tied to whether the hospital with which the group is affiliated has an approved teaching program during the applicable Texas Incentives for Physicians and Professional Services (TIPPS) program period that makes the hospital eligible to receive the IME add-on, instead of being tied to actual receipt of the add-on.

Response: HHSC declines to revise the rule as suggested. Eligibility for the IME physician group will be assessed at the time of application for the program period and will be determined based upon whether the hospital with which the group is affiliated is receiving the IME add-on at the time the application is made.

Comment: One commenter noted that neither the term "physician practice group" nor "physician group" is defined and that both are used throughout the proposed rules. The commenter requested HHSC adopt "physician practice group" throughout the rules and remove references to "physician group". The commenter also requested that whichever term is chosen to be defined.

Response: HHSC agrees with the commenter that only one term should be used throughout the rules. The correct term is "physician group." The rules are amended accordingly.

Eligibility for Participation in TIPPS

Comment: One commenter supports that the program allows individual members in a class to participate without the whole class.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: Multiple commenters noted that the rules do not define "professional services" or directly address their inclusion. The commenters asked HHSC to clarify whether and how the rules apply to other professional services, such as services provided by advanced practice nurse practitioners or physician assistants. The commenters also asked HHSC to clarify if proposed §353.1309(c)(1) includes other professional services.

Response: HHSC declines to make revisions based on this comment. The taxonomy code list associated with physician groups will be published online when the TIPPS application is posted. These taxonomy codes may include services delivered by other medical professionals operating as part of a physician group.

Comment: One commenter expressed appreciation for including community-based physicians in the program.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: Two commenters were concerned that the pool for Total Other Physicians concentrates all the benefits in metropolitan centers, and eliminates almost all benefits for rural areas, except a few physicians that are part of larger groups associated with HRI or IME. The commenters acknowledged and are appreciative of HHSC's efforts to implement a directed payment program for rural health clinics but said that the new program only pertains to clinical services and neglects to deal with the largest and critical rural Medicaid services, namely obstetrical and behavioral health care in rural communities. One of the commenters proposed HHSC include an additional class for physician practices employed, affiliated, or contracted with rural hospitals.

Response: HHSC declines to revise the rule as suggested. The rule as proposed does not exclude rural physicians from participating in TIPPS, unless they are unable to meet the participation requirements.

Comment: One commenter asked if HHSC will determine eligibility based on provider identifier (e.g., NPI or Texas Provider Identification (TPI) number), Tax Identification Number (TIN), or something else. For example, if a hospital has multiple physician groups, each with their own TIN, that all bill using the same billing entity/TPI, would the individual physician groups be eligible to participate separately in TIPPS if they meet the requirements for one of the three classes?

Response: No changes were made in response to this comment. Eligibility will be determined based upon the billing provider's NPI and taxonomy code combination.

Comment: One commenter asked where they can obtain a list of TIPPs eligible physician groups under IME.

Response: No changes were made in response to this comment. Eligibility in the IME add-on class is defined in the rule. The taxonomy code list associated with physician groups will be published online when the application is posted. HHSC will determine eligibility based on the applications received.

Comment: Two commenters are concerned that rural providers aren't allowed to participate in Component One or Component Two. The commenter said these services have been key to achieving quality improvement goals and are currently not reimbursed or significantly underpaid by MCOs. The other commenter said it appears that less than 10 percent of the program will be devoted to the other physician category, and that won't be enough to motivate small community physician practices to participate.

Response: No changes were made in response to this comment. The eligibility groups in TIPPS are not focused on a specific region or demographic criteria; therefore, rural providers are not categorically limited from participation in Component One or Component Two. HHSC recognizes that the number of physician groups that practice at hospitals meeting the criteria described or owned or operated by an HRI and located in a rural community may be limited. This program is designed as a transition from NAIP and DSRIP so a large focus of the funding allocations to Components One and Two are targeted to these historical program participants. However, in an effort to expand the program to new providers, HHSC created Component Three which is open to all other physician groups. HHSC will continue to evaluate the distribution of funds amongst the three components and will scale the components in accordance with the quality and value-incentives that the program seeks to create.

Comment: One of the commenters argued that Component One and Component Two represent a significant number of quality improvement activities that will cease after DSRIP due to zero funding or enhanced payment. This includes Care Coordination, Care Transitions, Telehealth and Preventive Health Screenings. One commenter also asked why primary care isn't included in Component Three.

Response: No changes were made in response to this comment. There is a separate process to submit feedback on measures and HHSC welcomes any suggestions for evidence-based measures. Many of the proposed measures are based on DSRIP measures and best practices to continue the success of DSRIP.

Comment: Multiple commenters recommended revisions to proposed §353.1309(c)(2) which specifies that physician groups must have a minimum denominator volume of 30 Medicaid managed care patients in at least 60 percent of the quality metrics in each component to be eligible to participate in the component. Most of the commenters recommended the language be clarified to allow physicians to meet the minimum requirements by counting their total Medicaid managed care patients rather than counting by health plan. These commenters reasoned that physicians who participate in Medicaid often contract with more than one Medicaid MCO, so while in aggregate they may have 30 Medicaid patients in at least 60 percent of the quality metrics, they may not for every plan. These commenters also recommended the threshold be set at 50 percent, at least for physicians eligible for Component Three, to accommodate a wider array of physician specialties.

One commenter recommended the language be amended to require a minimum of 30 Medicaid (both fee-for-service and managed care) patients in at least 60 percent of the quality metrics in each component to be eligible for that component. This commenter said tying the denominator to Medicaid managed care patients potentially ignores the fact that DSRIP, which is largely the predecessor to TIPPS, included Medicaid fee-for-service patients in addition to patients in managed care.

Another commenter said that HHSC should consider increasing the proposed minimum volume.

Response: The minimum denominator volume of 30 Medicaid managed care patients is intended to apply across all included Medicaid managed care program health plans and not by each individual health plan or managed care program. The minimum

volume is intended to align with the requirement that directed payment programs are based on Medicaid managed care utilization. The majority of Texas Medicaid patients are in managed care. The minimum volume of 30 aligns with use in other quality programs.

However, HHSC agrees that the program should accommodate many specialties and that a minimum patient denominator of 60 percent may be too limiting. HHSC made a change in response to this comment and revised the requirement in §353.1309(c)(2) from 60 percent to 50 percent based on stakeholder feedback.

Comment: Two commenters suggested that physician services provided to Medicaid patients by Federally Qualified Health Center (FQHC) and community-based practices be eligible to report on, participate in, and receive payments under proposed Components One, Two, and Three.

Response: HHSC declines to revise the rule as suggested. Physician services provided by and billed by FQHCs already have a federally directed enhanced reimbursement rate and are therefore excluded. Community-based groups may be eligible under the Other category.

Data sources for historical units of service and clients served

Comment: One commenter noted that relationships between MCOs and hospitals vary, as do payment methodologies. As a result, there are times when looking at information in a specific way, such as by Current Procedural Terminology (CPT) or by Diagnosis Related Group may present a distorted view of payment. In order to recognize these situations, but not distort program computations, the commenter recommended that HHSC use a methodology that accounts for related party payments where if a provider with the same Tax Identification Number as the payor is paid more than 200 percent of the Medicaid reimbursement fee schedule then a calculated average payment rate from the rest of the provider pool is applied to the related party units of service.

Response: HHSC agrees that when payments to a related-party exceed the average reimbursement rate paid to non-related parties, an adjustment to the data used for calculation of allocations and funds should be made. HHSC has amended the rule to add §353.1309(d)(10) to specify that 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.

Comment: Proposed §353.1309(d)(2) states that HHSC will use the most recently available Medicaid encounter data for a complete state fiscal year to determine eligibility status of other physician practices. Multiple commenters requested HHSC clarify in the rules where HHSC will obtain the data. The commenters said the rules imply but do not clearly specify that HHSC will rely upon data already available within its data warehouse rather than obtaining data from the MCOs or eligible physician practices. The commenters also noted that the rules do not outline a process for a physician practice to correct any potential data discrepancies between the state and practice level data.

Response: No changes were made in response to these comments. HHSC will use historical encounter data provided by MCOs. Physician groups will need to address any data discrepancies with their MCOs.

Comment: One commenter strongly agrees with using commercial rates to determine the various payment amounts described in TIPPS. However, on occasion, it might be possible that the rate for certain services cannot be calculated, often for lack of information. As such, the commenter requested HHSC add the following as new §353.1309(d)(7):

"If HHSC is unable to compute an actuarially sound payment rate based on private payor information described in subparagraph (d)(6) for any services, then those services will be removed from consideration from this program."

Response: HHSC agrees with the commenter and added the suggested language as new §353.1309(d)(7).

Comment: One commenter said that not all services are appropriate for rate increases under the auspices of the program as described and that they do not believe it was HHSC's intent to inadvertently allow certain services to be eligible for TIPPS. The commenter added that to the extent that TIPPS would replace DSRIP and NAIP, the experience from those programs should inform eligibility for TIPPS. The commenter requested HHSC add the following as new §353.1309(d)(8):

"All services delivered at an FQHC, dental services, and ambulance services are excluded from the scope of this program."

Response: HHSC agrees with the commenter and added the suggested language as new §353.1309(d)(8).

Comment: One commenter is concerned that only certain encounter data should be used when calculating payments. Encounters with a reported paid amount of zero or negative dollars would skew the calculations inappropriately. The commenter requested HHSC add the following as new §353.1309(d)(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 this program."

Response: HHSC agrees with the commenter and added the suggested language as new §353.1309(d)(9).

Comment: One commenter asked HHSC to share a list of eligible NPIs and taxonomy codes with the MCOs. This commenter referenced proposed §353.1309(d)(1) which says "HHSC will use encounter data and will identify encounters based upon the billing provider's national provider identification (NPI) number and taxonomy code combination that are billed as a professional encounter only."

Response: No changes were made in response to this comment. The taxonomy code list associated with physician groups will be published online when the application is posted. HHSC will determine eligibility based on the applications received.

Comment: One commenter asked HHSC to provide the list of CPT codes eligible for rate increases under Component Three. The commenter also asked if the same CPT codes are used in the attribution methodology.

Response: No changes were made in response to this comment. For the state fiscal year 2022 program proposal, specific CPT codes were posted in the TIPPS Requirements document here: https://hhs.texas.gov/sites/default/files/documents/laws-regu-

lations/policies-rules/Waivers/medicaid-1115-waiver/tipps-requirements.pdf.

Participation Requirements

Comment: Three commenters are concerned that proposed §353.1309(e)(2) would effectively make a physician practice group ineligible to participate in TIPPS if it has paid a consultant or lawyer fees for assistance with TIPPS if revenue from TIPPS payments is used to cover such fees, regardless of the underlying fee structure. The commenters added that while it appears that consulting fees and legal fees that are paid from a physician practice group's non-TIPPS revenue sources would not cause any issues under proposed §353.1309(e)(2), isolating revenue from TIPPS payments in such a way to ensure that such revenue is not utilized for consulting and legal services related to TIPPS may be administratively difficult for many physician practice groups.

If HHSC is unwilling to remove proposed §353.1309(e)(2) completely, the commenters recommend revising the certification to be more narrowly tailored and bars a group if it uses TIPPS revenue to pay fees to a consultant or legal advisor contingent on the amount of the group's TIPPS revenue.

Response: HHSC agrees with the commenter that the rule language should be refined to more clearly prohibit contingency fees for services that are based solely on the amount of the physician group's TIPPS revenue. HHSC also agrees that physician groups may utilize consultants, advisors, or legal counsel for a variety of reasons. HHSC has amended §353.1309(e)(2) to specify 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, and the certification must be received by HHSC with the enrollment application.

Comment: Three commenters strongly oppose proposed §353.1309(e)(3) and recommend it be removed. Proposed §353.1309(e)(3) would impose as a condition of participation in TIPPS that "[t]he entity that owns the physician practice group must submit to HHSC, upon demand, copies of contracts it has with third parties that reference the administration of, or payments from, TIPPS." The commenters strongly believe that this condition, particularly in combination with proposed §353.1309(e)(2), would not only impose a significant new administrative burden for participating private physician practice groups, but it would also constitute an intrusion of the state government into private contracting and enterprise.

Two of the commenters added that at a minimum, the broad language of §353.1309(e)(3) should be revised to state that "If a provider has changed ownership or management in the past five (5) 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 and/or the management of the provider and which reference the administration of, or payment from, this program."

Response: HHSC agrees with the commenter that HHSC does not wish to impose significant administrative burdens or to infringe upon third parties' relationships to which no governmental entity is a party. HHSC's intent of the proposed language was specific to instances where a change of ownership has occurred that would impact the eligibility of the provider. HHSC made a change to §353.1309(e)(3) to clarify the applicability of this provision.

Comment: One commenter agrees with the proposal to make TIPPS an application-based program but is concerned that the enrollment period in proposed §353.1309(e)(1) is too short. The commenter said without knowing what would be required in the application, 21 days could prove insufficient time to provide an accurate application. The commenter requested that §353.1309(e)(1) be amended to read "no less than 30 calendar days".

Response: HHSC declines to revise the rule as suggested. HHSC is working to ensure that the application for the program will minimize administrative burden on providers as much as possible.

Non-federal share of TIPPS payments

Comment: Two commenters noted that proposed §353.1309(f)(2) appears to require all sponsoring governmental entities to submit a declaration of intent to transfer IGT to HHSC for the entire program period. However, subsection (f)(1) only requires that HHSC provide notice of "suggested IGT responsibilities for the program period" to eligible and enrolled HRI and IME physician groups prior to the IGT declaration of intent deadline. The notice to those entities would include the "estimated utilization for eligible and enrolled other physician practice groups within the same service delivery area." The commenters said it is unclear whether HHSC intends to provide notice to sponsoring governmental entities of the "other" group or whether it intends for the sponsoring governmental entities of the HRI and IME physician groups to fund the non-federal share of the TIPPS rate increases to the "other" class.

The commenters asked HHSC to clarify whether the "other" class members will be required to identify a sponsoring governmental entity to be notified of suggested IGT amounts.

Response: No changes were made in response to this comment. IGT suggestions are informational in nature and are non-binding. HHSC will make IGT suggestions for governmental entities participating as HRI physician groups or IME physician groups. Actual IGT received will be pooled at the SDA level and will be used for all providers of any class within the SDA proportionally.

Comment: Multiple commenters recommended HHSC revise the rules to specify that if general revenue becomes available, it could be allocated to TIPPS. The commenters understand that general revenue is not currently available but believe the proposed language in §353.1309(f) precludes the possibility of gaining general revenue dollars in the future.

Response: No changes were made in response to this comment. If HHSC receives legislative direction to modify the program's funding source, HHSC will amend the rules at that time.

Comment: One commenter asked HHSC to confirm that the IGT notification in §353.1309(e)(1) and the "suggested IGT responsibility" in §353.1309(f)(1) are the same. The commenter also requested the terms be defined in the rule.

Response: HHSC amended §353.1309(b) to include definitions of these terms and made small modifications to other parts of the rule to more clearly distinguish between these terms.

Comment: Two commenters requested HHSC amend §353.1309(f)(3) to revise the timeline for collecting IGTs. One of the commenters requested HHSC allow for quarterly, instead of semi-annual IGTs. The other commenter asked HHSC to

consider collecting IGTs on a timeline that is more contemporaneous with the lump-sum payment distributions, similar to NAIP, DSRIP, Uncompensated Care (UC), and Disproportionate Share Hospital. This commenter said the proposed IGT process poses significant cash flow burdens on sponsoring governmental entities and is unnecessary if HHSC proceeds with directing lump-sum payments based on historical utilization because, like DSRIP, HHSC will have "known" payment amounts.

Response: IGT transfers for directed-payment programs will be made semi-annually for all programs. However, HHSC made edits to §353.1309(f)(2) and (3) in response to this comment to ensure units of local government have adequate time to prepare for the semi-annual IGT transfer.

Comment: One commenter said their understanding of the proposed rule is that if in a given service area, no sponsoring entity puts up funds, then no physician practice groups in the area would be eligible to earn TIPPS funds. The commenter recommended HHSC consider other approaches to pooling IGT for the program, including doing so at the state level while putting safeguards in place to ensure Medicaid providers that have a source of IGT (HRIs and IME hospitals) put up their fair share to participate.

Response: No changes were made in response to this comment. HHSC considered both statewide and SDA-wide pooling of funds during the development stage of the program, but believes that the majority of governmental entities prefer uniformity on an SDA-basis.

TIPPS capitation rate components

Comment: One commenter asked if they will get re-evaluated for their valuation amount for TIPPS or will their valuation stay the same from DSRIP into TIPPS. The commenter also asked how their valuation will be calculated.

Response: No changes were made in response to this comment. TIPPS payment amounts will be based upon the proportion of utilization of a provider to the total utilization of all participating providers. Actual amounts available may fluctuate from year to year. There are no pre-determined valuations as those in DSRIP.

Comment: One commenter asked if there is any indication of what the increase will be to meet the performance measures.

Response: No changes were made in response to this comment. This is out of the scope of the rules as measure performance requirements are being determined through a separate process.

Comment: Multiple commenters advocated for HHSC to limit participation in Component Three to community physicians only, which is the only TIPPS component these physicians are eligible to participate in. The commenters said that given the limited amount of dollars within this component (i.e., 10 percent of total TIPPS funding), the more physicians who are eligible and meet performance metrics, the fewer dollars will be available proportionately.

Response: No changes were made in response to this comment. HHSC believes that the targeted rate increase for the codes in Component Three will incentivize providers in all classes to provide access to quality care. For this reason, HHSC believes all classes of providers should be included in this component.

Comment: One commenter asked HHSC to clarify how and when each TIPPS component will be paid and what the practical difference is between the Component One PMPM increase and the rate increase for Component Two and Component Three.

Response: No changes were made in response to this comment. Component One will be paid on a monthly lump sum basis based upon historical numbers of clients served and subject to the reconciliation described in 353.1309(g)(1)(E). Component Two of TIPPS will be paid on a semi-annual lump sum basis based upon historical Medicaid utilization. Component Three will be paid as a uniform rate increase on per claim basis based upon actual Medicaid utilization.

Comment: One commenter asked if Component Two is for all charges for all managed care Medicaid patients, regardless of care setting.

Response: No changes were made in response to this comment. Component Two will be based upon historical paid claims, not charges, for the billing provider participating in the component.

Distribution of TIPPS Payments

Comment: One commenter asked if the payments will be made through a claim-by- claim basis or a lump sum.

Response: No changes were made in response to this comment. Component One will be paid on a monthly lump sum basis. Component Two of TIPPS will be paid on a semi-annual lump sum basis. Component Three will be paid as a uniform rate increase on per claim basis.

Comment: One commenter asked HHSC to discontinue the practice of using the MCO's claim system as an intermediary pass-through system. According to the commenter, IGT dollars are provided to MCOs capitation merely to pass-through payments to providers and MCOs should not be a fiduciary intermediary in funding providers. The commenter said maintaining the integrity of a claim system is paramount to avoid downstream confusions. The commenter asked HHSC to replicate the Quality Incentive Payment Program (QIPP) for Nursing Facilities in a similar way for TIPPS. In QIPP, upon completion, HHSC notifies the MCOs of the eligible incentive payment for the applicable providers and the funds provided are completely autonomous of the MCO's Claims System.

Response: No changes were made in response to this comment. Component One and Component Two of TIPPS will be paid on a basis that does not require modification of the claiming system. Component Three will require a modification to claims as HHSC is directing MCOs to increase rates on a uniform basis for achievement and to pay claims at the percentage increase.

Comment: Multiple commenters recommended the proposed payment requirements for Component Three be amended to include "improvement over self" (IOS) measures in §353.1309(h)(1)(E). For Component Three, a physician practice would have to "achieve a minimum of one benchmark measure to be eligible for full payment." The commenters noted that of the currently proposed six measures for Component Three, only one - comprehensive diabetes care - is a "benchmark measure." The currently proposed rules would therefore seem to impose a mandatory requirement that to receive payment, physician practices must achieve the benchmark measure for comprehensive diabetes care. Not all community physicians will be able to meet every measure in Component Three. For example, this benchmark measure generally does not apply to general pediatricians.

Response: HHSC agrees that achieving one benchmark may be challenging for community physicians and revised §353.1309(h)(1)(D), (E), and (F) to address achievement and minimum volume.

Comment: One commenter noted that proposed §353.1309(h)(1) describes the required achievement necessary for payment with respect to both Component Two and Component Three (i.e., number of benchmarks that must be met), but does not specify the same with respect to Component One. The commenter asked HHSC to clarify this difference.

Response: No changes were made in response to this comment. Component One includes structure measures that require reporting on status rather than achievement. If reporting is complete, then requirements have been met.

Comment: One commenter noted that proposed §353.1309(h)(1) describes the payment frequency with respect to both Component One (monthly) and Component Two (semi-annually), but does not appear to specify the same with respect to Component Three. The commenter asked HHSC to clarify how frequently payments will be made under Component Three.

Response: No changes were made in response to this comment. For Component Three, the payments to providers will be on a per claim basis and paid as a uniform rate increase above the Medicaid managed care contracted rate. However, eligibility to receive such an increase will be determined based upon achievement semi-annually.

Reconciliation

Comment: One commenter is concerned that there may be a conflict if different criteria are used to estimate the distribution of TIPPS funds as described in §353.1309(d) and the reconciliation as described in §353.1309(g)(1)(E).

Response: No changes were made in response to this comment. Subsection (d) describes the initial eligibility criteria whereas (g)(1)(E) describes the reconciliation process that will ensure the estimated clients served were actually served.

Comment: One commenter requested clarification around the MCO reconciliation process for all components. The commenter asked if HHSC is proposing a reconciliation process that will operate in the same manner as QIPP. The commenter said that if payments are made on a per claim basis, HHSC must make an assumption up front, and asked how the reconciliation is handled if that amount is insufficient.

Response: No changes were made in response to this comment. Reconciliations related to the transfer of intergovernmental transfer funds are made in accordance with the process described in §353.1301(g). In TIPPS an additional reconciliation will be performed for Component 1 if there is a variation between the historical number of clients served and actual clients served.

Funding Allocation

Comment: Considering critical physician groups' participation in historical DSRIP and NAIP, one commenter was concerned that the proposed eligibility and allocation methodology in TIPPS may not result in an equitable allocation of available funding. The commenter said this could result in material changes in funding for these historical participants and impact access for clients.

Response: No changes were made in response to this comment. This program is designed as a transition from NAIP and DSRIP, so a large focus of the funding allocations to Components One and Two are targeted to these historical program participants. However, in an effort to expand the program to new providers, HHSC created Component Three which is open to other physician groups. HHSC will continue to evaluate the distribution of funds amongst the three components and will scale the components in accordance with the quality and value-incentives that the program seeks to create.

Comment: One commenter said the pool for Total Other Physicians is unreasonably low and does not provide funding to follow the patients. From the data in the TIPPS model posted on HHSC's website, the Medicaid physician payments of $458 million comprise 66 percent of the total Medicaid expenditures, but only receive 9 percent of the TIPPS benefits. The Other Physicians receive an 11 percent increase, while HRI receives 238 percent increase and IME receive 134 percent increase. According to the commenter, to promote a program that increases the payments double and triple for only one third of the patients is not reasonable and is not geared to actually improving care. The commenter also thinks the disproportional distribution to urban areas is also unreasonable.

Response: No changes were made in response to this comment. The funding allocation in TIPPS is not focused on a specific region or demographic criteria; therefore, rural providers are not categorically limited from receiving payments through the program. This program is designed as a transition from NAIP and DSRIP so a large focus of the funding allocations to Components One and Two are targeted to these historical program participants. However, in an effort to expand the program to new providers, HHSC created Component Three which is open to other physician groups. HHSC will continue to evaluate the distribution of funds amongst the three components and will scale the components in accordance with the quality and value-incentives that the program seeks to create.

Comment: Referencing the TIPPS modeling HHSC shared, two commenters expressed concern with the community physician allocation for their service delivery area and noted that the allocation isn't proportional to the Medicaid enrollment for that service delivery area.

Response: No changes were made in response to this comment. HHSC released modeling for illustrative purposes only. Inclusion of other community physicians is based on their actual utilization. There is no participation allocation amongst the SDAs.

Comment: One commenter noted that they are eligible to receive the IME add-on but have not yet applied so they are not included in the modeling that HHSC posted to its website on January 22, 2021. The commenter said they plan to apply for the IME-add on for effect in SFY 2022 and asked if HHSC would update the modeling to include them.

Response: No changes were made in response to this comment. HHSC released modeling for illustrative purposes only. Physician groups will be able to enroll and provide HHSC with NPIs that they wish HHSC to use to determine eligibility at the time of the annual application.

Comment: One commenter said that they delegate their billing of professional services delivered to an IME hospital eligible to participate in the rule but were not included in HHSC's modeling for the program.

Response: No changes were made in response to this comment. HHSC released modeling for illustrative purposes only. Physician groups will be able to enroll and provide HHSC with NPIs that they wish HHSC to use to determine eligibility at the time of the annual application.

Comment: One commenter requested the HRI class be eligible to receive payments based on 100 percent of the average

commercial rate (ACR). The commenter reasoned that a significant portion of the program is dedicated to per member per month payments, thus further promoting value over volume, and believes the level of effort necessitated by TIPPS merits an increase in reimbursement. The commenter also reasoned that HRIs are providing at least some of the non-federal share of payments for the community physicians and that it appears from the modeling HHSC shared that payments to the community physicians are made possible through the ACR of the other two eligibility groups, which the commenter says has the impact of artificially reducing the payments that an HRI could receive through TIPPS.

Response: No changes were made in response to this comment. HHSC will determine the size of the program each year as a matter of policy after having considered program goals, available room under budget neutrality limits, and other factors that HHSC considers relevant. The proposed program size is not within the scope of the rules.

Comment: One commenter expressed concern with the annual pool size HHSC announced for the TIPPS program, saying it's significantly less than the pool size discussed during the workgroup in fall 2020. This commenter requested additional funding be dedicated to the TIPPS program and requested HHSC provide justification for the reduced TIPPS funding in light of increases in other programs, particularly increases in CHIRP funding.

Response: No changes were made in response to this comment. HHSC will determine the size of the program each year as a matter of policy after having considered program goals, available room under budget neutrality limits, and other factors that HHSC considers relevant. The proposed program size is not within the scope of the rules.

Quality Metrics

Comment: Multiple commenters said Medicaid MCOs have substantially similar quality and performance initiatives as part of their value-based payment (VBP) and quality improvement initiatives and are concerned that TIPPS could result in duplicative data collection and reporting. The commenters recommended HHSC clarify in the rules that if physicians already participate in an MCO VBP arrangement with substantially similar requirements, then that initiative could be a potential proxy for TIPPS, allowing physicians to still earn dollars without enrolling in a separate initiative.

Alternatively, the commenters said HHSC should consider collecting the aggregate of all Medicaid member quality data across all MCOs for each practice, do the calculation, and then direct each MCO on the amount of payment to make to the physician.

Response: No changes were made in response to this comment. HHSC encourages providers to participate in VBP initiatives with MCOs. HHSC is not involved in these varied arrangements so cannot require alignment of reporting. HHSC has made an effort to align measures with MCO quality programs, when known, to reduce provider burden and advance quality improvement in a coordinated manner. Due to data lags, MCO reported data would not be available in a timely fashion to trigger payments within the program year.

Comment: Multiple commenters expressed concern with the timeline between the release of the proposed quality metrics for the program and the publication of the finalized quality metrics. Some commenters recommended at least a 30-day comment period to allow physicians to sufficiently analyze the proposed metrics and the potential impact participating in the program will have on their practices, and to determine whether to participate. Other commenters recommended the notice, hearing, and finalization of the quality metrics be moved to earlier in the fiscal year to ensure providers have enough time for reporting systems to be in place prior to the applicable program year. One commenter recommended HHSC propose to CMS that any new measures not require data collection until year 2 of the program.

Response: No changes were made in response to this comment. Due to the timeline required for preprint submission to CMS and incorporation of public comment, the period cannot be extended. HHSC developed the proposed quality measures during stakeholder meetings in fall 2020. HHSC will begin engaging stakeholders in fall 2021 regarding quality requirements for Year 2 of TIPPS. CMS has stated that baseline data needs to be based on the year prior to the program or the first year, so HHSC must require data collection beginning in Year 1.

Comment: One commenter believes the proposed process creates a conflict between existing incentive processes, measures and expectations mandated by HHSC within the Uniform Managed Care Contract. Individual Providers, Groups and MCOs have more than 25 different measure options. The commenter said it is vital that quality incentive programs do not overextend on scope with a large mixture of measures causing incremental improvement in place of organic improvement across the State.

Response: No changes were made in response to this comment. The focus of the measures was based on stakeholder feedback gathered in fall 2020. Providers wanted a menu of measures to better align with variation in provider type and population served. CMS does not allow for a menu. Having a greater number of measures with achievement tied to a smaller number of measures was a solution to help providers focus efforts on most meaningful measures for their practice. There is a separate process to submit feedback on measures and HHSC welcomes any suggestions for evidence-based measures.

Performance Requirements

Comment: One commenter said that since they are a specialty clinic, they do not see specific populations and, therefore, do not have clients that fit the description of some of the metrics listed in Components Two and Three. The commenter asked if there will be an opportunity to be excluded from reporting and meeting those metrics.

Response: No changes were made in response to this comment. Physician groups are required to meet a minimum volume in measures in at least 50 percent of measures to be eligible for the Component. All measures must be reported while achievement is based on measures that meet the minimum denominator volume of 30 Medicaid managed care patients. Measures that do not meet the minimum volume are excluded from calculating achievement. CMS requires that all providers within a class report on the same measures.

Comment: One commenter asked how HHSC will determine if a provider meets the reporting criteria during the first quarter. Will it be determined by an attestation on the application that the provider will provide reporting?

Response: No changes were made in response to this comment. HHSC will require reporting be submitted to HHSC in the first quarter in a format defined by HHSC.

Comment: Multiple commenters requested HHSC clarify that a physician group is required to report only on the metrics for which the physician practice is eligible. Without the clarification, the proposed language could be interpreted to include all quality metrics in Components One, Two, and Three. The commenters pointed out that Community physicians are ineligible to participate in Components One and Two.

Response: HHSC agrees with the commenters that the reporting requirements should be clearer. HHSC added language to §353.1311(d)(1) to clarify that reporting is required of all measures within the Component in which a physician group is participating.

Comment: Two commenters said HHSC is explicitly proposing to condition TIPPS Components Two and Three, which together comprise 35 percent of the total TIPPS payment opportunity, on provider achievement of certain quality metrics. The commenters added that the pay-for-performance requirement under TIPPS is significantly more onerous than what CMS requires and what HHSC is proposing for the new hospital directed payment program, which only includes reporting requirements. One of the commenters requested an explanation for HHSC's rationale for creating very different standards and expectations in regard to quality metrics for TIPPS, specifically in comparison to CHIRP.

Response: No changes were made in response to this comment. Federal regulations permit states to direct payments made by MCOs to providers in certain circumstances when the payment arrangement is intended to advance a goal or objective in the Medicaid quality strategy. States may direct payments as either a value-based payment, a minimum fee schedule, a uniform rate increase, or a maximum fee schedule. HHSC currently utilizes all of these and decides which option it believes will best advance the quality goal or objective that is being addressed through the program.

Comment: Two commenters said HHSC should allow participating providers to carry forward reporting and payment opportunities, to the extent a participating provider fails to achieve a particular metric at the first reporting opportunity. One of the commenters requested HHSC consider permitting at least one carry-forward reporting opportunity, similar to those allowed under the DSRIP program.

Response: No changes were made in response to this comment. HHSC believes that payments should be made only for achievement of performance measures in the reporting period and that, if a provider fails to meet measures, funds should be redistributed to other providers who were successful. HHSC is also unable to carry forward program values from one program period as the reimbursement through actuarially sound capitated rates to the MCOs would not enable this to occur. HHSC will consider providers' lack of achievement in setting Year 2 goals and reporting timing.

Comment: One commenter asked how HHSC will communicate performance requirements have been met across all components with MCOs.

Response: No changes were made in response to this comment. Similar to the QIPP program, HHSC will provide a dashboard/scoring card to direct MCOs on performance and payments. HHSC will also make the scorecard available to the public.

Comment: One commenter said that MCOs believe it is important to align measures with current MCO and Alternative Payment Model (APM) measure as to not confuse or frustrate providers.

The commenter asked if measure calculations will be done for providers based on statewide performance as opposed to MCO or SDA performance. The commenter said that MCOs would prefer HHSC rank providers based on this data and make payment determinations.

Response: No changes were made in response to this comment. HHSC has proposed measures that align with other programs such as DSRIP, MCO P4Q program, and CMS Core Sets. Payment for performance will be based on provider- reported data and achievement. MCO and state data will be used for evaluation purposes. HHSC may consider other methods for payments in later years when IOS measures begin reporting performance.

Comment: One commenter asked if performance targets will be based solely on the Medicaid managed care payer population or all payers.

Response: No changes were made in response to this comment. Performance achievement will be based on Medicaid managed care.

MCOs

Comment: Multiple commenters said it's unclear if HHSC will administer some or all of the program. The commenters believe that if HHSC will be the administrator, it has the potential to create additional administrative complexity and costs. For example, as proposed, physician groups will be required to submit a separate TIPPS application to HHSC rather than to the MCO(s) in which they participate. The commenters said that given the vast majority of Medicaid patients are covered by MCOs, it seems more straightforward that MCOs instead be asked to amend current contract agreements with network physicians to allow them to enroll in TIPPS. The commenters also added that given the MCOs already have physician encounter data, it seems more straightforward for the MCOs to determine eligibility.

Response: No changes were made in response to this comment. Federal regulations permit states to direct payments made by MCOs to providers in certain circumstances when the payment arrangement is intended to advance a goal or objective in the Medicaid quality strategy. HHSC believes that by administering the enrollment process for the program, HHSC will be able to ensure that all Medicaid managed care utilization is considered when determining eligibility as some providers may not meet the minimum thresholds through encounters with each individual MCO.

Comment: One commenter said having funds pass through the MCOs adds another administrative layer and additional costs that can be better utilized by providers.

Response: No changes were made in response to this comment. Federal regulations permit states to direct payments made by MCOs to providers in certain circumstances when the payment arrangement is intended to advance a goal or objective in the Medicaid quality strategy. HHSC believes that TIPPS will meet this standard and will support Medicaid clients in accessing high quality services.

Comment: One commenter said MCOs need clarification around:

a. now amounts will be calculated and provided to plans;

b. data and reporting needed by HHSC and detailed information on how HHSC and the plans will exchange data;

c. expectations related to reconciliation; and

d. expectations related to agreements with providers and how these arrangements will impact existing provider contracts.

Response: No changes were made in response to this comment. The Medicaid managed care contracts between HHSC and the MCOs will describe the parties' responsibilities in implementing TIPPS.

Comment: One commenter said MCOs will need direction regarding how to identify and distinguish between the physician practice groups in their claims systems and time to make required claims systems modifications.

Response: No changes were made in response to this comment. The Medicaid managed care contracts between HHSC and the MCOs will describe the parties' responsibilities in implementing TIPPS.

General

Comment: One commenter expressed appreciation that the program ensures those physician practices participating in NAIP and DSRIP have a path to continue providing care.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: One commenter expressed appreciation for HHSC acknowledging the need to increase physician Medicaid payment rates.

Response: HHSC appreciates the support. No changes were made in response to this comment.

Comment: One commenter expressed concern about the Medicaid rates paid to physicians. The commenter proposed three solutions. First, to pair Medicaid with Medicare reimbursement. Second, to standardize all activities performed by Medicaid MCO plans. Third, to offer alternative healthcare models, such as the successful Medicaid ACO Model used by Ohio State.

Response: No changes were made in response to this comment. This comment is outside the scope of the rule proposal. This rule is not intended to address the base Medicaid reimbursement for physicians, but to direct certain payments used to advance a goal or objective in the Medicaid quality strategy.

Comment: One commenter noted that even though the target beneficiaries are Medicaid Star, Star+Plus and possibly Star Kids, the eligibility for Components Two and Three use the language Medicaid Managed care patients. The commenter said that per the HHSC website, it appears that all Medicaid Managed Care means all Star Programs and asked if the only outlier is Traditional Medicaid. If Traditional Medicaid is the only outlier, the commenter asked HHSC to confirm if the financial incentives would apply to all Medicaid Managed Care and not to traditional Medicaid patients even though the reporting for Components Two and Three includes all payers.

If all Medicaid managed care patients assigned to a physician associated with an HRI or IME would enable the PMPM increase under Component One, the commenter then asked how HHSC would advise a physician group to determine the total predicted value.

Response: No changes were made in response to this comment. HHSC will determine on an annual basis which Medicaid managed care models the TIPPS program will be included in. Financial incentives are based only on Medicaid managed care utilization. Components Two and Three require stratified reporting on participating managed care program, Other Medicaid, Uninsured, and Other Insurance.

Comment: In the introduction to §353.1309, it states that "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." Multiple commenters believe that as drafted, it does not appear that TIPPS, which itself is a type of value-based payment initiative, harmonizes or integrates with the state's Medicaid managed care program generally or the quality and value-based payment strategy specifically.

Response: No changes were made in response to this comment. TIPPS measures are intended to address the draft Quality Strategy goals of promoting optimal health for Texans, providing the right care in the right place at the right time, and promoting effective practices for people with chronic, complex, and serious conditions. The measures also align with some of the other MCO quality programs like P4Q.

Comment: Multiple commenters noted that the rules do not clearly articulate how the data will flow and be analyzed between the physicians, MCOs, and the state. The commenters asked if contracted physicians will submit their performance data to the MCOs for analysis and determination of achievement (or lack thereof) for each measure, or whether HHSC will make the determination.

Response: No changes were made in response to this comment. HHSC is proposing that data be reported to the State for analysis and determination.

Comment: Multiple commenters said that while they understand the imperative to implement the program within the year to maintain funding for physician practices currently receiving DSRIP funding, they recommend that after the semi-annual implementation date, HHSC (1) report on the number and percent of all eligible physician practices by component who elected to participate; (2) for those who chose to participate, report on their overall performance success rate by component and measure; (3) evaluate barriers to participation as identified by participating and nonparticipating practices; and (4) reconvene stakeholders to review findings and make recommendations.

Response: No changes were made in response to this comment. HHSC plans to begin engaging stakeholders in fall 2021 to prepare for requirements for Year 2 of TIPPS. Any quality data available at the time will be shared.

Comment: One commenter suggested HHSC implement separate rate enhancement and incentive pay-for-performance payment components rather than the proposed 100 percent pay-for-performance approach. The commenter believes that increasing physician payments will increase participating physicians and expand patient choice as well as attract high quality providers to participate in Medicaid. The commenter also said this modification would model the program more similarly to the CHIRP and QIPP programs.

Response: No changes were made in response to this comment. HHSC believes that the TIPPS program as designed incentivizes

value and quality in accordance with the program goals and federal regulations related to state directed payments.

STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under 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) Other physician group--A network physician group other than those specified under paragraphs (1) and (2) of this subsection.

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

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

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

(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. 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.

(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 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) served at least 250 unique Medicaid managed care clients in the prior state fiscal year.

(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 national provider identification (NPI) number and taxonomy code combination that are billed as a professional encounter only.

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

(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) Participation requirements. 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) 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.

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

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

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

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

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

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

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

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

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

(1) Component One.

(A) The total value of Component One will be equal to 65 percent of total program value.

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

(C) Monthly payments to HRI and IME physician groups will be triggered by performance requirements as described in §353.1311 of this subchapter.

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

(E) 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 180 days after the last day of the program period. This reconciliation will only be performed if the weighted average (weighted by Medicaid clients served during the program period) of the absolute values of percentage changes between each practice group's proportion of historical Medicaid clients served and actual Medicaid clients served is greater than 18 percent.

(2) Component Two.

(A) The total value of Component Two will be equal to 25 percent of total program value.

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

(C) Payments to physician groups will be triggered by achievement of performance requirements as described in §353.1311 of this subchapter.

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

(3) Component Three.

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

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

(C) Payments to physician groups will be triggered by achievement of performance requirements as described in §353.1311 of this subchapter during the reporting period prior to the payment period.

(4) Funds that are non-disbursed due to failure of one or more physician groups to meet performance requirements will be distributed across all qualifying physician groups in the service delivery area based on each physician group's proportion of total earned TIPPS funds from Components One, Two and Three combined at the end of the year.

(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, quality metric, and payment period. 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) Monthly payments from Component One as performance requirements are met will be equal to the total value of Component One for the physician group divided by twelve.

(B) Semi-annual 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 2.

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

(D) For purposes of the calculation described in subparagraph (B) of this paragraph, a physician group must achieve a minimum of 75 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients to be eligible for full payment of the benchmark measures. If a physician group achieves 50 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients, it is eligible for 75 percent payment. If a physician group achieves 25 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients, it is eligible for 50 percent payment.

(E) For purposes of the calculation described in subparagraph (C) of this paragraph, a physician group must achieve a minimum of 50 percent of benchmark measures for which the provider has a minimum denominator volume of 30 Medicaid managed care patients to be eligible for full payment.

(F) For purposes of the calculations described in subparagraph (C) of this paragraph, in situations where a practice does not have minimum denominator volume of 30 Medicaid managed care patients for a quality metric to be calculated, the funding associated with that metric will be evenly distributed across all remaining metrics within the component for which the provider has the minimum denominator volume of 30 Medicaid managed care patients.

(2) MCOs will distribute payments to enrolled physician groups as they meet their reporting and quality metric requirements. 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 and, as applicable, subsection (g)(1)(E) of this section.

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

§353.1311. Quality Metrics for the Texas Incentives for Physicians and Professional Services Program.

(a) Introduction. This section establishes the quality metrics that may be used in the Texas Incentives for Physician and Professional Services (TIPPS) program.

(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 §353.1309 of this subchapter (relating to the Texas Incentives for Physicians and Professional Services).

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

(2) Benchmark--A metric-specific initial standard set prior to the start of the program period and used as a comparison against a physician group's progress throughout the program period.

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

(c) Quality metrics. For each program period, HHSC will designate one or more metrics for each TIPPS capitation rate component.

(1) Each quality metric will be identified as a structure measure, improvement over self (IOS) measure, or benchmark measure.

(2) Any metric developed for inclusion in TIPPS will be evidence-based.

(d) Performance requirements. For each program period, HHSC will specify the performance requirement that will be associated with the designated quality metric. Achievement of performance requirements will trigger payments for the TIPPS capitation rate components as described in §353.1309 of this subchapter. The following performance requirements are associated with the quality metrics described in subsection (c) of this section.

(1) A physician group must report all quality metrics in any Component in which it is participating to be eligible for payment.

(2) Achievement of quality metrics.

(A) To achieve a structure measure, providers must report their progress on associated activities for each MP.

(B) Achievement of an IOS measure is based on reporting of the baseline for each MP. For each program period except the one beginning September 1, 2021, achievement is based on meeting or exceeding during the MP the benchmark set prior to the start of the program period.

(C) Achievement of a benchmark measure is based on reporting for each MP and meeting or exceeding during the MP the benchmark set prior to the start of the program period.

(3) Reporting frequency. Achievement will be reported semi-annually unless otherwise specified by the quality metric.

(e) Notice and hearing.

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

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

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

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

(f) Publication of Final Metrics and Performance Requirements. Final quality metrics and performance requirements will be provided through HHSC's website on or before February 28 of the calendar year that also contains the first month of the program period. If Centers for Medicare and Medicaid Services requires changes to quality metrics or performance requirements after February 28 of the calendar year but before the first month of the program period, HHSC will provide notice of the changes through HHSC's website.

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 March 1, 2021.

TRD-202100842
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: March 21, 2021
Proposal publication date: December 25, 2020
For further information, please call: (512) 424-6637

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TITLE 7. BANKING AND SECURITIES

PART 4. DEPARTMENT OF SAVINGS AND MORTGAGE LENDING

CHAPTER 75. APPLICATIONS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (department), adopts: the repeal of existing rules at 7 Texas Administrative Code (TAC) Chapter 75, Subchapter A, §§75.1 - 75.3, 75.5 - 75.7, 75.9, and 75.10; Subchapter C, §§75.31, 75.34, and 75.35; Subchapter D, §§75.83 - 75.86 and 75.90; and Subchapter E, §75.121, 75.123, and §75.125; new rules at 7 TAC Chapter 75, Subchapter A, §§75.1 - 75.3, 75.6, and 75.10; Subchapter C, §75.31 and §75.35; Subchapter D, §75.83 and §75.90; Subchapter E, §75.123; and new Subchapter F, §§75.201 - 75.204; and amendments to existing rules in 7 TAC Chapter 75, Subchapter A, §75.8; Subchapter B, §§75.25 - 75.27; Subchapter C, §§75.32, 75.33, 75.36, 75.38, 75.39, and 75.41; Subchapter D, §§75.81, 75.82, 75.87 - 75.89, and 75.91; and Subchapter E, §§75.122, 75.124, 75.126, and 75.127, without changes to the text as published in the January 1, 2021 issue of the *Texas Register* (46 TexReg 20). The rules will not be republished.

Explanation of and Justification for the Rules

The existing rules under 7 TAC Chapter 75 partially implement Finance Code Subtitle C, the Texas Savings Bank Act. The adopted rules were identified during the department's periodic review of 7 TAC Chapter 75, conducted pursuant to Government Code §2001.039.

Changes Concerning Additional Offices

Finance Code §92.063 requires a savings bank to obtain the approval of the department's commissioner (commissioner) in order to establish an office other than the savings bank's home office approved under its banking charter. Existing §75.31, among other things, reasserts the requirements of Finance Code §92.063. The adopted rules repeal and replace existing §75.31. Adopted new §75.31 (repealed and replaced), at subsection (e), contains a list of activities that, when performed at a location other than the home or a branch office of a savings bank, is deemed by rule not to constitute an additional office of the savings bank requiring prior approval of the commissioner to establish. Existing §75.32, concerning Types of Additional Offices, describes specific types of additional offices other than a home or a branch office that are recognized by the commissioner and require the commissioner's prior approval to establish. Existing §75.32(a) is amended to eliminate loan production offices, administrative offices, and deposit production offices as "additional offices" for purposes of the Texas Savings Bank Act, to correspond with the activities typically performed at these offices becoming sanctioned to be performed at a location other than an approved home or branch office, as provided by new § 75.31 (repealed and replaced). Other sanctioned activities in new §75.31 (repealed and replaced) include the operation of automated or remote banking equipment (*e.g.*, ATMs), advertising, the operation of information technology equipment, participation at trade association and community events, and the provision of customer service ancillary to banking functions. Adopted new §75.31 (repealed and replaced) requires a savings bank seeking to permanently close an approved office to comply with the notice requirements of federal law and provide the department with a copy of such notice. Adopted new §75.31 (repealed and replaced) also clarifies that upon closure of the office, any prior approval to have opened such office is deemed revoked and a savings bank seeking to reopen such office must seek new approval in order to do so.

Changes Concerning the Selling of Assets

Under existing §75.81, concerning Reorganization, Merger, Consolidation or Purchase and Assumption Transaction, sale of a savings bank's assets made "in bulk [and not] in the ordinary course of business" constitutes a purchase and assumption transaction under the rule, requiring application with the department and approval from the commissioner. The adopted rules amend §75.81 such that the selling of assets in this fashion is no longer considered to constitute a purchase and assumption transaction under the rule.

Changes Concerning Application Procedures

The adopted rules make various changes concerning how applications are filed with the department. The adopted rules create a new Subchapter F, concerning General Provisions, designed to contain requirements of general applicability in the chapter. Existing §75.121, concerning Definitions, containing definitions applicable to the entirety of Chapter 75, is repealed and its subject matter addressed by new Subchapter F, §75.201, concerning Definitions. Adopted new §75.201 largely reconstitutes the definitions in existing §75.121, however, new definitions are added for the terms "FDIC" and "managing officer," as that term is used in Finance Code §92.055. The existing rules in Chapter 75 provide that, for most application types, the applicant must publish a public notice of the application in a newspaper of general circulation in the county or counties affected by the relief sought by the application. A new §75.203 is added in new Subchapter F to establish uniform requirements for making such notices. The existing rules for each application type are also changed (amended, or by repeal and replacement of the rule) to clarify and establish by rule the county or counties where the public notice must be published.

Changes Concerning Hearings on Applications

Existing §75.10, concerning Change of Name, §75.33, concerning Branch Office Applications, §75.35, concerning Mobile Facilities, §75.38, concerning Change of Home or Branch Office Location, and §75.83, concerning Notice of Hearing (reorganization, merger, or consolidation), create processes and procedures governing how hearings are conducted for each application type addressed by each such rule by referring to and adopting the processes and procedures governing charter applications, contained in existing Chapter 75, Subchapter A. The adopted rules establish separate processes and procedures specific to each such rule, rather than by adopting by reference the processes and procedures applicable to charter applications. Existing §75.7, concerning Motions for Rehearing, which establishes certain timelines for a motion for rehearing made pursuant to Finance Code §91.006, is repealed, and its subject matter addressed by new Subchapter F, §75.203, concerning Motions for Rehearing. Adopted new §75.203 also extends the time period for filing a reply to a motion for rehearing from 25 days after the date the order was signed under existing §75.7, to 30 days after the date the order was signed.

Other Modernization and Update Changes.

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal for the rule amendments, new rules, and repeals recited a deadline of 30 days to receive public comments, or January 31, 2021. A public hearing in accordance with Government Code §2001.029 was not required. No comments were received.

SUBCHAPTER A. CHARTER APPLICATIONS

7 TAC §§75.1 - 75.3, 75.5 - 75.7, 75.9, 75.10

Statutory Authority

The repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

Filed with the Office of the Secretary of State on February 23, 2021.

TRD-202100747
Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
Effective date: March 15, 2021
Proposal publication date: January 1, 2021
For further information, please call: (512) 475-1535

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7 TAC §§75.1 - 75.3, 75.6, 75.8, 75.10

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§75.1 - 75.3 and 75.6 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraph (2) of that subsection; Chapter 92, Subchapter B; §92.203; and §92.601(b). 7 TAC §75.8 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (14) of that subsection; §92.051; §92.060; and §92.058. 7 TAC §75.10 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (14) of that subsection; and §92.063.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER B. EXPEDITED APPLICATIONS

7 TAC §§75.25 - 75.27

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§75.25 - 75.27 are adopted under the authority of, and to implement, Finance Code §96.002(a), for those specific subject matters outlined in paragraph (2) of that subsection.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER C. HOLDING COMPANIES

7 TAC §§75.31, 75.34, 75.35

Statutory Authority

The repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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7 TAC §§75.31 - 75.33, 75.35, 75.36, 75.38, 75.39, 75.41

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§75.31 - 75.33, 75.35, 75.36, 75.38, 75.39 and 75.41 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (14) of that subsection; and §92.063. 7 TAC §75.36 is also adopted under the authority of, and to implement, Finance Code §92.352.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
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Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER D. REORGANIZATION, MERGER, CONSOLIDATION, CONVERSION, PURCHASE, AND ASSUMPTION AND ACQUISITION

7 TAC §§75.81 - 75.83, 75.87 - 75.91

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect

public investment in Texas-chartered savings banks. 7 TAC §§75.81 - 75.83 and 75.88 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (13) of that subsection; and Chapter 92, Subchapters C and H. 7 TAC §75.88 is also adopted under the authority of, and to implement, Finance Code Chapter 92, Subchapter I. 7 TAC §75.89 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (13) of that subsection; and Chapter 92, Subchapter F. 7 TAC §75.90 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (13) of that subsection; and Chapter 92, Subchapter G. 7 TAC §75.91 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (13) of that subsection; and §92.052.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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7 TAC §§75.83 - 75.86, 75.90

Statutory Authority

The repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER E. CHANGE OF CONTROL

7 TAC §§75.121, 75.123, 75.125

Statutory Authority

The repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code, Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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7 TAC §§75.122 - 75.124, 75.126, 75.127

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§75.122 - 75.124, 75.126 and 75.127 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (10) of that subsection; and Chapter 92, Subchapter L. 7 TAC §75.122 is also adopted under the authority of Finance Code §96.002(b).

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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Proposal publication date: January 1, 2021
For further information, please call: (512) 475-1535

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SUBCHAPTER F. GENERAL PROVISIONS

7 TAC §§75.201 - 75.204

Statutory Authority

The rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§75.201 - 75.204 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (2) and (10) of that subsection; and Chapter 92, Subchapter L. 7 TAC §75.122 is also adopted under the authority of Finance Code §96.002(b).

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

Filed with the Office of the Secretary of State on February 23, 2021.

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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Proposal publication date: January 1, 2021
For further information, please call: (512) 475-1535

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CHAPTER 76. MISCELLANEOUS

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (department), adopts: the repeal of existing rules at 7 Texas Administrative Code (TAC) Chapter 76, Subchapter A, §76.3; Subchapter D, §76.61; Subchapter E, §§76.71 - 76.73; and Subchapter G, §76.121; and amendments to existing rules in 7 TAC Chapter 76, Subchapter A, §§76.1, 76.2, 76.4 - 76.7, and 76.12; Subchapter B, §§76.21 - 76.26; Subchapter C, §§76.41 - 76.47; Subchapter F, §§76.91 - 76.97, 76.99 - 76.103, and 76.105 - 76.110; and Subchapter H, §76.122. Amended §76.94 is adopted with a minor non-substantive change to correct a typographical error and is republished to reflect such change. Amended §76.109 is further adopted with substantive changes to the published text due to a formatting error upon publication, and is republished to reflect such changes. The remaining sections affected by the proposal (§§76.1 - 76.7, 76.12, 76.21 - 76.26, 76.41 - 76.47, 76.61, 76.71 - 76.73, 76.91 - 76.93, 76.95 - 76.97, 76.99 - 76.103, 76.105 - 76.108, 76.110, 76.121, 76.122) are adopted without changes to the text as published in the January 8, 2021, issue of the *Texas Register* (46 TexReg 239) and will not be republished.

Explanation of and Justification for the Rules

The existing rules under 7 TAC Chapter 76 partially implement Finance Code Subtitle C, the Texas Savings Bank Act. The adopted rules were identified during the department's periodic review of 7 TAC Chapter 76, conducted pursuant to Government Code §2001.039.

Notice to Consumers Changes

Existing §76.122, concerning Savings Bank Complaint Notices, requires Texas-chartered savings banks to make a disclosure to consumers concerning the department's regulatory oversight and the ability to file complaints with the department. The adopted rules clarify the existing requirement for a savings bank to make a disclosure on its website by clarifying that the requirement applies only to websites accessible by the public and further clarifying how to conspicuously display such notice on a website in order to comply with the rule.

Books and Records Changes Existing §76.1, concerning Location of Books and Records, addresses how and where a savings bank keeps its books and records. The adopted rules amend §76.1 to clarify that a savings bank must comply with the applicable requirements of federal law in making and keeping its books and records, and require that records be kept in accordance with established best practices of the Federal Financial Institution Examination Council. Amended §76.3 further clarifies that, while records may be kept at a location other than the savings bank's home office, the savings bank must ensure that a complete set of its records is readily accessible at the home office. The title of §76.1 is also amended to better reflect the subject matter of the rule as amended. Existing §76.3 authorizes a savings bank to keep copies of its records, including by electronic means. The adopted rules repeal existing §76.3, and consolidate its subject matter in amended §76.1, which provides that records may be kept in an electronic, digital, or magnetic format.

Changes Concerning Reports from a Holding Company

Existing §76.42, concerning Reports, requires holding companies and their subsidiaries to file reports with the commissioner including any reports or other information it is required to file with the appropriate federal banking agency. The adopted rules clarify that a holding company need not file with the commissioner reports it has filed with the appropriate federal banking agency that are publicly available.

Change of Control Fee Changes

Existing §76.101, concerning Fee for Change of Control, establishes the fee for making an application for change of control of a savings bank in accordance with Finance Code Chapter 92, Subchapter L. The adopted rules lower the applicable fee from $10,000 to $5,000.

Changes Concerning Hearings on Applications

Existing §§76.71 - 76.73, concerning Hearings Officer, Rules of Procedure for Contested Hearings, and Publication of Hearing Notice, respectively, establish certain processes and procedures governing adjudicative hearings (contested cases) on applications filed with the commissioner. The adopted rules repeal these rules to coincide with a separate rules adoption for 7

TAC Chapter 75, wherein the subject matter of existing §§76.71 - 76.73 is addressed in such chapter.

Other Modernization and Update Changes

The adopted rules make changes to modernize and update the rules including: adding and replacing language for clarity and to improve readability; removing unnecessary or duplicative provisions; and updating terminology.

Summary of Public Comments

Publication of the commission's proposal for the rule amendments, new rules, and repeals recited a deadline of 30 days to receive public comments, or February 7, 2021. A public hearing in accordance with Government Code §2001.029 was not required. No comments were received.

SUBCHAPTER A. BOOKS, RECORDS, ACCOUNTING PRACTICES, FINANCIAL STATEMENTS AND RESERVES

7 TAC §§76.1, 76.2, 76.4 - 76.7, 76.12

Statutory Authority

The adopted rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §76.1 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (3) and (5) of that subsection; §92.201; and §96.056. 7 TAC §76.2 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (3) and (4) of that subsection; and §92.201. 7 TAC §76.4 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (7) and (11) of that subsection; §96.051; and §96.053. 7 TAC §76.5 is adopted under the authority of, and to implement, Finance Code §96.002(a), for those specific subject matters outlined in paragraph (11) of that subsection. 7 TAC §76.6 is adopted under the authority of, and to implement, Finance Code §96.002(a), for those specific subject matters outlined in paragraph (9) of that subsection. 7 TAC §76.7 is adopted under the authority of, and to implement, Finance Code §96.002(a), for those specific subject matters set forth in paragraph (11) of that subsection. 7 TAC §76.12 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraph (11) of that subsection; §92.051(b)(2); §92.058(c)(2); §92.062; §92.157; and §92.205.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

Filed with the Office of the Secretary of State on February 24, 2021.

TRD-202100785

Iain A. Berry

Associate General Counsel

Department of Savings and Mortgage Lending

Effective date: March 16, 2021

Proposal publication date: January 8, 2021

For further information, please call: (512) 475-1535

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7 TAC §76.3

Statutory Authority

The adopted repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry

Associate General Counsel

Department of Savings and Mortgage Lending

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For further information, please call: (512) 475-1535

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SUBCHAPTER B. CAPITAL AND CAPITAL OBLIGATIONS

7 TAC §§76.21 - 76.26

Statutory Authority

The adopted rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also made under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §76.21 and §76.22 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters set forth in paragraphs (1) and (11) of that subsection; §92.052(b); §92.053(b); §92.054; §92.102; and §92.203. 7 TAC §76.23 is adopted under the authority of, and to implement, Finance Code: 96.002(a), for those specific subject matters set forth in paragraphs (1) and (11) of that subsection; §92.203; and Chapter 96, Subchapter C. 7 TAC §§76.24 - 76.26 is adopted under the authority of, and to implement, Finance Code: 96.002(a), for those subject matters set forth in paragraph (11); and §93.004(b).

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER C. HOLDING COMPANIES

7 TAC §§76.41 - 76.47

Statutory Authority

The adopted rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§76.41 - 76.47 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraphs (11) and (15) of that subsection; and §97.002. 7 TAC §76.41 is further adopted under the authority of, and to implement, Finance Code §97.002. 7 TAC §76.42 is further adopted under the authority of, and to implement, Finance Code §97.004. 7 TAC §76.43 is further adopted under the authority of, and to implement, Finance Code §97.005. 7 TAC §76.44 is further adopted under the authority of, and to implement, Finance Code §97.006. 7 TAC §76.45 is further adopted under the authority of, and to implement, Finance Code §97.007. 7 TAC §76.46 is further adopted under the authority of, and to implement, Finance Code §97.003. 7 TAC §76.47 is further adopted under the authority of, and to implement, Finance Code Chapter 98, Subchapter B.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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TRD-202100788
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Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER D. FOREIGN SAVINGS BANKS

7 TAC §76.61

Statutory Authority

The adopted repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER E. HEARINGS

7 TAC §§76.71 - 76.73

Statutory Authority

The adopted repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
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For further information, please call: (512) 475-1535

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SUBCHAPTER F. FEES AND CHARGES

7 TAC §§76.91 -76.97, 76.99 - 76.103, 76.105 - 76.110

Statutory Authority

The adopted rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §§76.91 - 76.97, 76.99 - 76.103, 76.105 - 76.110 are adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraph (2) of that subsection; §91.007; and 16.003(c). 7 TAC §76.91 is further adopted under the authority of, and to implement, Finance Code §92.051(a)(2). 7 TAC §76.92 is further adopted under the authority of, and to implement, Finance Code §92.063. 7 TAC §76.97 is further adopted under the authority of, and to implement, Finance Code §93.004(b). 7 TAC §76.107 is further adopted under the authority of, and to implement, Finance Code §97.001.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

§76.94. Fee for Change of Name or of Location.

Applicants for change of name or change of location of any branch office, approved or existing, must pay a fee of $500. In addition, the applicants must pay any cost incurred by the Department in connection with the hearing, investigation and travel expenses.

§76.109. Fee for Protest Filing.

A person or entity filing a protest to an application must pay a fee of $2,500 simultaneously with such protest filing. The purpose of this fee is to partially offset the Department's increased cost of processing an application and reduce costs incurred by the applicant that result solely from the protest.

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 February 24, 2021.

TRD-202100791
Iain A. Berry
Associate General Counsel
Department of Saving and Mortgage Lending
Effective date: March 16, 2021
Proposal publication date: January 8, 2021
For further information, please call: (512) 475-1535

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SUBCHAPTER G. STATEMENTS OF POLICY

7 TAC §76.121

Statutory Authority

The adopted repeals are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

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TRD-202100792
Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
Effective date: March 16, 2021
Proposal publication date: January 8, 2021
For further information, please call: (512) 475-1535

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SUBCHAPTER H. COMPLAINT PROCEDURES

7 TAC §76.122

Statutory Authority

The adopted rules are adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rules are also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §76.122 is adopted under the authority of, and to implement, Finance Code: §96.002(a), for those specific subject matters outlined in paragraph (11) of that subsection; §96.054; and Chapter 96, Subchapter C.

The adopted rules affect the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

Filed with the Office of the Secretary of State on February 24, 2021.

TRD-202100793
Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
Effective date: March 16, 2021
Proposal publication date: January 8, 2021
For further information, please call: (512) 475-1535

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CHAPTER 77. LOANS, INVESTMENTS, SAVINGS, AND DEPOSITS

SUBCHAPTER A. AUTHORIZED LOANS AND INVESTMENTS

7 TAC §77.10

The Finance Commission of Texas (commission), on behalf of the Department of Savings and Mortgage Lending (department), adopts amendments to existing 7 TAC §77.10, without changes to the text as published in the January 8, 2021, issue of the *Texas Register* (46 TexReg 251). The rule will not be republished.

Explanation of and Justification for the Rule

Existing 7 TAC §77.10 partially implements Finance Code Subtitle C, the Texas Savings Bank Act, and specifically §94.002 of such act. The adopted rule was identified during the department's periodic review of 7 TAC Chapter 77, conducted pursuant to Government Code, §2001.039.

Existing §77.10, concerning Non-Real Estate Commercial Loans, determines the circumstances under which a savings bank may engage in commercial real estate loans, and the requirements for such loans. The amended rule clarifies within the text of the rule that the rule pertains only to commercial loans.

Summary of Public Comments

Publication of the commission's proposal for the rule amendments recited a deadline of 30 days to receive public comments, or February 7, 2021. A public hearing in accordance with Government Code §2001.029 was not required. No comments were received.

Statutory Authority

The adopted rule is adopted under the authority of Finance Code §11.302(a), which authorizes the commission to adopt rules applicable to state savings banks. The adopted rule is also adopted under the authority of Finance Code §96.002(a), which authorizes the commission to adopt rules necessary to supervise and regulate Texas-chartered savings banks and to protect public investment in Texas-chartered savings banks. 7 TAC §77.10 is also adopted under the authority of, and to implement Finance Code §94.002.

The adopted rule affects the statutes contained in Finance Code Subtitle C, the Texas State Savings Bank Act.

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

Filed with the Office of the Secretary of State on February 23, 2021.

TRD-202100757
Iain A. Berry
Associate General Counsel
Department of Savings and Mortgage Lending
Effective date: March 15, 2021
Proposal publication date: January 8, 2021
For further information, please call: (512) 475-1535

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TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 1. LIBRARY DEVELOPMENT

SUBCHAPTER C. MINIMUM STANDARDS FOR ACCREDITATION OF LIBRARIES IN THE STATE LIBRARY SYSTEM

13 TAC §1.87

The Texas State Library and Archives Commission (Commission) adopts new 13 TAC §1.87, Emergency Waiver of Accreditation Criteria, with no changes to the proposed text as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8443). The rule will not be republished.

EXPLANATION OF ADOPTED NEW SECTION. The new rule is necessary to provide a means by which an accredited library may retain accreditation if the library is unable to meet minimum accreditation criteria through no fault of their own, but due to circumstances caused by a disaster, public health emergency, or other extraordinary hardship. The rule authorizes Commission staff to waive one or more criteria for library accreditation in an accreditation year, thereby preventing loss of accreditation, if a library shows it was unable to meet that criteria for good cause.

The rule defines "good cause" as a public health emergency, including a pandemic or epidemic; a natural or man-made disaster, including a tornado, hurricane, flood, wildfire, explosion, or chemical spill; or other extraordinary hardship which is beyond the control of the library as determined by the agency.

If a library requests a waiver of one or more accreditation criteria under the rule but Commission staff does not waive the criteria, the library may appeal the potential loss of accreditation to the Library Systems Act Advisory Board, which will make a recommendation to the Director and Librarian for decision. A decision of the Director and Librarian may be appealed to the Commission under 13 TAC §2.55.

EMERGENCY RULEMAKING. On November 9, 2020, the Commission adopted this rule on an emergency basis under Government Code, §2001.034, which authorizes adoption of an emergency rule without prior notice or hearing upon finding that an imminent peril to the public health, safety, or welfare requires adoption on fewer than 30 days' notice. Emergency rules adopted under Government Code, §2001.034 may be effective for not longer than 120 days and may be renewed for not longer than 60 days. When this rule is effective, it will replace the rule adopted on an emergency basis. The language of this rule is identical to the rule that was adopted on an emergency basis.

SUMMARY OF COMMENTS. The commission did not receive any comments on the proposed new rule.

STATUTORY AUTHORITY. This new rule is adopted under Government Code, §441.006(a)(2), which authorizes the Commission to adopt policies and rules to aid and encourage the development of and cooperation among all types of libraries, including public, academic, special, and other types of libraries; and Government Code, §441.127, which authorizes the Commission to set accreditation standards for libraries.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441, Subchapter I.

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 February 24, 2021.

TRD-202100777
Sarah Swanson
General Counsel
Texas State Library and Archives Commission
Effective date: March 16, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 463-5591

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TITLE 22. EXAMINING BOARDS

PART 6. TEXAS BOARD OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

CHAPTER 133. LICENSING
SUBCHAPTER G. EXAMINATIONS

22 TAC §133.67

The Texas Board of Professional Engineers and Land Surveyors (Board) adopts an amendment to 22 Texas Administrative Code, Subchapter G, Chapter 133, §133.67, regarding examinations on the Principles and Practice of Engineering without changes to the proposed text as published in the January 1, 2021, issue of the *Texas Register* (46 TexReg 50). The rule will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULE

The rules under 22 Texas Administrative Code Chapter 133 implement Texas Occupations Code, Chapter 1001, the Texas Engineering Practice Act.

Board rule §133.67 (Related to Examination on the Principles and Practice of Engineering) has a requirement that examinees taking the Principles and Practice of Engineering examination must complete the exam in a specified number of years. The adopted rule extends the examination deadline by one year for applicants for licensure as a professional engineer in Texas who have been unable to take the Principles and Practice of Engineering examination as a result of examination cancellations due to the COVID-19 pandemic.

PUBLIC COMMENT

Pursuant to §2001.029 of the Texas Government Code, the Board gave all interested persons a reasonable opportunity to provide oral and/or written commentary concerning the adoption of the rule. The 30-day public comment period began on January 1, 2021, and ended January 31, 2021. The Board received no comments from the public.

STATUTORY AUTHORITY

The rule is adopted pursuant to Texas Occupations Code §§1001.101 and 1001.202, which authorize the Board to regulate engineering and land surveying and make and enforce all rules and regulations and bylaws consistent with the Act as necessary for the performance of its duties, the governance of its own proceedings, and the regulation of the practices of engineering and land surveying in this state. This rule is also adopted under Texas Occupations Code §1001.2721, which authorizes the Board to adopt, recognize, develop, or contract for an examination.

No other codes, articles, or statutes are affected by this adoption.

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

Filed with the Office of the Secretary of State on March 1, 2021.

TRD-202100833
Lance Kinney, Ph.D., P.E.
Executive Director
Texas Board of Professional Engineers and Land Surveyors
Effective date: March 21, 2021
Proposal publication date: January 1, 2021
For further information, please call: (512) 440-3080

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CHAPTER 138. COMPLIANCE AND PROFESSIONALISM FOR SURVEYORS
SUBCHAPTER E. PROFESSIONAL AND TECHNICAL STANDARDS

22 TAC §138.81

The Texas Board of Professional Engineers and Land Surveyors (Board) adopts a new rule to 22 Texas Administrative Code, Chapter 138, specifically §138.81, regarding professional practice requirements for professional land surveyors in Texas without changes to the proposed texas as published in the December 11, 2020, issue of the *Texas Register* (45 TexReg 8819). The rule will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 22 Texas Administrative Code Chapter 138 implement Texas Occupations Code, Chapter 1001, the Texas Engineering Practice Act, and Occupations Code, Chapter 1071, the Professional Land Surveying Practices Act.

The adopted rule implements necessary changes as required by House Bill (HB) 1523, 86th Legislature, Regular Session (2019), related to the merger of operations of the Texas Board of Professional Engineers and the Texas Board of Professional Land Surveying into the Texas Board of Professional Engineers and Land Surveyors (TBPELS).

As required by HB 1523, the operations of the two agencies have been merged into one, including compliance and enforcement and professional practice requirements for Registered Professional Land Surveyors (RPLS) and Licensed State Land Surveyors (LSLS). The Texas Board of Professional Land Surveying's rules (22 Texas Administrative Code, Chapter 663), relating to standards of professional responsibility and rules of conduct for land surveyors, have been merged into Chapter 138 per the guidance of the Secretary of State. These rules have been formatted to be similar to the compliance and professionalism rules for engineers (Chapter 137), and edited for formatting and clarity.

PUBLIC COMMENT

Pursuant to §2001.029 of the Texas Government Code, the Board gave all interested persons a reasonable opportunity to provide oral and/or written commentary concerning the adoption of the rules. The 30-day public comment period began on December 11, 2020, and ended January 10, 2021. The Board received no comments from the public.

STATUTORY AUTHORITY

The rule is adopted pursuant to Texas Occupations Code §§1001.201 and 1001.202, which authorize the Board to regulate engineering and land surveying and make and enforce all rules and regulations and bylaws consistent with the Act and Texas Occupations Code §1071, as necessary for the performance of its duties, the governance of its own proceedings, and the regulation of the practices of engineering and land surveying in this state.

No other codes, articles, or statutes are affected by this adoption.

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

Filed with the Office of the Secretary of State on March 1, 2021.

TRD-202100832
Lance Kinney, Ph.D., P.E.
Executive Director
Texas Board of Professional Engineers and Land Surveyors
Effective date: March 21, 2021
Proposal publication date: December 11, 2020
For further information, please call: (512) 440-3080

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PART 8. TEXAS APPRAISER LICENSING AND CERTIFICATION BOARD

CHAPTER 153. RULES RELATING TO PROVISIONS OF THE TEXAS APPRAISER LICENSING AND CERTIFICATION ACT

22 TAC §153.15

The Texas Appraiser Licensing and Certification Board (TALCB) adopts amendments to 22 TAC §153.15, Experience Required for Licensing, without changes to the proposed text, as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8447). The rule will not be republished.

The amendments clarify the type of supporting documentation that must be submitted to TALCB to verify an applicant's experience and the circumstances when additional documentation may be requested by TALCB.

The amendments also allow TALCB staff to inform supervisory appraisers of its communications with supervisory appraisers' respective trainee, and to provide supervisory appraisers a better understanding of a trainee's progress in the licensure process and professional development.

No comments were received on the amendments as published.

The amendments are adopted under Occupations Code §1103.151, which allows TALCB to adopt rules for certifying or licensing an appraiser or appraiser trainee in this state that are in accordance with Chapter 1103 and consistent with applicable federal law.

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 February 26, 2021.

TRD-202100820
Kathleen Santos
General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: March 18, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 936-3652

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22 TAC §153.24

The Texas Appraiser Licensing and Certification Board (TALCB) adopts amendments to §153.24, Complaint Processing, without changes to the proposed text as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8448). The rule will not be republished.

The amendments clarify the process in which complaints or allegations that staff determines are not within the TALCB's jurisdiction; found not to exist; or are inappropriate or without merit are investigated and dismissed in accordance with Texas Occupations Code §1103.452.

No comments were received on the amendments as published.

The amendments are adopted under Occupations Code §1103.151, which allows TALCB to adopt rules for certifying or licensing an appraiser or appraiser trainee and §1103.154, which authorizes TALCB to adopt rules relating to professional conduct.

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-202100821
Kathleen Santos
General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: March 18, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 936-3652

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22 TAC §153.28

The Texas Appraiser Licensing and Certification Board (TALCB) adopts new rule §153.28, Peer Investigative Committee Review, without changes to the proposed text, as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8453). The rule will not be republished.

The new rule outlines the complaint review process of the Peer Investigative Committee pursuant to Texas Occupations Code §1103.453. The new rule identifies who may serve on the committee, terms of appointment, delineates functions of the committee members and TALCB staff in the review process, and establishes process deadlines. The rule also specifies the types of complaints that are subject or not subject to the review of the

Peer Investigative Committee, and the manner committee members and staff may communicate during the review process.

The new rule is intended to more clearly establish the agency's Peer Investigative Committee Review process and identify the roles of both committee members and TALCB staff. This rule also allows the Peer Investigative Committee members to provide TALCB Enforcement Division recommendations on complaints where adverse action is sought.

No comments were received on the new rule as published.

The new rule is adopted under Texas Occupations Code §1103.151, which authorizes TALCB to adopt rules for certifying or licensing an appraiser or appraiser trainee and §1103.154, which authorizes TALCB to adopt rules relating to professional conduct.

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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Kathleen Santos
General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: March 18, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 936-3652

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PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 295. PHARMACISTS

22 TAC §295.13

The Texas State Board of Pharmacy adopts amendments to §295.13, concerning Drug Therapy Management by a Pharmacist under Written Protocol of a Physician. These amendments are adopted without changes to the proposed text as published in the December 11, 2020, issue of the *Texas Register* (45 TexReg 8822). The rule will not be republished.

The amendments update the notification requirements for a pharmacist who signs a prescription for a dangerous drug pursuant to a written protocol and corrects grammatical errors.

The Board received a comment from Jeenu Phillip with Walgreen Co. expressing concern about requiring a pharmacy to submit a copy of the initial written protocol and any updates to the Board, and suggested that the Board remove these requirements, or alternatively, require a copy of the initial written protocol and any updates to be retained by the pharmacy and made available to the Board upon request. The Board declines to make these changes as §157.101(b-1)(2)(E) of the Texas Occupations Code requires that the pharmacist submit a copy of the protocol to the Board.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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 February 22, 2021.

TRD-202100717
Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director
Texas State Board of Pharmacy
Effective date: March 14, 2021
Proposal publication date: December 11, 2020
For further information, please call: (512) 305-8010

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CHAPTER 315. CONTROLLED SUBSTANCES

22 TAC §315.15

The Texas State Board of Pharmacy adopts amendments to 22 TAC §315.15, concerning Access Requirements. These amendments are adopted without changes to the proposed text as published in the December 11, 2020, issue of the *Texas Register* (45 TexReg 8825). The rule will not be republished.

The amendments clarify that the duty to consult the Prescription Monitoring Program database before dispensing an opioid, benzodiazepine, barbiturate, or carisoprodol is limited to outpatient prescriptions.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

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 February 22, 2021.

TRD-202100718
Allison Vordenbaumen Benz, R.Ph., M.S.
Executive Director
Texas State Board of Pharmacy
Effective date: March 14, 2021
Proposal publication date: December 11, 2020
For further information, please call: (512) 305-8010

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PART 23. TEXAS REAL ESTATE COMMISSION

CHAPTER 534. GENERAL ADMINISTRATION

22 TAC §534.7

The Texas Real Estate Commission (TREC) adopts the repeal of 22 TAC §534.7, Vendor Protest Procedures, in Chapter 534, General Administration, without changes to the text, as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8470). The rule will not be republished.

The repeal of §534.7 eliminates the agency's use of vendor protest procedures adopted by the Texas Facilities Commission. TREC will replace these vendor protest procedures in rule with a new set of vendor protest procedures that better meet the agency's needs and provide greater transparency to both members of the public and parties seeking to protest.

No comments were received on the repeal as published.

The repeal is adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

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 February 24, 2021.

TRD-202100798
Vanessa Burgess
General Counsel
Texas Real Estate Commission
Effective date: March 16, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 936-3284

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22 TAC §534.7

The Texas Real Estate Commission (TREC) adopts new 22 TAC §534.7, Vendor Protest Procedures, in Chapter 534, General Administration, without changes to the proposed text as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8470). The rule will not be republished.

The adopted new §534.7 creates new vendor protest procedures that better meet the agency's needs than the previous version. This new rule also more clearly establishes the agency's protest review and appeal process and identifies the roles and requirements of both TREC staff and the protesting party.

No comments were received on the amendments as published.

The new rule is adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

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-202100799
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General Counsel
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CHAPTER 535. GENERAL PROVISIONS
SUBCHAPTER I. LICENSE RENEWAL

22 TAC §535.91

The Texas Real Estate Commission (TREC) adopts an amendment to 22 TAC §535.91, Renewal of a Real Estate License, in Chapter 535, General Provisions, with non-substantive changes to the proposed text, as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8472). The rule will be republished. The non-substantive changes update "of this chapter" to "of this title" throughout the section to conform to *Texas Register* referencing preferences.

The amendment to §535.91 corrects a reference within the rule to include the appropriate subsection.

No comments were received on the amendment as published.

The amendment is adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

§535.91. Renewal of a Real Estate License.

(a) Renewal application.

(1) A real estate license expires on the date shown on the face of the license issued to the license holder.

(2) If a license holder intends to renew an unexpired license, the license holder must, on or before the expiration date of the current license:

(A) file a renewal application through the online process on the Commission's website or on the applicable form approved by the Commission;

(B) submit the appropriate fee required by §535.101 of this title (relating to Fees);

(C) comply with the fingerprinting requirements under the Act; and

(D) except as provided for in subsection (g) of this section, satisfy the continuing education requirements applicable to that license.

(3) The Commission may request additional information be provided to the Commission in connection with a renewal application.

(4) A license holder is required to provide information requested by the Commission not later than the 30th day after the date the commission requests the information. Failure to provide information is grounds for disciplinary action.

(b) Renewal Notice.

(1) The Commission will deliver a license renewal notice to a license holder three months before the expiration of the license holder's current license.

(2) If a license holder intends to renew a license, failure to receive a license renewal notice from the Commission does not relieve a license holder from the requirements of this subsection.

(3) The Commission has no obligation to notify any license holder who has failed to provide the Commission with the person's mailing address and email address or a corporation, limited liability company, or partnership that has failed to designate an officer, manager, or partner who meets the requirements of the Act.

(c) Timely renewal of a license.

(1) A renewal application for an individual broker or sales agent is filed timely if it is received by the Commission, or postmarked, on or before the license expiration date.

(2) A renewal application for a business entity broker is filed timely if the application and all required supporting documentation is received by the Commission, or postmarked, not later than the 10th business day before the license expiration date.

(3) If the license expires on a Saturday, Sunday or any other day on which the Commission is not open for business, a renewal application is considered to be filed timely if the application is received or postmarked no later than the first business day after the expiration date of the license.

(d) Initial renewal of sales agent license. A sales agent applying for the first renewal of a sales agent license must:

(1) submit documentation to the Commission showing successful completion of the additional educational requirements of §535.55 of this title (relating to Education and Sponsorship Requirements for a Sales Agent License) no later than 10 business days before the day the sales agent files the renewal application; and

(2) fulfill the continuing education requirements of §535.92(a)(1), (a)(2), and (a)(4) of this title (relating to Continuing Education Requirements), if applicable.

(e) Renewal of license issued to a business entity. The Commission will not renew a license issued to a business entity unless the business entity:

(1) has designated a corporate officer, an LLC manager, an LLC member with managing authority, or a general partner who:

(A) is a licensed broker in active status and good standing with the Commission; and

(B) completes any applicable continuing education required under §535.92 of this title;

(2) maintains errors and omissions insurance with a minimum annual limit of $1 million per occurrence if the designated broker owns less than 10 percent of the business entity; and

(3) is currently eligible to transact business in Texas.

(f) Renewal and pending complaints.

(1) The Commission may renew the current license of a license holder that has a complaint pending with the Commission, provided the license holder meets all other applicable requirements of this section.

(2) Upon completion of the investigation of the pending complaint, the Commission may suspend or revoke the license, after notice and hearing in accordance with the Administrative Procedure Act, Texas Government Code, Chapter 2001.

(g) Renewal with deferred continuing education.

(1) A license holder may renew an active license without completion of required continuing education and may defer completion of any outstanding continuing education requirements for an additional 60 days from the expiration date of the current license if the license holder:

(A) meets all other applicable requirements of this section; and

(B) pays the continuing education deferral fee required by §535.101 of this title at the time the license holder files the renewal application with the Commission.

(2) If after expiration of the 60 day period set out in paragraph (1) of this subsection, the Commission has not been provided with evidence that the license holder has completed all outstanding continuing education requirements, the license holder's license will be placed on inactive status.

(3) To activate an inactive license, the license holder must meet the requirements of Subchapter L of this Chapter.

(4) Credit for continuing education courses for a subsequent licensing period does not accrue until after all deferred continuing education has been completed for the current licensing period.

(h) Denial of Renewal. The Commission may deny an application for renewal of a license if the license holder is in violation of the terms of a Commission order.

(i) Renewal of license for military service member. A license holder on active duty in the United States armed forces is entitled to two years of additional time to renew an expired license without being subject to any increase in fee, any education or experience requirements or examination if the license holder:

(1) provides a copy of official orders or other official documentation acceptable to the Commission showing that the license holder was on active duty during the license holder's last renewal period; and

(2) pays the renewal application fee in effect when the previous license expired.

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 February 24, 2021.

TRD-202100800
Vanessa Burgess
General Counsel
Texas Real Estate Commission
Effective date: March 16, 2021
Proposal publication date: November 27, 2020
For further information, please call: (512) 936-3284

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SUBCHAPTER Q. ADMINISTRATIVE PENALTIES

22 TAC §535.191

The Texas Real Estate Commission (TREC) adopts amendments to 22 TAC §535.191, Schedule of Administrative Penalties, in Chapter 535, General Provisions, without changes to the proposed text as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8474). The rule will not be republished.

The amendment corrects a reference within the agency's schedule of administrative penalties that corresponds to statutory changes enacted by the 86th Legislature in SB 624.

No comments were received on the amendments as published.

The amendments are adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

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

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For further information, please call: (512) 936-3284

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SUBCHAPTER R. REAL ESTATE INSPECTORS

22 TAC §535.216

The Texas Real Estate Commission (TREC) adopts amendments to §535.216, Renewal of License, in Subchapter R of Chapter 535, General Provisions, without changes to the proposed text, as published in the November 27, 2020, issue of the *Texas Register* (45 TexReg 8475). The rule will not be republished.

The amendments implement statutory changes enacted by the 83rd Legislature in HB 2911 stating that applicants for reinstatement of license under Chapter 1102 of the Texas Occupations Code who previously held the same license within the two years preceding the application date are eligible for reinstatement so long as they have completed the required continuing education hours for renewal and satisfy the agency's requirements for honesty, trustworthiness, and integrity. Applicants meeting those criteria are not required to retake the exam for licensure. Additionally, applicants for a real estate inspector license reinstatement must submit evidence of sponsorship by a professional inspector.

The amendments were recommended by the Texas Real Estate Inspector Committee.

No comments were received on the amendments as published.

The amendments are adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

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

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CHAPTER 537. PROFESSIONAL AGREEMENTS AND STANDARD CONTRACTS

22 TAC §537.45, §537.52

The Texas Real Estate Commission (TREC) adopts amendments to 22 TAC §537.45, Standard Contract Form TREC No. 38-6 and §537.52, Standard Contract Form TREC No. 45-1 and the forms adopted by reference in Chapter 537, Professional Agreements and Standard Contracts, without changes to the proposed text or forms adopted by reference, as published in the December 11, 2020, issue of the *Texas Register* (45 TexReg 8825). The rules will not be republished.

Texas real estate license holders are generally required to use forms promulgated by TREC when negotiating contacts for the sale of real property. These forms are drafted and recommended for proposal by the Texas Real Estate Broker-Lawyer Committee, an advisory body consisting of six attorneys appointed by the President of the State Bar of Texas, six brokers appointed by TREC, and one public member appointed by the governor.

The Broker-Lawyer Committee previously recommended revisions to the contract forms adopted by reference under Chapter 537 to address issues that have arisen since the last contract revisions. Changes to those contract forms were adopted at the November 10, 2020, Commission meeting. These amendments are for two contract forms which were inadvertently omitted during the previous round of revisions. The amendments correct a paragraph reference to align with those changes.

The Notice of Buyer's Termination of Contract adopted by reference in §537.45 is amended to correct a reference in Paragraph 1. The reference to Paragraph 23 is replaced with a reference to Paragraph 5 to align with the previous changes made to the contract forms.

The Short Sale Addendum adopted by reference in §537.52 is amended to correct a reference in paragraph F. The reference

to Paragraph 23 is replaced with a reference to Paragraph 5 to align with the previous changes made to the contract forms.

No comments were received on the amendments as published.

The amendments are adopted under Texas Occupations Code §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102.

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 February 24, 2021.

TRD-202100795
Abby Lee
Deputy General Counsel
Texas Real Estate Commission
Effective date: April 1, 2021
Proposal publication date: December 11, 2020
For further information, please call: (512) 936-3057

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 280. PEDIATRIC TELECONNECTIVITY RESOURCE PROGRAM FOR RURAL TEXAS

26 TAC §§280.1, 280.3, 280.5

The Texas Health and Human Services Commission (HHSC) adopts new §280.1, concerning Purpose; §280.3, concerning Definitions; and §280.5, concerning Grant Program Administration. New §§280.1, 280.3, and 280.5 are adopted without changes to the proposed text as published in the December 18, 2020, issue of the *Texas Register* (45 TexReg 8998), and therefore will not be republished.

BACKGROUND AND JUSTIFICATION

The new sections implement Texas Government Code, Chapter 541, added by House Bill (H.B.) 1697, 85th Legislature, Regular Session, 2017. Chapter 541 directs HHSC to establish a pediatric tele-connectivity resource program for rural Texas to award grants to nonurban health care facilities to connect the facilities with pediatric specialists and pediatric subspecialists who provide telemedicine services. Rider 94 of the 2020-21 General Appropriations Act (H.B. 1, 86th Legislature, Regular Session, 2019, Article II, Special Provisions) appropriates funds to HHSC to implement Chapter 541.

The Pediatric Tele-Connectivity Resource Program for Rural Texas allows HHSC to provide financial assistance to enable eligible, nonurban health care facilities to connect with pediatric specialists and pediatric subspecialists who provide telemedicine services and to cover related expenses, including necessary equipment.

COMMENTS

The 31-day comment period ended January 19, 2021.

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

STATUTORY AUTHORITY

The new sections are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, Texas Government Code §531.0055, which directs the Executive Commissioner to adopt rules and policies for the operation of and provision of health and human services; and Texas Government Code §541.008, which provides that the Executive Commissioner may adopt rules necessary to help implement the pediatric tele-connectivity resource program for rural Texas.

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 February 23, 2021.

TRD-202100732
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: March 15, 2021
Proposal publication date: December 18, 2020
For further information, please call: (512) 239-8300

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER A. AUTOMOBILE INSURANCE

DIVISION 3. MISCELLANEOUS INTERPRETATIONS

28 TAC §5.205

The Commissioner of Insurance adopts amended 28 TAC §5.205, relating to the Motor Vehicle Crime Prevention Authority pass-through fee. The amendments are necessary to implement Senate Bill 604, 86th Legislature, 2019, and House Bill 2048, 86th Legislature, 2019. The amendments are adopted with changes to the proposed text published in the September 25, 2020, issue of the *Texas Register* (45 TexReg 6686). The Texas Department of Insurance (TDI) revised §5.205 in response to public comments and made additional nonsubstantive changes to the proposed text. The rule will be republished.

REASONED JUSTIFICATION. Amendments to §5.205 are necessary to ensure that the rule and the notice it requires reflect changes in law made by SB 604 and HB 2048. Before 2019,

the Automobile Burglary and Theft Prevention Authority (ABTPA) was governed by Tex. Rev. Civ. Stat. Ann. art. 4413(37). SB 604 renamed the ABTPA as the Motor Vehicle Crime Prevention Authority (MVCPA). SB 604 also codified art. 4413(37) as Transportation Code Chapter 1006. Additionally, HB 2048 increased the fee amount that insurers must pay from $2.00 to $4.00 as that requirement was adopted in Transportation Code §1006.153. SB 604 and HB 2048 were both effective on September 1, 2019.

Section 5.205. Motor Vehicle Crime Prevention Authority Pass-Through Fee. Throughout §5.205, the name of the entity is changed from ABTPA to MVCPA.

Amendments to subsection (a) update the statutory reference to the Transportation Code and the fee to $4.00. The last sentence of subsection (a) as adopted is changed from the text as proposed to clarify that the insurer may recoup some or all of the fee from an insurer.

Subsection (b) requires a notice to help policyholders understand the charge. For clarity, subsection (b) distinctly enumerates the notice requirements for an insurer that recoups a fee from a policyholder. Insurers must use notice language that is the same or similar to the language in new subsection (b)(1). In response to comments, TDI changed the notice requirement in sunsection (b)(1) as proposed to allow an insurer to use language similar to suggested text rather than requiring specific language.

Amendments to subsection (b) include revised notice language, written in plain language. TDI previously issued Commissioner's Bulletin B-0006-19, alerting insurers of the statutory changes. The amended rule includes language that tracks the notice language suggested in the bulletin, except for removing the acronym "MVCPA." This acronym is not included in the language adopted by the rule because it is not necessary.

The new notice does not expressly include a $4.00 fee amount. Rather, it includes brackets to allow an insurer to insert the dollar amount the insurer charges the policyholder. This is because insurers are not required to recoup the entire $4.00 fee; they may charge a policyholder for all, part, or none of the fee. The brackets also allow flexibility if the legislature later changes the fee amount.

New subsections (b)(2) and (b)(3) give insurers flexibility in how they provide the notice. Insurers must include the notice on or with each motor vehicle insurance policy that is delivered, issued for delivery, or renewed in Texas. Insurers may, but are not required to, include the notice in a policy. However, an insurer must at least mention the charge on the declarations page, renewal certificate, or billing, if there is a charge but the full notice is not given in one of those places.

For flexibility, subsection (c) allows an insurer to comply with the notice requirements by using a notice previously filed with TDI if the notice contains the correct fee amount, has the name "Automobile Burglary and Theft Prevention Authority" replaced with "Motor Vehicle Crime Prevention Authority," and has outdated statutory references updated or removed. In response to comment, TDI has changed the proposed text of subsection (c) to remove a requirement that the notice become a part of the insurer's policy and replace it with this option regarding notice language previously filed with TDI.

Subsection (d) clarifies that a notice that complies with subsection (c) is considered similar to the notice language required by subsection (b). Subsection (d) has been added to the proposed text of the section to coordinate the changes made to subsection (b) and (c) in response to comments.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received five comments. Commenters in support of the proposal with changes were AmWINS Specialty Auto, Inc.; Cox Insurance Group; Home State Insurance Group, Inc.; National Association of Mutual Insurance Companies; and Old American County Mutual Fire Insurance Company.

Comment on Specific Notice Language in §5.205

Comment: All commenters request flexibility in the language required by the notice to avoid additional costs due to changes to forms or a need to refile policy forms to include mandatory notice language, because many companies already revised their notice forms in response to guidance in Commissioner's Bulletin B-0006-19.

Agency response: TDI has changed the notice language requirements as adopted to allow insurers to use language similar to the language in new paragraph (b)(1). Subsections (c) and (d) allow insurers to continue providing a notice used on or before the effective date of the rule if the notice contains the correct fee amount, refers to the MVCPA, and updates or removes the statutory reference in the notice.

Comment on the Location of Notice Language in §5.205

Comment: Many commenters requested more flexibility in the placement of the notice.

Agency response: As adopted, TDI has changed the requirement in subsection (c) so that it does not mandate the notice become part of the policy.

STATUTORY AUTHORITY. The Commissioner adopts the amendments to 28 TAC §5.205 under Transportation Code §1006.153 and Insurance Code §36.001.

Transportation Code §1006.153 provides that the fee amount that insurers must pay to the Motor Vehicle Crime Prevention Authority is $4.00 per motor vehicle years of insurance, as defined by that section.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§5.205. Motor Vehicle Crime Prevention Authority Pass-Through Fee.

(a) Each insurer must pay a fee of $4.00 per "motor vehicle year of insurance" to the Motor Vehicle Crime Prevention Authority, as required by Transportation Code §1006.153. The insurer is authorized to recoup some or all of this fee from the policyholder.

(b) If an insurer recoups the fee from the policyholder under subsection (a) of this section, the insurer must:

(1) provide the policyholder with a notice using the following or similar language, in at least 10-point type: "Your payment includes a $[_____] fee per vehicle each year. This fee helps fund (1) auto burglary, theft, and fraud prevention, (2) criminal justice efforts, and (3) trauma care and emergency medical services for victims of accidents due to traffic offenses. By law, this fee funds the Motor Vehicle Crime Prevention Authority.";

(2) include the notice on or with each motor vehicle insurance policy, as defined in 43 TAC §57.48 (relating to Motor Vehicle

Years of Insurance Calculations), that is delivered, issued for delivery, or renewed in this state, including those policies issued through the Texas Automobile Insurance Plan Association; and

(3) if the notice language required by paragraph (1) of this subsection is provided somewhere other than the declarations page, renewal certificate, or billing, also include the following or similar language on the declarations page of the policy, renewal certificate, or billing: "Motor Vehicle Crime Prevention Authority Fee $[_____] (See enclosed explanation)."

(c) An insurer may continue providing a notice used on or before the effective date of this section if the notice:

(1) contains the correct fee amount;

(2) includes "Motor Vehicle Crime Prevention Authority" in place of "Automobile Burglary and Theft Prevention Authority;" and

(3) has any statutory references removed or updated to change Tex. Rev. Civ. Stat. Ann. art. 4413(37) to Transportation Code Chapter 1006.

(d) A notice that complies with subsection (c) of this section is considered similar to the notice language required by subsection (b) of this section.

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

Filed with the Office of the Secretary of State on February 24, 2021.

TRD-202100779
James Person
General Counsel
Texas Department of Insurance
Effective date: March 16, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 676-6587

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CHAPTER 19. LICENSING AND REGULATION OF INSURANCE PROFESSIONALS

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY

28 TAC §§19.1702, 19.1705, 19.1709 - 19.1711, 19.1716 - 19.1718

The Commissioner of Insurance adopts amendments to 28 TAC §§19.1702, 19.1705, 19.1709 - 19.1711, 19.1716 - 19.1718, relating to utilization reviews for health care that are provided under a health benefit plan or a health insurance policy. The amendments are adopted with changes to the proposed text published in the October 23, 2020, issue of the *Texas Register* (45 TexReg 7525). TDI adopts §§19.1702, 19.1705, 19.1709 - 19.1711, 19.1716, and 19.1717 without changes to the proposed text. The rules will not be republished. TDI adopts §19.1718 with nonsubstantive changes to the proposed text. TDI revised §19.1718(j)(6) in response to public comment. In addition, TDI revised §19.1718(k)(2) by removing the quotation marks around the word "predetermination" to mirror the statutory language of Insurance Code §1451.208. The rule will be republished.

REASONED JUSTIFICATION. The amendments are necessary to implement House Bill 1584, HB 2486, HB 3041, and Senate Bill 1742, all enacted by the 86th Legislature, 2019, or to align the rules with one another.

HB 1584 prohibits a health benefit plan that provides coverage for stage-four, advanced metastatic cancer and associated conditions (stage-IV cancer) from requiring the enrollee to fail to successfully respond to a different drug or prove history of failure of a different drug before providing coverage of a prescription drug that is consistent with best practices; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration.

HB 2486 specifies preauthorization requirements for employee benefit plans or health policies that provide dental benefits.

HB 3041 requires health benefit plan issuers that are subject to Insurance Code Chapter 1222 and that require preauthorization as a condition of payment to provide a preauthorization renewal process that allows a provider to request renewal of an existing preauthorization at least 60 days before it expires. It also requires insurers receiving a request to renew an existing preauthorization to review the request and issue a determination before the existing preauthorization expires, if practicable.

SB 1742 includes provisions requiring the following:

- a shorter response time for a health maintenance organization (HMO) to provide certain information concerning the preauthorization process to a participating physician or provider who requests it,

- a shorter response time for a preferred or exclusive provider health benefit plan issuer to provide certain information concerning the preauthorization process to a preferred provider who requests it,

- requirements for HMOs and preferred or exclusive provider health benefit plan issuers (collectively, health benefit plan issuers) to post certain preauthorization information on their websites, and

- new requirements that utilization review agents (URAs) must meet.

Section 19.1702. Applicability. An amendment to §19.1702(b) adds Insurance Code Chapter 1222 and Chapter 1451, Subchapter E, to the list of Insurance Code provisions that apply to the rules in 28 TAC Chapter 19, Subchapter R.

In addition, nonsubstantive punctuation and grammatical changes that reflect updates to statutory language are made to §19.1702(a)(1) to change existing rule text to "the medical necessity, the appropriateness, or the experimental or investigational nature."

Section 19.1705. General Standards of Utilization Review. Adopted §19.1705(a) includes a requirement that the physician who reviews and approves a URA's utilization review plan be licensed to practice medicine in Texas.

Adopted §19.1705(b) includes three paragraphs. The text of the previously existing section is now in paragraph (1). New paragraphs (2) and (3) prohibit a health benefit plan that provides coverage for stage-IV cancer from requiring that an enrollee with stage-IV cancer fail to successfully respond to a different drug or

prove history of failure of a different drug before the plan provides coverage for certain prescription drugs.

In addition, nonsubstantive punctuation and grammatical changes that reflect updates to statutory language are adopted to §19.1705(d) to change previous rule text to "the medical necessity, the appropriateness, or the experimental or investigational nature."

Section 19.1709. Notice of Determinations Made in Utilization Review. Adopted §19.1709 includes time frames for requesting renewal of an existing preauthorization and issuing the determination on the request.

Adopted §19.1709 includes new subsection (b), which provides that health benefit plan issuers that require preauthorization as a condition for payment must provide a renewal process that allows for the renewal of a preauthorization to be requested at least 60 days before the existing preauthorization expires. The subsections that follow new subsection (b) have been redesignated as appropriate to reflect the addition of the new subsection.

The amendments also add new paragraph (4) to redesignated subsection (e). Adopted §19.1709(e)(4) requires that a URA review a request to renew a preauthorization and make and issue a determination before the existing preauthorization expires, if practicable.

Section 19.1710. Requirements Prior to Issuing an Adverse Determination. The adopted amendments to §19.1710 are nonsubstantive punctuation and grammatical changes that reflect updates to statutory language in the first paragraph of §19.1710 to change existing rule text to "the medical necessity, the appropriateness, or the experimental or investigational nature."

Section 19.1711. Written Procedures for Appeal of Adverse Determinations. The adopted amendments to §19.1711(a)(6) add text to clarify that the requirements of the paragraph concerning review by a particular type of specialty provider are available to the health care provider either when appealing an adverse determination or after an adverse determination appeal has been denied. The adopted amendments to paragraph (6) also revise text to clarify that a health care provider merely needs to request a particular type of specialty provider review the case and is no longer required to provide good cause in writing for the request.

The amendments to §19.1711(a)(7) revise text to clarify that the requirement to have a method for expedited appeals applies in regard to denial of another service if the requesting health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient.

In addition, nonsubstantive punctuation and grammatical changes that reflect updates to statutory language are made to §19.1711(a)(5) to change existing rule text to "the medical necessity, the appropriateness, or the experimental or investigational nature." Another nonsubstantive grammatical change was made to §19.1711(a)(7) to move the placement of existing rule text "is available" to improve the rule's clarity.

Section 19.1716. Specialty URA. The adopted amendments to §19.1716 revise subsections (b) and (d) to specify that utilization review of specialty health care services must be conducted by a health care provider licensed or authorized in Texas to provide the specialty health care service being reviewed.

In addition, nonsubstantive punctuation and grammatical changes that reflect updates to statutory language are made to §19.1716(f), changing existing rule text to "the medical necessity, the appropriateness, or the experimental or investigational nature."

Section 19.1717. Independent Review of Adverse Determinations. Adopted §19.1717 includes an amendment to §19.1717(a) to revise a reference to §19.1709(d)(3), changing it to §19.1709(e)(3) to reflect the redesignation of subsection (d) as (e) in that section. In addition, a nonsubstantive punctuation change is adopted to §19.1717(c) to reflect TDI's current rule drafting style that "internet" not be capitalized.

Section 19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans. The amendments to §19.1718(c) revise the deadline for health benefit plan issuers that use a preauthorization process to provide a list of the medical care and health care services that require preauthorization as well as information about the preauthorization process to preferred providers who request this information, changing the deadline from the 10th to the fifth working day after the date a request is made, for consistency with SB 1742. In addition, the amendments replace the "and" in existing text with "or" to reflect a change in statutory language so that the subsection applies to health benefit plan issuers that use a preauthorization process for "medical care or health care services."

The amendments add new subsection (j) to address the posting of preauthorization requirements for medical and health care services. This subsection requires an HMO or a preferred provider benefit plan that uses a preauthorization process for medical care or health care services to make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, health care providers, and the general public by posting the requirements and information on the HMO's or the preferred provider benefit plan's public internet website. The subsection describes requirements applicable to the preauthorization requirements and information; it addresses how an HMO or preferred provider benefit plan should handle licensed, proprietary, or copyrighted material; it addresses changes to preauthorization requirements; it provides a remedy for noncompliance with the subsection; and it specifies that the provisions of the subsection may not be waived, voided, or nullified by contract. The proposed text in §19.1718(j)(6) was changed in the adoption order in response to a comment that the underlying statutes provide that the relief specified in that paragraph is not limited to subsection (j). The adoption order clarifies that §19.1718(j)(6) applies to §19.1718 except for subsections (f), (k), and (l).

The amendments add new subsection (k) to address preauthorizations for employee benefit plans or health policies that provide dental benefits. The subsection addresses applicability of relevant definitions to prior authorization for dental care services under an employee benefit plan or health insurance policy. The subsection also addresses what an employee benefit plan or health insurance policy provider or issuer must provide to a dentist in a written prior authorization of benefits for a dental care service. The subsection also addresses what an employee benefit plan or health insurance policy provider or issuer must provide in a denial of a dental care service. In addition, TDI revised §19.1718(k)(2) by removing the quotation marks around the word "predetermination" to mirror the statutory language of Insurance Code §1451.208.

The amendments add new subsection (l), to address preauthorization requests to renew existing preauthorizations. The subsection specifies requirements that apply if preauthorization is

required as a condition of payment for a medical or health care service, stating that a preauthorization renewal process must be provided that allows the renewal of an existing preauthorization to be requested by a physician or health care provider at least 60 days before the date the preauthorization expires. The subsection also states that if a request from a physician or health care provider to renew an existing preauthorization is received before an existing preauthorization expires, the request must be reviewed and a determination indicating whether the medical or health care service is preauthorized issued before the existing preauthorization expires, if practicable.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: Commenters in support of the proposal with changes were Superior Health Plan, the Texas Association of Health Plans, and the Texas Medical Association.

Comment on §19.1702

Comment: One commenter asks TDI to clarify that Subchapter R applies to exclusive provider benefit plans in addition to preferred provider benefit plans and HMOs. The commenter notes that under Insurance Code Chapter 1301, health plan preauthorization and verification requirements apply equally to preferred provider benefit plans and exclusive provider benefit plans. The commenter suggests adding a new subsection to §19.1702 to clarify that provisions of Subchapter R that apply to either a preferred provider benefit plan or an HMO also apply to an exclusive provider benefit plan.

Agency Response: TDI agrees with the commenter that Subchapter R applies to exclusive provider benefit plans; however, it disagrees that the requested change is necessary. As the commenter notes, Insurance Code Chapter 1301 provides that health plan preauthorization and verification requirements applying to a preferred provider benefit plan also apply to an exclusive provider benefit plan. Because this is clearly addressed in the statute, it is not necessary that TDI address it in the rule.

Comment on §19.1705(a)

Comment: One commenter asks TDI to confirm that a Texas physician license is required only for review and approval of the utilization review plan and not requests for prior authorization.

Agency Response: TDI agrees that the Texas physician license requirement in amended §19.1705(a) applies only to the review and approval of the utilization plan. However, TDI disagrees with the commenter that a Texas physician license is required *only* for the review and approval of the utilization plan. Under Insurance Code §4201.152, a URA must also conduct utilization review under the direction of a physician licensed in Texas. In addition, not all utilization plans require the review of and approval by a Texas-licensed physician. Utilization plans for Specialty URAs, which are not subject to §19.1705(a), must be reviewed and approved by a health care provider of the appropriate specialty who is licensed or otherwise authorized to provide the specialty health care service in Texas.

Comment on §19.1718(j)(2)(A)(iii)

Comment: One commenter opposes specifying that HMOs and health insurers must post preauthorization requirements in a format that uses design and accessibility standards defined in §508 of the U.S. Rehabilitation Act. The commenter notes that while SB 1742 requires posting of preauthorization requirements in a format that is easily searchable and accessible, it does not specify the accessibility standards. The commenter objects to specifying that the format meet the federal standards, "particularly in the context of required disclosures to physicians and other licensed providers." The commenter requests that TDI clarify that this standard applies only to information posted for the general public.

Agency Response: TDI disagrees with the commenter and declines to make this change. Under Insurance Code §843.3481 and §1301.1351, the posted information *is* for the general public, in addition to physicians and other licensed providers. In this context, "accessible" refers to whether a webpage that does not rely on a single sense or ability and can be used in a variety of ways so that all individuals visiting the website can efficiently use it and locate information they seek. In addition--even if the information was only for physicians and other licensed providers--physicians, health providers, or their employees may have accessibility challenges.

Section 843.3481 and §1301.1351 require that the information be posted on the company's internet website "in a format that is easily searchable and accessible." Section 508 of the U.S. Rehabilitation Act addresses electronic and information technology accessibility. It is a standard that most website information technology specialists will be familiar with. Specifying §508 ensures that the posted preauthorization requirements are easily searchable and accessible as required by SB 1742.

Comment on §19.1718(j)(2)(D)(iv)

Comment: One commenter asks whether an HMO or insurer may report the approval and denial statistics for all pharmacy requests together, rather than having to provide the information separately by each medication, indication, provider, and type. The commenter also asks whether the approval and denial statistics for all clinician-administered drug requests can also be reported together. The commenter also asks whether the approval and denial statistics for "all pharmacy requests (pharmacy benefits and clinician-administered drugs/bio-pharmacy)" can be reported as one service rather than providing the information separately by each medication, indication, provider, and type. The commenter recommends allowing for the required information for all pharmacy benefits to be posted as one group.

Agency Response: TDI disagrees with the commenter's suggested change because it is inconsistent with Insurance Code §843.3481(b)(4)(D) and §1301.1351(b)(4)(D), which §19.1718(j)(2)(D)(iv) implements.

Section 843.3481 and §1301.1351 require HMOs or health insurers that use a preauthorization process for health care services or medical care to make the requirements and information about their preauthorization process readily accessible to enrollees (for HMOs) or insureds (for health insurers), physicians, health care providers, and the general public on their internet website. The information must include a current and accurate list of the health care services (for HMOs) or health care services and medical care (for health insurers) that require preauthorization.

For each service that requires preauthorization, the posted information must include information about supporting documents required, applicable screening criteria, and statistics for the approval and denial rates for the service in the preceding calendar year. Except for the screening criteria, the information must be written in plain language that is easily understandable by insureds, physicians, health care providers, and the general public.

Under Insurance Code §843.3481(b)(4)(D) and §1301.1351(b)(4)(D), each service's approval and denial statistics must include the following categories:

- physician or provider type and specialty, if any;

- indication offered;

- reasons for request denial;

- denials overturned on internal appeal;

- denials overturned by an independent review organization; and

- total annual preauthorization requests, approvals, and denials for the service.

If the statistics for all pharmacy requests that require preauthorization are bundled into the category "pharmacy benefits," the approval and denial statistics provided would neither meet the statutory requirement to provide information specific to each service requiring preauthorization nor provide meaningful information for all the various categories.

Comment on §19.1718(j)(5)

Comment: One commenter believes that the provisions relating to posting changes in preauthorization requirements should not apply to pharmacy and clinician-administered drugs and recommends removing changes to preauthorization requirements for pharmacy and clinician-administered drugs from the applicability of this paragraph.

Agency Response: TDI disagrees with the commenter because the suggested change is inconsistent with Insurance Code §843.3482 and §1301.1352, which §19.1718(j)(5) implements.

Section 843.3482 requires an HMO to provide notice before a change to the preauthorization requirements for "health care services" becomes effective. Insurance Code §843.002(13), which is applicable to Insurance Code §843.3482, defines "health care services" as " . . . services provided to an individual to prevent, alleviate, cure, or heal human illness or injury. The term includes: (A) pharmaceutical services; . . . and (D) care or services incidental to the health care services described by Paragraphs (A) - (C) . . .."

Similarly, Insurance Code §1301.1352 requires that a health insurer provide notice before changing the preauthorization requirements for "medical care or health care services" becomes effective. Although Chapter 1301 does not define "health care services," §1301.001(1-a) defines "health care provider" as " . . . a practitioner, institutional provider, or other person or organization that *furnishes health care services* and that is licensed or otherwise authorized to practice in this state. *The term includes a pharmacist and a pharmacy* . . . ." (emphasis added.)

Section 843.3482 and §1300.1352 do not exclude any changes in preauthorization requirements for medical services or health care services from the posting requirement. The required amount of notice is reduced for a preauthorization requirement that is either being removed or changed in a way that is less burdensome--but even then, the HMO or health insurer must post the change at least five days before the change is effective.

Comment on §19.1718(j)(6)

Comment: One commenter expresses concern that §19.1718(j)(6) narrows the applicability of the statutory noncompliance remedy provided to a violation of subsection (j) only when the underlying statutes provide broader applicability. The commenter suggests replacing "subsection" with "section" and adding a sentence that the paragraph does not apply to subsections (f), (k), or (l).

Agency Response: TDI agrees that the Insurance Code provides that the noncompliance remedy described in §19.1718(j)(6) also applies to violations of other subsections of §19.1718. For clarity, the adopted language has been changed from the proposed language to address the commenter's concerns. The adopted language clarifies that the remedy also applies to the other subsections of §19.1718 except for subsections (f), (k), and (l).

STATUTORY AUTHORITY. The Commissioner adopts the amendments to 28 TAC §§19.1702, 19.1705, 19.1709 - 19.1711, and 19.1716 - 19.1718 under Insurance Code §§843.151, 1301.007, 4201.003, and 36.001.

Insurance Code §843.151 provides that the Commissioner may adopt reasonable rules as necessary and proper to implement Insurance Chapter 843, addressing HMOs.

Insurance Code §1301.007 provides that the Commissioner adopt rules as necessary to implement Chapter 1301 addressing preferred provider plans.

Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement Chapter 4201 addressing URAs.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

§19.1718. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The words and terms defined in Insurance Code Chapter 1301 and Chapter 843 have the same meaning when used in this section, except as otherwise provided by this subchapter, unless the context clearly indicates otherwise.

(b) An HMO or preferred provider benefit plan that requires preauthorization as a condition of payment to a preferred provider must comply with the procedures of this section for determinations of medical necessity, appropriateness, or the experimental or investigational nature of care for those services the HMO or preferred provider benefit plan identifies under subsection (c) of this section.

(c) An HMO or preferred provider benefit plan that uses a preauthorization process for medical care or health care services must provide to each contracted preferred provider, not later than the fifth working day after the date a request is made, a list of medical care and health care services that allows a preferred provider to determine which services require preauthorization and information concerning the preauthorization process.

(d) An HMO or preferred provider benefit plan must issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. This determination must be issued and transmitted once a preauthorization request for proposed services that require preauthorization is received from a preferred provider. The HMO or preferred provider benefit plan must respond to a request for preauthorization within the following time periods:

(1) For services not included under paragraphs (2) and (3) of this subsection, a determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO or preferred provider benefit plan. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring appropriate personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request, followed within three working days after the transmittal of the determination by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. If the request for medical or health care services for concurrent hospitalization care is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within 24 hours from the beginning of the next time period requiring appropriate personnel.

(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this title (relating to Definitions), the HMO or preferred provider benefit plan must issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee, but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. The determination must be provided to the provider of record. If the HMO or preferred provider benefit plan issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider benefit plan must provide to the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1717(a) and (b) of this title (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination via telephone from the HMO or preferred provider benefit plan. An HMO or preferred provider benefit plan must have appropriate personnel as described in §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon, Central Time, on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan must have a telephone system capable of accepting or recording incoming requests after 6:00 p.m., Central Time, Monday through Friday and after noon, Central Time, on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider benefit plan providing a preauthorization determination under subsection (d) of this section must, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(f) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (e) of this section with respect to those services. An HMO providing routine vision services or dental health care services as a single health care service plan must:

(1) have appropriate personnel as described in §19.1706 of this title reasonably available at a toll-free telephone number to provide the preauthorization determination between 8:00 a.m. and 5:00 p.m., Central Time, Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming requests after 5:00 p.m., Central Time, Monday through Friday and all day on Saturday, Sunday, and legal holidays, and must acknowledge each of those calls not later than the next working day after the call is received; and

(3) when providing a preauthorization determination under subsection (d) of this section, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(g) If an HMO or preferred provider benefit plan has preauthorized medical care or health care services, the HMO or preferred provider benefit plan may not deny or reduce payment to the physician or provider for those services based on medical necessity, appropriateness, or the experimental or investigational nature of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

(h) If an HMO or preferred provider benefit plan issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1709 of this title (relating to Notice of Determinations Made in Utilization Review) and §19.1710 of this title (relating to Requirements Prior to Issuing Adverse Determination) must be provided to the enrollee or an individual acting on behalf of the enrollee, and the enrollee's provider of record. An enrollee, an individual acting on behalf of the enrollee, or the enrollee's provider of record may appeal any adverse determination under §19.1711 of this title (relating to Written Procedures for Appeal of Adverse Determination).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan contracts to perform utilization review, or to whom the HMO or preferred provider benefit plan delegates the performance of preauthorization of proposed medical or health care services. Delegation of preauthorization services does not limit in any way the HMO or preferred provider benefit plan's responsibility to comply with all statutory and regulatory requirements.

(j) The provisions in this subsection apply to an HMO or a preferred provider benefit plan that uses a preauthorization process for medical or health care services.

(1) An HMO or a preferred provider benefit plan must make the requirements and information about the preauthorization process readily accessible to enrollees, physicians, health care providers, and the general public by posting the requirements and information on the HMO's or the preferred provider benefit plan's public internet website.

(2) The preauthorization requirements and information described by paragraph (1) of this section must:

(A) be posted:

(i) conspicuously in a location on the public internet website that does not require the user to login or input personal information to view the information; except as provided by paragraph (3) or (4) of this subsection;

(ii) in a format that is easily searchable; and

(iii) in a format that uses design and accessibility standards defined in Section 508 of the U.S. Rehabilitation Act;

(B) except for the screening criteria under subparagraph (D)(iii) of this paragraph, be written:

(i) using plain language standards, such as the Federal Plain Language Guidelines found on www.PlainLanguage.gov; and

(ii) in language that aims to reach a 6th to 8th grade reading level, if the information is for enrollees and the public;

(C) include a detailed description of the preauthorization process and procedure; and

(D) include an accurate and current list of medical or health care services for which the HMO or the preferred provider benefit plan requires preauthorization that includes the following information specific to each service:

(i) the effective date of the preauthorization requirement;

(ii) a list or description of any supporting documentation that the HMO or preferred provider benefit plan requires from the physician or health care provider ordering or requesting the service to approve a request for that service;

(iii) the applicable screening criteria, which may include Current Procedural Terminology codes and International Classification of Diseases codes; and

(iv) statistics regarding the HMO's or the preferred provider benefit plan's preauthorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:

(I) physician or health care provider type and specialty, if any;

(II) indication offered;

(III) reasons for request denial;

(IV) denials overturned on internal appeal;

(V) denials overturned by an independent review organization; and

(VI) total annual preauthorization requests, approvals, and denials for the service.

(3) This subsection may not be construed to require an HMO or a preferred provider benefit plan to provide specific information that would violate any applicable copyright law or licensing agreement. To comply with a posting requirement described by paragraph (2) of this subsection, an HMO or a preferred provider benefit plan may, instead of making that information publicly available on the HMO's or the preferred provider benefit plan's public internet website, supply a summary of the withheld information sufficient to allow a licensed physician or other health care provider, as applicable for the specific service, who has sufficient training and experience related to the service to understand the basis for the HMO's or the preferred provider benefit plan's medical necessity or appropriateness determinations.

(4) If a requirement or information described by paragraph (1) of this subsection is licensed, proprietary, or copyrighted material that the HMO or the preferred provider benefit plan has received from a third party with which the HMO or the preferred provider benefit plan has contracted, to comply with a posting requirement described by paragraph (2) of this subsection, the HMO or the preferred provider benefit plan may, instead of making that information publicly available on the HMO's or the preferred provider benefit plan's public internet website, provide the material to a physician or health care provider who submits a preauthorization request using a nonpublic secured internet website link or other protected, nonpublic electronic means.

(5) The provisions in this paragraph apply when an HMO or a preferred provider benefit plan makes changes to preauthorization requirements.

(A) Except as provided by subparagraph (B) of this paragraph, not later than the 60th day before the date a new or amended preauthorization requirement takes effect, an HMO or a preferred provider benefit plan must provide notice of the new or amended preauthorization requirement and disclose the new or amended requirement in the HMO's or the preferred provider benefit plan's newsletter or network bulletin, if any, and on the HMO's or the preferred provider benefit plan's public internet website.

(B) For a change in a preauthorization requirement or process that removes a service from the list of medical and health care services requiring preauthorization or amends a preauthorization requirement in a way that is less burdensome to enrollees or participating physicians or health care providers, an HMO or a preferred provider benefit plan must provide notice of the change in the preauthorization requirement and disclose the change in the HMO's or the preferred provider benefit plan's newsletter or network bulletin, if any, and on the HMO's or the preferred provider benefit plan's public internet website not later than the fifth day before the date the change takes effect.

(C) Not later than the fifth day before the date a new or amended preauthorization requirement takes effect, an HMO or a preferred provider benefit plan must update its public internet website to disclose the change to the HMO's or the preferred provider benefit plan's preauthorization requirements or process and the date and time the change is effective.

(6) In addition to any other penalty or remedy provided by law, an HMO or a preferred provider benefit plan that uses a preauthorization process for medical or health care services that violates this section with respect to a required publication, notice, or response regarding its preauthorization requirements, including by failing to comply with any applicable deadline for the publication, notice, or response, must provide an expedited appeal under Insurance Code §4201.357 for any health care service affected by the violation. This paragraph does not apply to subsections (f), (k), and (l) of this section.

(7) The provisions of this subsection may not be waived, voided, or nullified by contract.

(k) The provisions of this subsection apply to dental care services under an employee benefit plan or health insurance policy that require prior authorization.

(1) In this subsection, the definitions in Texas Insurance Code §1451.201 for "dental care service," "employee benefit plan," and "health insurance policy" apply.

(2) In this subsection, "prior authorization" means a written and verifiable determination that one or more specific dental care services are covered under the patient's employee benefit plan or health insurance policy and are payable and reimbursable in a specific stated amount, subject to applicable coinsurance and deductible amounts. The term includes preauthorization and similar authorization. The term does not include predetermination as that term is defined by Insurance Code §1451.207(c).

(3) For services for which a prior authorization is required, on request of a patient or treating dentist, an employee benefit plan or health insurance policy provider or issuer must provide to the dentist a written prior authorization of benefits for a dental care service for the patient. The prior authorization must include a specific benefit payment or reimbursement amount. Except as provided by paragraph (4) of this subsection, the plan or policy provider or issuer may not pay or reimburse the dentist in an amount that is less than the amount stated in the prior authorization.

(4) An employee benefit plan or health insurance policy provider or issuer that preauthorizes a dental care service under para-

graph (3) of this subsection may deny a claim for the dental care service or reduce payment or reimbursement to the dentist for the service only if:

(A) the denial or reduction is in accordance with the patient's employee benefit plan or health insurance policy benefit limitations, including an annual maximum or frequency of treatment limitation, and the patient met the benefit limitation after the date the prior authorization was issued;

(B) the documentation for the claim fails to reasonably support the claim as preauthorized;

(C) the preauthorized dental service was not medically necessary based on the prevailing standard of care on the date of the service, or is subject to denial under the conditions for coverage under the patient's plan or policy in effect at the time the service was preauthorized, because of a change in the patient's condition or because the patient received additional dental care after the date the prior authorization was issued;

(D) a payor other than the employee benefit plan or health insurance policy provider or issuer is responsible for payment of the claim;

(E) the dentist received full payment for the preauthorized dental care service on which the claim is based;

(F) the claim is fraudulent;

(G) the prior authorization was based wholly or partly on a material error in information provided to the employee benefit plan or health insurance policy provider or issuer by any person not related to the provider or the issuer; or

(H) the patient was otherwise ineligible for the dental care service under the patient's employee benefit plan or health insurance policy and the plan or policy issuer did not know, and could not reasonably have known, that the patient was ineligible for the dental care service on the date the prior authorization was issued.

(l) If a health benefit plan issuer subject to Insurance Code Chapter 1222 requires preauthorization as a condition of payment for a medical or health care service, the heath benefit plan issuer must provide a preauthorization renewal process that allows a physician or health care provider to request renewal of an existing preauthorization at least 60 days before the date the preauthorization expires. When practicable, a URA must review and issue a determination on a renewal request before the existing preauthorization expires if the URA receives the request before the existing preauthorization expires. The determination must indicate whether the medical or health care service is preauthorized.

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 February 25, 2021.

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James Person
General Counsel
Texas Department of Insurance
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Proposal publication date: October 23, 2020
For further information, please call: (512) 676-6584

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 35. EMERGENCY AND TEMPORARY ORDERS AND PERMITS; TEMPORARY SUSPENSION OR AMENDMENT OF PERMIT CONDITIONS

SUBCHAPTER E. EMERGENCY ORDERS FOR UTILITIES

30 TAC §35.202

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts new §35.202 *without changes* to the proposed text as published in the October 16, 2020, issue of the *Texas Register* (45 TexReg 7393). The rule will not be republished.

Background and Summary of the Factual Basis for the Adopted Rule

The rulemaking adoption implements statutory changes made by House Bill (HB) 3542 and Senate Bill (SB) 700 of the 86th Texas Legislature, 2019.

SB 700 amends Texas Water Code (TWC), Chapters 5 and 13 to authorize the TCEQ to issue emergency orders with or without a hearing to compel a retail public utility to provide water and/or sewer service to ensure safe drinking water or environmental protection. Additionally, TCEQ can issue an emergency order to compel a retail public utility to provide an emergency interconnection for not more than 90 days if necessary to ensure safe drinking water or environmental protection. The legislation also amends TWC, Chapter 5 to allow the commission by order or rule to delegate to the executive director of the TCEQ the authority to receive applications, issue emergency orders under TWC, §13.041(h), and authorize in writing a representative or representatives to act on the executive director's behalf. SB 700 took effect on September 1, 2019.

Corresponding rulemaking is published in this issue of the *Texas Register* concerning 30 Texas Administrative Code (TAC) Chapter 291, Utility Regulations.

Section Discussion

In addition to the adopted revisions associated with this rulemaking, the rulemaking adoption also includes various stylistic, non-substantive changes to update rule language to current *Texas Register* style and format requirements. Such changes include appropriate and consistent use of acronyms, section references, rule structure, and certain terminology. Where the proposal of additional subsections, paragraphs, subparagraphs, etc. are adopted, subsequent re-lettering or renumbering are modified accordingly. These changes are non-substantive and are not specifically discussed in this preamble.

§35.202, Emergency Order to Compel Utility to Provide Service or Interconnection

The commission adopts new §35.202 to allow the commission or executive director to issue emergency orders to compel a retail public utility to provide water and/or sewer service to ensure

safe drinking water or environmental protection, or provide an emergency interconnection for not more than 90 days.

Final Regulatory Impact Determination

The rulemaking adoption is intended to implement statutory changes made by HB 3542 and SB 700 of the 86th Texas Legislature, 2019, to add a new section to reflect changes to TWC, Chapters 5 and 13. New §35.202 adds authority to allow the executive director to issue emergency orders to compel a retail public utility to provide water and/or sewer service to ensure safe drinking water or environmental protection, or provide an emergency interconnection for not more than 90 days.

The commission reviewed the rulemaking adoption in light of the regulatory analysis requirements of Texas Government Code, §2001.0225 and determined that the rulemaking is not subject to Texas Government Code, §2001.0225. Texas Government Code, §2001.0225 applies to a major environmental rule which is defined in Texas Government Code, §2001.0225(g)(3) as a rule with a specific intent "to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state."

First, the rulemaking adoption does not meet the statutory definition of a major environmental rule. The specific intent is to protect the environment or reduce risks to human health from environmental exposure. However, the adopted rule will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. It is not anticipated that the cost of complying with the adopted rule will be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the adopted rule will not adversely affect in a material way the economy, a sector of the economy, competition, or jobs.

Second, the rulemaking adoption does not meet any of the four applicability requirements for a major environmental rule listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 only applies to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking adoption does not meet any of the four preceding applicability requirements because this rulemaking: 1) does not exceed any standard set by federal law; 2) does not exceed any express requirement of TWC, Chapter 5 or 13, which relates to orders issued by the commission, orders issued by the executive director, and emergency orders; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; and 4) is not proposed solely under the general powers of the agency.

Since this rulemaking adoption does not meet the statutory definition of a major environmental rule" nor does it meet any of the four applicability requirements for a major environmental rule this rulemaking is not subject to Texas Government Code, §2001.0225.

Takings Impact Assessment

The commission prepared a takings impact assessment for the adopted rule pursuant to Texas Government Code, §2007.043. The specific purpose of the adopted rule is to ensure consistency between the rules and their applicable statutes as amended by recent legislation and grant the commission and executive director authority to compel a retail public utility with a certificate of public convenience and necessity to provide water and/or sewer service that complies with statutory and regulatory requirements of the commission and to compel a retail public utility to provide an emergency interconnection with a neighboring retail public utility for the provision of temporary water and/or sewer service for up to 90 days.

The adopted regulations will not affect a landowner's rights in private real property because this rulemaking adoption will not burden, restrict, or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulations. The adopted rule does not constitute a taking because it will not burden private real property.

Consistency with the Coastal Management Program

The commission reviewed the adopted rules and found that they are neither identified in Coastal Coordination Act implementation rules, 31 TAC §505.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act implementation rules, 31 TAC §505.11(a)(6). Therefore, the adopted rules are not subject to the Texas Coastal Management Program (CMP).

The commission invited public comment regarding the consistency with the CMP during the public comment period. No comments were received regarding the CMP.

Public Comments

The commission held a public hearing on November 10, 2020. The comment period closed on November 17, 2020. The commission received an oral comment from the Assistant Director of Public Works with the City of Belton. Although the City of Belton expressed concerns that the rulemaking lacks necessary details and considerations, it did not provide any suggested revisions to the proposed rule language.

Response to Comments

Comment

The City of Belton commented that the rule language does not require public notice, the ability to deny a commission ordered interconnection, correct billing issues, provide protection from poor water quality issues, address the inability to provide water or sewer service, specify any indicators for when an emergency order will be issued for an interconnection, address that the order issuance may cause capacity and overflow problems, and expressed concerns that the regulation lacks these necessary details and considerations. The City of Belton did not provide any suggested revisions to the proposed rule language.

Response

The adopted rules implement the exact language contained in HB 3542 and SB 700. TWC, §§5.501, 5.502, and 5.504 and 30 TAC Chapter 35, Subchapter C include notice and opportunity for hearing requirements for emergency orders. These notice and hearing requirements apply to emergency interconnection. Prior to the transfer of the Utility program to the Public Utility Com-

mission of Texas (PUC) on September 1, 2014, TCEQ had the authority in 30 TAC §291.14(a)(2) to compel a retail public utility to provide an emergency interconnection with a neighboring retail public utility for the provision of temporary water or sewer service, or both, for not more than 90 days. Currently the TCEQ has the authority after notice and hearing in 30 TAC §291.114(2) to order two or more public utilities or water supply or sewer service corporations to establish specified facilities for interconnecting service. The proposed rulemaking expands the TCEQs authority to issue emergency orders to include retail public utilities. In the context of an emergency order, a specific trigger is not feasible, because TCEQ must be able to respond to diverse and unpredictable conditions. In any case, TCEQ staff will work with both entities prior to issuing any emergency order to ensure that issuing such an order is the best course of action given the circumstances. Additionally, TCEQ and PUC have agreed to coordinate per the Memo of Understanding signed January 2020, to address situations that may require the issuance of an emergency order pursuant to TWC, §13.041. No changes were made to the rules in response to this comment.

Statutory Authority

The new rule is adopted under Texas Water Code (TWC), §5.102, concerning General Powers, which provides the commission with the general powers to carry out its duties under the TWC; TWC, §5.103, concerning Rules, which provides the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC and other laws of this state; and TWC, §13.041(b), concerning General Powers of Utility Commission and Commission; Rules; Hearings, which provides the commission with the authority to adopt any rules reasonably required in the exercise of its powers and jurisdiction.

The adopted new rule implements Senate Bill 700 passed by the 86th Texas Legislature, 2019.

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 February 26, 2021.

TRD-202100813
Charmain Backens
Director, Litigation Division
Texas Commission on Environmental Quality
Effective date: March 18, 2021
Proposal publication date: October 16, 2020
For further information, please call: (512) 239-2678

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CHAPTER 291. UTILITY REGULATIONS

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts amendments to §291.14 and §291.142.

The amendments to §291.14 and §291.142 are adopted *without changes* to the proposal as published in the October 16, 2020, issue of the *Texas Register* (45 TexReg 7396) and, therefore, will not be republished.

Background and Summary of the Factual Basis for the Adopted Rules

The rulemaking adoption implements statutory changes made by House Bill (HB) 3542 and Senate Bill (SB) 700 of the 86th Texas Legislature, 2019.

HB 3542 amends Texas Water Code (TWC), Chapter 13 and adds additional criteria that allow the TCEQ to appoint a person to temporarily manage a utility. Specifically, TWC, §13.4132(a)(3) authorizes the appointment of a temporary manager if a utility provides retail water or sewer utility service through fewer than 10,000 taps or connections and violates a final order of the commission by failing to provide system capacity that is greater than the required raw water or groundwater production rate or the anticipated daily demand of the system; provide a minimum pressure of 35 pounds per square inch (psi) throughout the distribution system under normal operating conditions; or maintain accurate or properly calibrated testing equipment or other means of monitoring the effectiveness of a chemical treatment or pathogen inactivation or removal process. HB 3542 took effect on September 1, 2019.

SB 700 amended TWC, Chapters 5 and 13 to authorize the TCEQ to issue emergency orders with or without a hearing to compel a retail public utility to provide water and/or sewer service to ensure safe drinking water or environmental protection. Additionally, TCEQ can issue an emergency order to compel a retail public utility to provide an emergency interconnection for not more than 90 days if necessary to ensure safe drinking water or environmental protection. The legislation also amends TWC, Chapter 5 to allow the commission by order or rule to delegate to the executive director of the TCEQ the authority to receive applications, issue emergency orders under TWC, §13.041(h), and authorize in writing a representative or representatives to act on the executive director's behalf. SB 700 took effect on September 1, 2019.

Corresponding rulemaking is published in this issue of the *Texas Register* concerning 30 Texas Administrative Code (TAC) Chapter 35, Emergency and Temporary Orders and Permits; Temporary Suspension or Amendment of Permit Conditions.

Section by Section Discussion

In addition to the adopted revisions associated with this rulemaking, the rulemaking adoption also includes various stylistic, non-substantive changes to update rule language to current *Texas Register* style and format requirements. Such changes included appropriate and consistent use of acronyms, section references, rule structure, and certain terminology. Where the proposal of additional subsections, paragraphs, subparagraphs, etc. are adopted, subsequent re-lettering or renumbering are modified accordingly. These changes are non-substantive and are not specifically discussed in this preamble.

§291.14, Emergency Orders

The commission adopts amended §291.14(a) by moving portions of the existing criteria into adopted subsection (a)(1) and to include two additional criteria as adopted subsection (a)(2) and (3) that will allow the commission or the executive director to issue emergency orders.

§291.142, Operation of Utility That Discontinues Operation or Is Referred for Appointment of a Receiver

The commission adopts to add §291.142(a)(3) to include additional criteria that will allow the commission or the executive director to appoint a person to temporarily manage a utility.

Final Regulatory Impact Determination

The rulemaking adoption is intended to implement statutory changes made by HB 3542 and SB 700 to amend sections to reflect changes to TWC, Chapters 5 and 13. The intent of the changes to §291.14 is to add criteria to allow the executive director to issue emergency orders to compel a retail public utility to provide water and/or sewer service to ensure safe drinking water or environmental protection, or provide an emergency interconnection for not more than 90 days. The intent on the changes to §291.142 is to add additional criteria that will allow the commission or executive director to appoint a person to temporarily manage a utility.

The commission reviewed the rulemaking adoption in light of the regulatory analysis requirements of Texas Government Code, §2001.0225 and determined that the rulemaking is not subject to Texas Government Code, §2001.0225. Texas Government Code, §2001.0225 applies to a major environmental rule which is defined in Texas Government Code, §2001.0225(g)(3) as a rule with a specific intent "to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state."

First, the rulemaking adoption does not meet the statutory definition of a major environmental rule. The specific intent is to protect the environment or reduce risks to human health from environmental exposure. However, the adopted rules will not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. It is not anticipated that the cost of complying with the adopted rules will be significant with respect to the economy as a whole or with respect to a sector of the economy; therefore, the adopted rules will not adversely affect in a material way the economy, a sector of the economy, competition, or jobs.

Second, the rulemaking adoption does not meet any of the four applicability requirements for a major environmental rule listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 only applies to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking adoption does not meet any of the four preceding applicability requirements because this rulemaking: 1) does not exceed any standard set by federal law; 2) does not exceed any express requirements of TWC, Chapter 5 or 13, which relate to orders issued by the commission, orders issued by the executive director, and emergency orders; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; and 4) is not proposed solely under the general powers of the agency.

Since this rulemaking adoption does not meet the statutory definition of a major environmental rule nor does it meet any of the four applicability requirements for a major environmental rule, this rulemaking is not subject to Texas Government Code, §2001.0225.

Takings Impact Assessment

The commission prepared a takings impact assessment for the adopted rules pursuant to Texas Government Code, §2007.043. The specific purpose of these adopted rules is to ensure consistency between the rules and their applicable statutes as amended by recent legislation; to grant the commission and executive director authority, with or without a hearing; to compel a retail public utility with a certificate of public convenience and necessity to provide water and/or sewer service that complies with statutory and regulatory requirements of the commission; to compel a retail public utility to provide an emergency interconnection with a neighboring retail public utility for the provision of temporary water and/or sewer service for up to 90 days; to establish what qualifies as adequate notice to a retail public utility if an emergency order is issued without a hearing; and to add criteria which will allow the commission or the executive director to appoint a person to temporarily manage a utility.

The adopted regulations will not affect a landowner's rights in private real property because this rulemaking adoption will not burden, restrict, or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulations. The adopted rules do not constitute a taking because they will not burden private real property.

Consistency with the Coastal Management Program

The commission reviewed the adopted rules and found that they are neither identified in Coastal Coordination Act implementation rules, 31 TAC §505.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act implementation rules, 31 TAC §505.11(a)(6). Therefore, the adopted rules are not subject to the Texas Coastal Management Program (CMP).

The commission invited public comment regarding the consistency with the CMP during the public comment period. No comments were received regarding the CMP.

Public Comments

The commission held a public hearing on November 10, 2020. The comment period closed on November 17, 2020. The commission received an oral comment from the Assistant Director of Public Works with the City of Belton. Although the City of Belton expressed concerns that the rulemaking lacks necessary details and considerations, it did not provide any suggested revisions to the proposed rule language.

Response to Comments

Comment

The City of Belton commented that the rule language does not require public notice, the ability to deny a commission ordered interconnection, correct billing issues, provide protection from poor water quality issues, address the inability to provide water or sewer service, specify any indicators for when an emergency order will be issued for an interconnection, address that the order issuance may cause capacity and overflow problems, and expressed concerns that the regulation lacks these necessary details and considerations. The City of Belton did not provide any suggested revisions to the proposed rule language.

Response

The adopted rules implement the exact language contained in HB 3542 and SB 700. TWC, §§5.501, 5.502, 5.504 and 30 TAC Chapter 35, Subchapter C include notice and opportunity for hearing requirements for emergency orders. These notice and

hearing requirements apply to emergency interconnection. Prior to the transfer of the Utility program to the Public Utility Commission of Texas (PUC) on September 1, 2014, TCEQ had the authority in 30 TAC §291.14(a)(2) to compel a retail public utility to provide an emergency interconnection with a neighboring retail public utility for the provision of temporary water or sewer service, or both, for not more than 90 days. Currently the TCEQ has the authority after notice and hearing in 30 TAC §291.114(2) to order two or more public utilities or water supply or sewer service corporations to establish specified facilities for interconnecting service. The proposed rulemaking expands the TCEQ's authority to issue emergency orders to include retail public utilities. In the context of an emergency order, a specific trigger is not feasible, because TCEQ must be able to respond to diverse and unpredictable conditions. In any case, TCEQ staff will work with both entities prior to issuing any emergency order to ensure that issuing such an order is the best course of action given the circumstances. Additionally, TCEQ and PUC have agreed to coordinate per the Memo of Understanding signed January 2020, to address situations that may require the issuance of an emergency order pursuant to TWC, §13.041. No changes were made to the rules in response to this comment.

SUBCHAPTER A. GENERAL PROVISIONS

30 TAC §291.14

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.102, concerning General Powers, which provides the commission with the general powers to carry out its duties under the TWC; TWC, §5.103, concerning Rules, which provides the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC and other laws of this state and TWC, §13.041(b), concerning General Powers of Utility Commission and Commission; Rules; Hearings, which provides the commission with the authority to adopt any rules reasonably required in the exercise of its powers and jurisdiction.

The adopted amendment implements Senate Bill 700 passed by the 86th Texas Legislature, 2019.

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 February 26, 2021.

TRD-202100814
Charmaine Backens
Director, Litigation Division
Texas Commission on Environmental Quality
Effective date: March 18, 2021
Proposal publication date: October 16, 2020
For further information, please call: (512) 239-2678

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SUBCHAPTER J. ENFORCEMENT, SUPERVISION AND RECEIVERSHIP

30 TAC §291.142

Statutory Authority

The amendment is adopted under Texas Water Code (TWC), §5.102, concerning General Powers, which provides the commission with the general powers to carry out its duties under the TWC; TWC, §5.103, concerning Rules, which provides the commission with the authority to adopt any rules necessary to carry out its powers and duties under the provisions of the TWC and other laws of this state; and TWC, §13.041(b), concerning General Powers of Utility Commission and Commission; Rules; Hearings, which provides the commission with the authority to adopt any rules reasonably required in the exercise of its powers and jurisdiction.

The adopted amendment implements House Bill 3542 passed by the 86th Texas Legislature, 2019.

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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Charmaine Backens
Director, Litigation Division
Texas Commission on Environmental Quality
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Proposal publication date: October 16, 2020
For further information, please call: (512) 239-2678

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 53. FINANCE

SUBCHAPTER A. FEES

DIVISION 3. TRAINING AND CERTIFICATION FEES

31 TAC §53.50

The Texas Parks and Wildlife Commission in a duly noticed meeting on November 10, 2020, adopted an amendment to 31 TAC §53.50, concerning Training and Certification Fees, without changes to the proposed text as published in the September 25, 2020, issue of the *Texas Register* (45 TexReg 6708). The rule will not be republished.

The amendment establishes a fee of $10 for online marine safety enforcement officer instruction by a department-approved third-party provider and allows for the provider to charge and retain a service fee in addition to the $10 fee forwarded to the department. An adopted rulemaking published elsewhere in this issue implements an online option for marine safety enforcement officer instruction.

The amendment is a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires each state agency to review each of its regulations no less frequently than every four years and to re-adopt, adopt with changes, or repeal each rule as a result of the review.

The department received no comments concerning adoption of the rules as proposed.

The amendment is adopted under the authority of Parks and Wildlife Code, §31.121, which requires the commission to promulgate rules to establish and collect a fee to recover the administrative costs associated with the certification of marine safety enforcement officers.

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 February 23, 2021.

TRD-202100737
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: March 15, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 389-4775

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SUBCHAPTER G. BOAT SPEED LIMIT AND BUOY STANDARDS

31 TAC §55.302, §55.303

The Texas Parks and Wildlife Commission in a duly noticed meeting on November 10, 2020, adopted amendments to 31 TAC §55.303, concerning Boat Speed Limit and Buoy Standards, without changes to the proposed text as published in the November 25, 2020, issue of the *Texas Register* (45 TexReg 6709). The rules will not be republished. Section 55.302 is adopted with changes and will be republished.

The amendments modify language regarding certain areas of public water regulated by political subdivisions. Parks and Wildlife Code, §31.092, provides authority to various types of local governments to designate areas of public water within their jurisdictions as bathing, fishing, swimming, or otherwise restricted areas and to make rules and regulations relating to the operation and equipment of boats deemed necessary for the public safety. Current rules make specific reference to "Slow, No Wake" zones, which the department has learned has caused some local entities to interpret the regulatory authority at their disposal too narrowly. By removing references to "Slow, No Wake" designations, the department hopes to make clear that a governing board has greater latitude than the authority to establish "Slow, No Wake" zones.

The amendments are a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires each state agency to review each of its regulations no less frequently than every four years and to re-adopt, adopt with changes, or repeal each rule as a result of the review.

The department received no comments concerning adoption of the rules as proposed.

The amendments are adopted under the authority of Parks and Wildlife Code, §31.142, which authorizes the department to provide for a standard buoy-marking program for the inland water of the state; §31.002, which establishes the duty of the state to promote recreational water safety and the uniformity of laws relating to water safety; and §31.091, which reserves the basic authority to regulate boating to the state.

§55.302. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Department--Texas Parks and Wildlife Department.

(2) Governing board--The governing board of an incorporated city or town, a commissioners court of a county, or the governing board of a political subdivision of the state created pursuant to the Texas Constitution, Article XVI, §59, as identified in the Parks and Wildlife Code, §31.092(c).

(3) Headway speed--Slow, idle speed, or speed only fast enough to maintain steerage on course.

(4) Regulated area--Any area on public water designated and posted as a regulated area by a governing board as provided in Parks and Wildlife Code, §31.092.

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 February 23, 2021.

TRD-202100741
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: March 15, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 389-4775

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SUBCHAPTER H. PARTY BOATS

31 TAC §55.401, §55.402

The Texas Parks and Wildlife Commission in a duly noticed meeting on November 10, 2020, adopted amendments to 31 TAC §55.401 and §55.402, concerning Party Boats, without changes to the proposed text as published in the September 25, 2020, issue of the *Texas Register* (45 TexReg 6711). The rules will not be republished.

Under Parks and Wildlife Code, Chapter 31, Subchapter G, the department is required to license and regulate party boats, which are defined by statute as boats operated by the owner of the vessel or an employee of the owner and rented or leased by the owner for a group recreational event for more than six passengers. The department has encountered instances in which persons who own and operate party boats have erroneously interpreted the provisions in the rules that exempt livery vessels (a rented vessel for which operation and provisioning are the responsibility of the renter rather than the owner of the vessel) from the applicability of the rules to also exempt party boats from the statutory requirements of Parks and Wildlife Code, §31.040, which prescribes the licensing and titling requirements for livery vessels. To remedy the misunderstanding, the amendment removes the definition of "livery vessel" from §55.401, concerning Definitions, and amends §55.402, concerning Applicability and Exceptions, by adding a generic description in of the types of

rental craft that are exempt from the provisions of the subchapter.

The amendments are a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires each state agency to review each of its regulations no less frequently than every four years and to re-adopt, adopt with changes, or repeal each rule as a result of the review.

The department received no comments concerning adoption of the rules as proposed.

The amendments are adopted under the authority of Parks and Wildlife Code, §31.176, which requires the commission to promulgate rules regarding the requirements and procedures for the issuance and renewal of a party boat operator license to protect the public health and safety and §31.180, which requires the commission to adopt and enforce rules necessary to implement Parks and Wildlife Code, Chapter 31, Subchapter G.

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-202100743
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: March 15, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 389-4775

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SUBCHAPTER L. MARINE SAFETY ENFORCEMENT--TRAINING AND CERTIFICATION STANDARDS

The Texas Parks and Wildlife Commission, in a duly noticed meeting on November 10, 2020, adopted the repeal of 31 TAC §55.805 and amendments to §§55.802 - 55.804 and 55.807, concerning Marine Safety Enforcement - Training and Certification Standards. The amendments and repeal were adopted without changes to the proposed text as published in the September 25, 2020, issue of the *Texas Register* (45 TexReg 6712), and will not be republished.

The amendments eliminate requirements for the training of instructors from outside agencies, provide for online instruction for certification as a marine safety enforcement officer (MSEO), and modernize terminology. The department has steadily increased the availability, where possible, of online options for learning applications (for instance, boater education and hunter education requirements can now be satisfied online). Law Enforcement Division staff have determined that the Marine Safety Enforcement Officer Course can be offered online to better serve the department's sister agencies as well as allow for more efficient resource allocation by the department. It is not uncommon for agency marine units to host MSEO course complements of only one or two officers, which consumes department resources and diverts personnel availability for other duties. Offering an online option will mitigate if not eliminate these situations. In another adopted rulemaking published elsewhere in this issue, the department establishes a fee of $10 for online marine safety enforcement officer instruction.

Additionally, demand for the department's MSEO instructor course is non-existent, primarily because outside law enforcement entities find it convenient to obtain MSEO training directly from department law enforcement personnel. Additionally, the Texas Commission on Law Enforcement (TCOLE) has implemented administrative processes that make recordkeeping and reporting functions problematic with respect to outside instructors. Therefore, the department proposes to cease offering the MSEO instructor training course, which necessitates the proposed repeal of §55.805, concerning Marine Safety Enforcement Officer Instructor Course Standards.

The amendments also update references to the Texas Commission on Law Enforcement Officer Standards, which is the former name of TCOLE.

The repeal and amendments are a result of the department's review of its regulations under the provisions of Government Code, §2001.039, which requires each state agency to review each of its regulations no less frequently than every four years and to re-adopt, adopt with changes, or repeal each rule as a result of the review.

The department received no comments concerning adoption of the rules as proposed.

31 TAC §§55.802 - 55.804, 55.807

The amendments are adopted under the authority of Parks and Wildlife Code, §31.121, which requires the commission by rule to establish standards for training and certifying marine safety enforcement officers and instructors.

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 February 23, 2021.

TRD-202100738
James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: March 15, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 389-4775

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31 TAC §55.805

The repeal is adopted under the authority of Parks and Wildlife Code, §31.121, which requires the commission by rule to establish standards for training and certifying marine safety enforcement officers and instructors.

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 February 23, 2021.

TRD-202100740

James Murphy
General Counsel
Texas Parks and Wildlife Department
Effective date: March 15, 2021
Proposal publication date: September 25, 2020
For further information, please call: (512) 389-4775

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 1. MANAGEMENT
SUBCHAPTER F. ADVISORY COMMITTEES

43 TAC §1.85

The Texas Department of Transportation (department) adopts amendments to §1.85, concerning Department Advisory Committees. The amendments to §1.85 are adopted without changes to the proposed text as published in the December 25, 2020 issue of the *Texas Register* (45 TexReg 9400). The rule will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The Texas Transportation Commission (commission) charged the TxDOT Bicycle Advisory Committee (BAC) with reviewing and making recommendations on "...expanding the charge of the committee to address a wider range of related transportation service options, including pedestrian options and personal mobility devices..." through Minute Order 115565 - August 29, 2019.

The BAC discussed both the complementary elements and unique differences between the bicycle, pedestrian, and personal mobility modes including their function, funding, use of infrastructure, and representation. After careful deliberation, the BAC determined that including representatives of and discussion on these additional modes during committee efforts would lead to a better understanding of issues and more balanced, inclusive recommendations for all modes.

The commission is amending §1.85, Department Advisory Committees, to expand the scope of the BAC to include pedestrian issues and the consideration of personal mobility devices, which are also referred to as micromobility devices, as they relate to bicycle and pedestrian issues. Currently, no TxDOT advisory committee is specifically charged with considering pedestrians or personal mobility devices. Additionally, revisions to the BAC's duties are proposed to provide committee input on the current federal bicycle and pedestrian infrastructure funding program.

Amendments to §1.85(a)(3), Bicycle Advisory Committee, make various changes to the paragraph.

Subparagraph (A), Purpose, is amended to change the committee's name to Bicycle and Pedestrian Advisory Committee, to add pedestrians' issues as part of the committee's purpose, and to change the name of the funding program to reflect the current federal bicycle and pedestrian infrastructure funding source.

Amendments to subparagraph (B), Duties, make various changes to organization and content of the current subparagraph. Clauses (i) and (iii) are interchanged. The content of former clause (iii), which is now clause (i), is amended to include pedestrians' issues. Clause (ii) is amended to reflect the current federal bicycle and pedestrian infrastructure funding program. Clause (iii) is former clause (i) with no change to its substance. Clause (iv) is new and adds the duty to review and consider how personal mobility devices relate to bicycling and pedestrian issues and to other road users.

A new subparagraph (C), Committee membership composition, is added to provide guidelines for the composition of the committee's membership reflecting a diverse mix of bicycle and pedestrian stakeholders, including stakeholders representing the interest of persons with disabilities, and people knowledgeable about personal mobility device issues.

Current subparagraph (C), Manner of reporting, is redesignated as subparagraph (D) and amended to reflect the current federal bicycle and pedestrian infrastructure funding program.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department, and more specifically, Transportation Code, §201.117, which provides the commission with the authority to establish advisory committees.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, §201.117.

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

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For further information, please call: (512) 463-8630

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CHAPTER 9. CONTRACT AND GRANT MANAGEMENT
SUBCHAPTER H. REMEDIES FOR NONCOMPLIANCE

The Texas Department of Transportation (department) adopts amendments to §9.130, Purpose, and §9.131, Definitions, the repeal of §§9.132 - 9.139, and new §§9.132 - 9.135, all concerning the remedies for failure to comply with applicable federal or state law, conditions, or contractual agreements related to grants. The amendments to §9.130 and §9.131, the repeal of §§9.132 - 9.139, and new §§9.132 - 9.135 are adopted without changes to the proposed text as published in the December 25, 2020, issue of the *Texas Register* (45 TexReg 9403). The rules will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS, REPEAL, AND NEW SECTIONS

The department is required by federal and state law to monitor grantee compliance. For example, Title 2, Code of Federal Regulations, Part 200 states that non-federal entities that provide grants to carry out part of a federal program must monitor the activities of the grantee to ensure the grant is used for authorized purposes, in compliance with federal statutes and regulations and the terms and conditions grant. The non-federal entity must also consider taking enforcement action against noncompliant grantees as described in Title 2, Code of Federal Regulations, §200.339, Remedies for noncompliance.

Amendments to §9.130, Purpose, and §9.131, Definitions, replace language regarding grant sanctions with remedies for noncompliance to align with federal regulations and other department rules. Proposed rules repeal current §§9.132 - 9.139 regarding grant sanctions and replace them with new §§9.132 - 9.135 regarding department remedies for grantee noncompliance. The new proposed sections align with updated federal regulations on additional award conditions and remedies that may be imposed for noncompliance with grant requirements. The proposed rules apply to all grants issued by the department and are needed to ensure accountability for the expenditure of public funds.

New §9.132, Additional Award Conditions, outlines additional award conditions the department may impose to ensure compliance with applicable laws and standard grant conditions and requirements. Under §9.132, if the department imposes one or more additional award conditions, the department will provide the grantee notice of the condition, the reason for the additional condition, time allowed for completing the additional condition, if applicable, and the action, if any, the grantee may take to end the application of the additional condition.

New §9.133, Remedies for Noncompliance, lists the remedies for noncompliance the department may impose if the department determines the grantee failed to comply with federal or state law, a grant condition, or the grant agreement. The list of remedies for noncompliance align with the remedies available to the department under federal grant regulations.

New §9.134, Notice of Remedies, states that if the department takes an action under §9.133, the department will notify the grantee in writing of the action being taken, a summary of the facts and circumstances underlying the action being taken, and an explanation of how the action was selected.

New §9.135, Appeal of Decision on Remedies, outlines the process by which a grantee may appeal a determination under §9.133 to the executive director of the department. The executive director may delegate the powers and duties assigned under §9.135. A decision on the appeal is final.

The title of Subchapter H is changed to Remedies for Noncompliance to reflect the content of the subchapter, as changed by this rulemaking.

COMMENTS

No comments on the proposed amendments, repeal, and new sections were received.

43 TAC §§9.130 - 9.135

STATUTORY AUTHORITY

The amendments, repeal, and new sections are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

None.

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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43 TAC §§9.132 - 9.139

STATUTORY AUTHORITY

The amendments, repeal, and new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTE

None.

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