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

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §355.112

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.112, concerning Attendant Compensation Rate Enhancement.

BACKGROUND AND PURPOSE

Title 42, Code of Federal Regulations (CFR), §441.301(c)(4)(i) - (v), requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules to implement individualized skills and socialization in the December 23, 2022, issue of the *Texas Register.*

The 2022-2023 General Appropriations Act (GAA), Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-Based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023.

The proposal replaces day habilitation with individualized skills and socialization services for the purposes of the Attendant Compensation Rate Enhancement Program.

The proposed amendment clarifies that providers contracted with a managed care organization to provide attendant care services may participate in the Attendant Compensation Rate Enhancement Program through their managed care organizations. The amendment removes references to Community Based Alternatives (CBA)--Assisted Living/Residential Care (AL/RC) and CBA--Home and Community Support Services (HCSS). These programs were carved into managed care in 2015, and HHSC neither enrolls these providers in the Attendant Compensation Rate Enhancement Program nor determines spending requirements associated with the program.

The proposed amendment modifies several aspects of the Attendant Compensation Rate Enhancement Program. The proposed amendment changes requirements for participating providers to submit an attendant compensation report for determining spending requirements in the Attendant Compensation Rate Enhancement Program. The proposed amendment clarifies that if providers are required to submit a cost report for a rate year, HHSC will use the cost report as an attendant compensation report. For rate years in which participating providers are not required to submit a cost report, HHSC will require a subset of participating providers to submit an accountability report to serve as an attendant compensation report. These providers will be selected at random from the total number of participating contracts that are not required to submit a cost report for a rate year. The number selected will represent a statistically valid sample of participating providers. The proposed amendment modifies report submission requirements for contracts participating in the Attendant Compensation Rate Enhancement Program undergoing a change of ownership or a contract termination by relaxing the requirement that these providers must submit a report to HHSC. The proposed amendment removes provisions allowing limited providers to submit the request for revision report or request for recalculation while modifying parameters regarding limitations.

The proposed amendment implements some recommendations in HHSC's legislative report, *Rates: Intermediate Care Facilities and Certain Waiver Providers,* required by the 2022-2023 GAA, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30). The proposed amendment repeals the requirement that an attendant must perform attendant functions at least 80 percent of his or her total time worked to be considered an attendant for determining spending requirements in the Attendant Compensation Rate Enhancement Program or for calculating the attendant compensation rate component. The amendment provides that any staff who performs attendant functions to prevent a break in service will be considered an attendant.

The proposed amendment modifies the methodology HHSC uses to calculate the attendant compensation rate component for each attendant service. HHSC proposes to calculate the attendant compensation rate component by calculating a median of attendant compensation cost center data weighted by each attendant service units of service from the most recent Medicaid cost report database. The attendant compensation cost component will be inflated using HHSC's inflation methodology from the cost reporting period to the prospective rate period and limited to available levels of state and federal appropriations.

SECTION-BY-SECTION SUMMARY

The proposed amendment removes references to CBA--AL/RC and CBA--HCSS throughout the rule. The amendment adds new subsection (b), which provides that providers contracted with a managed care organization to provide attendant care ser-

vices may participate in the Attendant Compensation Rate Enhancement Program through their managed care organizations. The amendment removes references to CBA--AL/RC and CBA--HCSS as these programs were carved into managed care in 2015, and HHSC neither enrolls these providers in the Attendant Compensation Rate Enhancement Program nor determines spending requirements associated with the program. All following subsections are renumbered.

The proposed amendment deletes current §355.112(b)(1) to repeal the requirement that an attendant must perform attendant functions at least 80 percent of his or her total time worked to be considered an attendant to determine spending requirements in the Attendant Compensation Rate Enhancement Program or for calculating the attendant compensation rate component.

The proposed amendment replaces references to day habilitation with individualized skills and socialization for the DBMD, HCS, and TxHmL programs throughout the rule.

The proposed amendment to current subsection (e) provides that open enrollment ends on the next business day if the last day of open enrollment falls on a weekend day or state or national holiday.

The proposed amendment to current subsection (h) defines an attendant compensation report as a report reflecting the provider's activities while delivering contracted services from the first day of the rate year through the last day of the rate year or provider's fiscal period while participating in the Attendant Compensation Rate Enhancement Program. The proposed amendment specifies that both cost and accountability reports are considered attendant compensation reports.

New subsection (i)(2) specifies HHSC will require a subset of participating contracted providers to submit an annual attendant compensation report. If a provider is required to submit a cost report for a rate year, HHSC will use the cost report as an attendant compensation report. For providers not required to submit a cost report for a rate year, HHSC will select a subset of these providers at random to submit an accountability report serving as their attendant compensation report. The number of selected providers will represent a statistically valid sample of participating providers for the rate year. The proposed amendment also relaxes the requirement that participating providers who terminate their contracts or undergo a change of ownership must submit an attendant compensation report to HHSC.

The proposed amendment to current subsection (l) modifies the methodology HHSC uses to calculate the attendant compensation rate component for each attendant service. HHSC proposes to calculate the attendant compensation rate component by calculating a median of attendant compensation cost center data weighted by each attendant service units of service from the most recent Medicaid cost report database. The attendant compensation cost components will be inflated using HHSC's inflation methodology from the cost reporting period to the prospective rate period and limited to available levels of state and federal appropriations.

The proposed amendment deletes current §355.112(s)(4), as §355.727 is being repealed through a different proposed amendment.

The proposed amendment to current subsection (t) deletes paragraph (2) as HHSC no longer performs requests for recalculation.

The proposed amendment to current subsection (u) deletes paragraph (2) to remove the option for participating providers to submit a request for revision report to overturn a limitation.

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rule is in effect is an estimated cost of $5,970,073 in General Revenue (GR) ($17,170,185 All Funds (AF)) in fiscal year (FY) 2023, $10,868,693 GR ($27,260,328 AF) in FY 2024, $10,865,942 GR ($27,267,107 AF) in FY 2025, $10,865,942 GR ($27,267,107 AF) in FY 2026, $10,865,942 GR ($27,267,107 AF) in FY 2027. This fiscal note represents only costs associated with direct care rate components, including attendant compensation and other direct care cost areas.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed rule will limit an existing rule;

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and is amended to reduce the burden or responsibilities imposed on regulated persons by the rule.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be reduced administrative burden on providers partic-

ipating in the Attendant Compensation Rate Enhancement Program.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because it is a voluntary program and does not impose a cost to comply on participating providers.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R040" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; 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; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

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

§355.112. Attendant Compensation Rate Enhancement.

(a) Eligible programs. Providers contracted in the following programs are eligible to participate in the attendant compensation rate enhancement:

~~[(1) Community Based Alternatives (CBA)--Assisted Living/Residential Care (AL/RC);]~~

~~[(2) CBA--Home and Community Support Services (HCSS);]~~

(1) [~~(3)~~] Community Living Assistance and Support Services (CLASS)--Direct Service Agency (DSA);

(2) [~~(4)~~] Day Activity and Health Services (DAHS);

(3) [~~(5)~~] Deaf-Blind with Multiple Disabilities Waiver (DBMD);

(4) [~~(6)~~] Home and Community-based Services (HCS);

(5) [~~(7)~~] Intermediate Care Facilities for Individuals with Intellectual Disability or Related Conditions (ICF/IID) ("Related Conditions" has the same meaning as in 26 TAC §261.203 [~~40 TAC §9.203~~] (relating to Definitions));

(6) [~~(8)~~] Primary Home Care (PHC);

(7) [~~(9)~~] Residential Care (RC) [~~RC~~]; and

(8) [~~(10)~~] Texas Home Living (TxHmL).

(b) Managed Care Providers. A provider contracted with a managed care organization (MCO) to provide attendant care services may participate in any Attendant Compensation Rate Enhancement Program through the MCO with whom it is contracted, as provided by the MCO's managed care contract with HHSC. Each MCO is responsible for managing any Attendant Compensation Rate Enhancement Program for its contracted providers, including provider enrollment and compliance with the program's spending requirements or any spending requirements imposed under state or federal law.

(c) [~~(b)~~] Definition of attendant. For the purposes of the Attendant Compensation Rate Enhancement Program [~~attendant compensation rate enhancement,~~] under this section, an attendant is an [~~the~~] unlicensed caregiver providing direct assistance to individuals with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL).

~~[(1) For the ICF/IID, DAHS, RC, and CBA AL/RC programs and the HCS supervised living (SL)/residential support services (RSS) and HCS and TxHmL day habilitation (DH) settings, the attendant may perform some nonattendant functions. In such cases, the attendant must perform attendant functions at least 80% of his or her total time worked. Staff in these settings not providing attendant services at least 80% of their total time worked are not considered attendants. Time studies must be performed in accordance with §355.105(b)(2)(B)(i) of this subchapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures) for staff in the ICF/IID, DAHS, RC, and CBA AL/RC programs and the HCS SL/RSS and HCS and TxHmL DH settings that are not full-time attendants but perform attendant functions to determine if a staff member meets this 80% requirement. Failure to perform the time studies for these staff will result in the staff not being considered attendants. Staff performing attendant functions in both the HCS SL/RSS and HCS and TxHmL DH settings that combine to equal at least 80% of their total hours worked would be included in this designation.]~~

(1) [~~(2)~~] Attendants do not include the director, administrator, assistant director, assistant administrator, clerical and secretarial staff, professional staff, other administrative staff, licensed staff, attendant supervisors, cooks and kitchen staff, maintenance and groundskeeping staff, activity director, DBMD Interveners I, II or III, Qualified Intellectual Disability Professionals (QIDPs) or assistant QIDPs, direct care worker supervisors, direct care trainer supervisors, job coach supervisors, foster care providers, and laundry and housekeeping staff. Staff [~~In the ease of HCS supported home living (SHL) and HCS Community First Choice Personal Assistance Services/Habilitation (CFC PAS HAB), TxHmL community support services (CSS), and TxHmL CSS/CFC PAS HAB, PHC, CLASS, CBA--HCSS, and DBMD, staff~~] other than attendants may deliver attendant services and be considered an attendant if they must perform attendant services that cannot be delivered by another attendant to prevent a break in service.

(2) [(3)] An attendant also includes the following:

(A) a driver who is transporting individuals in the [CBA AL/RC,] DAHS, ICF/IID, and RC programs and the HCS SL/RSS and HCS and TxHmL individualized skills and socialization [DH] settings;

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

(C) direct care workers, direct care trainers, job coaches, employment assistance direct care workers, and supported employment direct care workers.

(d) [(c)] Attendant compensation cost center. This cost center will include employee compensation, contract labor costs, and personal vehicle mileage reimbursement for attendants as defined in subsection (c) [(b)] of this section.

(1) Attendant compensation is the allowable compensation for attendants defined in §355.103(b)(1) of this title (relating to Specifications for Allowable and Unallowable Costs) and required to be reported as either salaries and/or wages, including payroll taxes and workers' compensation, or employee benefits. Benefits required by §355.103(b)(1)(A)(iii) of this title to be reported as costs applicable to specific cost report line items, except as noted in paragraph (3) of this subsection, are not to be included in this cost center. For ICF/IID, attendant compensation is also subject to the requirements detailed in §355.457 of this title (relating to Cost Finding Methodology). For HCS and TxHmL, attendant compensation is also subject to the requirements detailed in §355.722 of this title (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

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

(3) Mileage reimbursement paid to the attendant for the use of his or her personal vehicle and which is not subject to payroll taxes is considered compensation for this cost center.

(e) [(d)] Rate year. The rate year begins on the first day of September and ends on the last day of August of the following year.

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

(g) [(f)] Enrollment contract amendment.

(1) For [CBA--HCSS and AL/RC,] CLASS--DSA, DBMD, DAHS, RC and PHC, an initial enrollment contract amendment is required from each provider choosing to participate in the attendant compensation rate enhancement. On the initial enrollment contract amendment, the provider must specify for each contract a desire to participate or not to participate and a preferred participation level.

[(A)] For the PHC program, the participating provider must also specify whether the attendant compensation rate enhancement should apply to the provider's provision of priority, nonpriority, or both priority and nonpriority services.]

[(B) For providers delivering both RC and CBA AL/RC services in the same facility, participation includes both the RC and CBA AL/RC programs.]

(2) For ICF/IID, HCS and TxHmL, an initial enrollment contract amendment is required from each provider choosing to participate in the attendant compensation rate enhancement. On the initial enrollment contract amendment, the provider must specify for each component code a desire to participate or not to participate and a preferred participation level. All contracts of a component code within a specific program must either participate at the same level or not participate.

(A) For the ICF/IID program, the participating provider must also specify the services the provider wishes to have participate in the attendant compensation rate enhancement. Eligible services are residential services and day habilitation services. The participating provider must specify whether the provider wishes to participate for residential services only, day habilitation services only or both residential services and day habilitation services.

(B) For the HCS and TxHmL programs, eligible services are divided into three categories. The three categories of services eligible for rate enhancement are the following:

(i) non-individualized skills and socialization [non-day habilitation] services:

(I) SHL/CFC PAS HAB/CSS;

(II) in-home respite (IHR) and out-of-home respite (OHR);

(III) supported employment (SE); and

(IV) employment assistance (EA);

(ii) individualized skills and socialization [day habilitation] services; and

(iii) residential services:

(I) SL; and

(II) RSS.

(C) The participating provider must specify which combination of the three categories of services the attendant compensation rate enhancement will apply to. For providers delivering services in both the HCS and TxHmL programs, the selected categories must be the same for their HCS and TxHmL programs, except for residential services which are only available in the HCS program.

(3) After initial enrollment, participating and nonparticipating providers may request to modify their enrollment status during any open enrollment period as follows:

(A) a nonparticipant can request to become a participant;

(B) a participant can request to become a nonparticipant; or

(C) a participant can request to change its participation level.

(4) Providers whose prior year enrollment was limited by subsection (v) [(u)] of this section who request to increase their enrollment levels will be limited to increases of three or fewer enhancement levels during the first open enrollment period after the limitation. Providers that were subject to an enrollment limitation may request to participate at any level during open enrollment beginning two years after limitation.

(5) Requests to modify a provider's enrollment status during an open enrollment period must be received by HHSC [Rate Analysis] by the last day of the open enrollment period as per subsection (f) [(e)] of this section. If the last day of open enrollment is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted.

(6) For PHC, DAHS, RC, and CLASS--DSA [, CBA--HCSS, DBMD, and CBA--AL/RC,] providers from which HHSC [Rate Analysis] has not received an acceptable request to modify their enrollment by the last day of the open enrollment period will continue at the level of participation in effect during the open enrollment period within available funds until the provider notifies HHSC in accordance with subsection (y) [(x)] of this section that it no longer wishes to participate or until the provider's enrollment is limited in accordance with subsection (v) [(u)] of this section.

[(7) For ICF/IID, HCS, and TxHmL, all participating and nonparticipating providers must request to modify their enrollment status during the 2021 enrollment period.]

[(A) A nonparticipant can request to become a participant; a participant can request to become a nonparticipant; and a participant can request to change its participation level.]

[(B) This request to modify enrollment status will constitute a revised enrollment. Providers who have not submitted to HHSC Rate Analysis an acceptable revised enrollment by the last day of the open enrollment period will become non-participating providers.]

[(C) Once the revised enrollment has been completed, providers will continue to participate at the level of participation in effect during the last open enrollment period within available funds until the provider notifies HHSC in accordance with subsection (x) of this section that it no longer wishes to participate or until the provider's enrollment is limited in accordance with subsection (u) of this section.]

(7) [(8)] To be acceptable, an enrollment contract amendment must be completed according to instructions, signed by an authorized representative as per HHSC's signature authority designation form applicable to the provider's contract or ownership type, and legible.

(h) [(g)] Enrollment of new [New] contracts. For the purposes of this section, for each rate year a new contract is defined as a contract or component code whose effective date is on or after the first day of the open enrollment period, as defined in subsection (f) [(e)] of this section, for that rate year. Contracts that underwent a contract assignment or change of ownership and new contracts that are part of an existing component code are not considered new contracts. For purposes of this subsection, an acceptable contract amendment is defined as a legible enrollment contract amendment that has been completed according to instructions, signed by an authorized representative as per HHSC's signature authority designation form applicable to the provider's contract or ownership type, and received by HHSC [Rate Analysis] within 30 days of notification to the provider that such an enrollment contract amendment must be submitted. If the 30th day is on a weekend day, state holiday, or national holiday, the next business day will be considered the last day requests will be accepted. New contracts will receive the nonparticipant attendant compensation rate as specified in subsection (m) [(l)] of this section with no enhancements. For new contracts specifying their desire to participate in the attendant compensation rate enhancement on an acceptable enrollment contract amendment, the attendant compensation rate is adjusted as specified in subsection (s) [(r)] of this section, effective on the first day of the month following receipt by HHSC of an acceptable enrollment contract amendment. If the granting of newly requested enhancements was limited by subsection (q)(2)(B) [(p)(2)(B)] of this section during the most recent enrollment, enrollment for new contracts will be subject to that same limitation. If the most recent enrollment was cancelled by subsection (f) [(e)] of this section, new contracts will not be permitted to be enrolled.

(i) [(h)] Attendant Compensation Report [submittal requirements].

(1) Definition of [Annual] Attendant Compensation Report. An attendant compensation report is a report reflecting the provider's activities while delivering contracted services from the first day of the rate year through the last day of the rate year or provider's cost report year while participating in the attendant compensation rate enhancement program. This report is used as the basis for determining compliance with the spending requirements as described in subsection (t) of this section. Cost and accountability reports requested by HHSC are considered attendant compensation reports, and preparers must complete mandatory training requirements per §355.102(d) of this subchapter (relating to General Principles of Allowable and Unallowable Costs).

(2) Providers must file Attendant Compensation Reports as follows. HHSC will require a subset of [All] participating contracted providers to submit an annual Attendant Compensation Report to [will provide] HHSC [Rate Analysis,] in a method specified by HHSC. [Rate Analysis, an annual Attendant Compensation Report reflecting the activities of the provider while delivering contracted services from the first day of the rate year through the last day of the rate year.]

(A) Cost reports serving as Attendant Compensation Reports. If HHSC requires a participating provider to file a cost report for a rate year, HHSC will use that provider's cost report as an Attendant Compensation Report as the basis for determining compliance with the spending requirements as described in subsection (t) of this section.

(B) Accountability reports serving as Attendant Compensation Reports. HHSC will require a select number of participating providers who are not required to submit a cost report for a rate year to submit an accountability report, which will serve as an Attendant Compensation Report as the basis for determining compliance with the spending requirements as described in subsection (t) of this section. These providers will be selected at random from the total number of participating contracts that are not required to submit a cost report for a rate year. The number selected must represent a statistically valid sample of participating providers.

(C) The Attendant Compensation Report [This report] must be submitted for each participating contract if the provider requested participation individually for each contract; or, if the provider requested participation as a group, the report must be submitted as a single aggregate report covering all contracts participating at the end of the rate year within one program of the provider. A participating contract that has been terminated in accordance with subsection (w) [(v)] of this section or that has undergone a contract assignment in accordance with subsection (x) [(w)] of this section will be considered to have participated on an individual basis for compliance with reporting requirements for the owner prior to the termination or contract assignment. [This report will be used as the basis for determining compliance

with the spending requirements and recoupment amounts as described in subsection (s) of this section.]

(D) If required to submit a report by HHSC, contracted [Contracted] providers failing to submit an acceptable annual Attendant Compensation Report within 60 days of the end of the rate year will be placed on vendor hold until such time as an acceptable report is received and processed by HHSC [Rate Analysis].

(E) [(A)] When a participating provider changes ownership through a contract assignment, the prior owner may be required to [must] submit an Attendant Compensation Report covering the period from the beginning of the rate year to the effective date of the contract assignment as determined by HHSC, or its designee. If required, this [This] report will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section. The new owner may [will] be required to submit an Attendant Compensation Report covering the period from the day after the date recognized by HHSC, or its designee, as the contract-assignment effective date to the end of the rate year.

(F) [(B)] Participating providers whose contracts are terminated voluntarily or involuntarily may be required to [must] submit an Attendant Compensation Report covering the period from the beginning of the rate year to the date recognized by HHSC or its designee as the contract termination date. If required, this [This] report will be used as the basis for determining recoupment as described in subsection (t) [(s)] of this section.

(G) [(C)] Participating providers who voluntarily withdraw from participation, as described in subsection (y) [(x)] of this section, may be required to [must] submit an Attendant Compensation Report within 60 days from the date of withdrawal as determined by HHSC. If required, this [This] report must cover the period from the beginning of the rate year through the date of withdrawal as determined by HHSC and will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section.

(H) [(D)] Participating providers whose cost report year, as defined in §355.105(b)(5) of this subchapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures), coincides with the state of Texas fiscal year, are exempt from the requirement to submit a separate Attendant Compensation Report. For these contracts, their cost report will be considered their Attendant Compensation Report.

(3) [(2)] Cost Reports. Cost reports as described in §355.105(b) - (c) of this subchapter will serve as the Attendant Compensation Report with the following exceptions. [:]

(A) When a participating provider changes ownership through a contract assignment or change of ownership, the previous owner may be required to [must] submit an Attendant Compensation Report covering the period from the beginning of the provider's cost reporting period to the date recognized by HHSC, or its designee, as the contract-assignment or ownership-change effective date. If required, this [This] report will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section. The new owner may be required to [must] submit a cost report covering the period from the day after the date recognized by HHSC or its designee as the contract-assignment or ownership-change effective date to the end of the provider's fiscal year.

(B) When one or more contracts or, for the ICF/IID, HCS, and TxHmL programs, component codes of a participating provider are terminated, either voluntarily or involuntarily, the provider may be required to [must] submit an Attendant Compensation Report for the terminated contract(s) or component code(s) covering the period from the beginning of the provider's cost reporting period to the date recognized by HHSC, or its designee, as the contract or component code termination date. This report will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section.

(C) When one or more contracts or, for the ICF/IID, HCS and TxHmL programs, component codes of a participating provider are voluntarily withdrawn from participation as per subsection (y) [(x)] of this section, the provider may be required to [must] submit an Attendant Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the provider's cost reporting period to the date of withdrawal as determined by HHSC. If required, this [This] report will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section. These providers may [must] still be required to submit a cost report covering the entire cost reporting period. The cost report will [not] be used for determining any recoupment amounts.

(D) For new contracts as defined in subsection (h) [(g)] of this section, the cost reporting period will begin with the effective date of participation in the enhancement.

(E) Existing providers who become participants in the enhancement as a result of the open enrollment process described in subsection (f) [(e)] of this section on any day other than the first day of their fiscal year may be required to [must] submit an Attendant Compensation Report with a reporting period that begins on their first day of participation in the enhancement and ends on the last day of the provider's fiscal year. If required, this [This] report will be used as the basis for determining any recoupment amounts as described in subsection (t) [(s)] of this section. These providers may [must] still be required to submit a cost report covering the entire cost reporting period. The cost report will [not] be used for determining any recoupment amounts.

(F) A participating provider that is required to submit a cost report or Attendant Compensation Report under this paragraph will be excused from the requirement to submit a report if the provider did not provide any billable attendant services to HHSC recipients during the reporting period.

(4) [(3)] Other reports. HHSC may require other reports from all contracts as needed.

(5) [(4)] Vendor hold. HHSC, or its designee, will place on hold the vendor payments for any participating provider who does not submit a timely report as described in paragraph (2) [(1)] of this subsection completed in accordance with all applicable rules and instructions. This vendor hold will remain in effect until HHSC [Rate Analysis] receives an acceptable report.

(A) Participating contracts or, for the ICF/IID, HCS and TxHmL programs, component codes may be required to submit an Attendant and Compensation Report. Participating facilities required to submit an Attendant and Compensation Report that do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the due dates described in this subsection or, for cost reports, the due dates described in §355.105(b) of this subchapter will become nonparticipants retroactive to the first day of the reporting period in question and will be subject to an immediate recoupment of funds related to participation paid to the contractor for services provided during the reporting period in question. These contracts or component codes will remain nonparticipants and recouped funds will not be restored until they submit an acceptable report and repay to HHSC, or its designee, funds identified for recoupment from subsection (t) [(s)] of this section. If an acceptable report is not received within 365 days of the due date, the recoupment will become perma-

nent and, if all funds associated with participation during the reporting period in question have been recouped by HHSC, or its designee, the vendor hold associated with the report will be released.

(B) Participating contracts or, for the ICF/IID, HCS, and TxHmL programs, component codes that have terminated or undergone a contract assignment or ownership-change from one legal entity to a different legal entity may be required to submit an Attendant and Compensation Report. Participating facilities required to submit an Attendant and Compensation Report that [~~and~~] do not submit an acceptable report completed in accordance with all applicable rules and instructions within 60 days of the contract assignment, ownership-change, or termination effective date will become nonparticipants retroactive to the first day of the reporting period in question. These contracts or component codes will remain nonparticipants, and recouped funds will not be restored until they submit an acceptable report and repay to HHSC, or its designee, funds identified for recoupment under subsection (t) [~~(s)~~] of this section. If an acceptable report is not received within 365 days of the contract assignment, ownership-change, or termination effective date, the recoupment will become permanent and, if all funds associated with participation during the reporting period in question have been recouped by HHSC, or its designee, the vendor hold associated with the report will be released.

(6) [~~(5)~~] Provider-initiated amended Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports. Reports must be received before the date the provider is notified of compliance with spending requirements for the report in question in accordance with subsection (t) [~~(s)~~] of this section.

(j) [~~(i)~~] Report contents. Each Attendant Compensation Report and cost report functioning as an Attendant Compensation Report will include any information required by HHSC to implement this attendant compensation rate enhancement.

(k) [~~(j)~~] Completion of compensation reports. All Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports must be completed in accordance with the provisions of §§355.102 - 355.105 of this subchapter (relating to General Principles of Allowable and Unallowable Costs; Specifications for Allowable and Unallowable Costs; Revenues; and General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this subchapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). All Attendant Compensation Reports and cost reports functioning as Attendant Compensation Reports must be completed by preparers who have attended the required cost report training for the applicable program under §355.102(d) of this subchapter. For the ICF/IID program, cost reports functioning as Attendant Compensation Reports must also be completed in accordance with the provisions of §355.456 of this chapter (relating to Reimbursement Methodology). For the HCS and TxHmL programs, cost reports functioning as Attendant Compensation Reports must also be completed in accordance with the provisions of §355.722 of this chapter (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

(l) [~~(k)~~] Enrollment. Providers choosing to participate in the attendant compensation rate enhancement must submit to HHSC a signed enrollment contract amendment as described in subsection (g) [~~(f)~~] of this section. Participation is determined separately for each program specified in subsection (a) of this section, except that [~~for providers delivering both RC and CBA AL/RC services in the same facility, participation includes both the RC and CBA AL/RC programs and~~] for providers delivering both HCS and TxHmL services, participation includes both the HCS and TxHmL programs. For PHC, participation is also determined separately for priority and nonpriority services. For ICF/IID, participation is also determined separately for residential services and day habilitation services. For HCS and TxHmL, participation is also determined separately for the non-individualized skills and socialization services, individualized skills and socialization services, and residential services categories [~~non-day habilitation services category and the day habilitation services category~~] as defined in subsection (g)(2)(B) [~~(f)(2)(B)~~] of this section. Participation will remain in effect, subject to availability of funds, until the provider notifies HHSC, in accordance with subsection (y) [~~(x)~~] of this section, that it no longer wishes to participate or until HHSC excludes the contract from participation for reasons outlined in subsection (v) [~~(u)~~] of this section. Contracts or component codes voluntarily withdrawing from participation will have their participation end effective with the date of withdrawal as determined by HHSC. Contracts or components codes excluded from participation will have their participation end effective on the date determined by HHSC.

(m) [~~(l)~~] Determination of attendant compensation rate component for nonparticipating contracts.

(1) For CLASS--DSA; DAHS; DBMD; PHC; RC; STAR+PLUS AL; STAR+PLUS HCBS and Non-HCBS programs, HHSC will calculate an attendant compensation rate component for nonparticipating contracts by calculating a median of attendant compensation cost center data as defined in subsection (d) of this section for each applicable attendant service, weighted by the applicable attendant service's units of service from the most recently examined cost report database for each program, and adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 (related to Determination of Inflation Indices).

(A) The weighted median cost component is multiplied by 1.044 for CLASS--DSA, DBMD, PHC, STAR+PLUS HCBS, and Non-HCBS; and by 1.07 for DAHS, RC and STAR+PLUS AL. The result is the attendant compensation rate component for nonparticipating contracts.

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

[~~(1) For the PHC; DAHS; RC; CLASS--DSA; CBA--HCSS; DBMD; and CBA--AL/RC programs, HHSC will calculate an attendant compensation rate component for nonparticipating contracts as follows.~~]

[~~(A) Determine for each contract included in the cost report database used in determination of rates in effect on September 1, 1999, the attendant compensation cost center from subsection (c) of this section.~~]

[~~(B) Adjust the cost center data from subparagraph (A) of this paragraph in order to account for inflation utilizing the inflation factors used in the determination of the September 1, 1999 rates.~~]

[~~(C) For each contract included in the cost report database used to determine rates in effect on September 1, 1999, divide the result from subparagraph (B) of this paragraph by the corresponding units of service. Provider projected costs per unit of service are rank-ordered from low to high, along with the provider's corresponding units of service. For DAHS, the median cost per unit of service is selected. For all other programs, the units of service are summed until the median unit of service is reached. The corresponding projected cost per unit of service is the weighted median cost component. The result is multiplied by 1.044 for PHC, CLASS--DSA, CBA--HCSS, and DBMD; and by 1.07 for RC, CBA--AL/RC, and DAHS. The result is~~

the attendant compensation rate component for nonparticipating contracts.]

[(D) The attendant compensation rate component for nonparticipating contracts will remain constant over time, except in the case of increases to the attendant compensation rate component for nonparticipating contracts explicitly mandated by the Texas legislature and for adjustments necessitated by increases in the minimum wage. Adjustments necessitated by increases in the minimum wage are limited to ensuring that these rates are adequate to cover mandated minimum wage levels.]

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

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

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

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

[(2) For ICF/IID DH, ICF/IID residential services, HCS SL/RSS, HCS DH, HCS SHL/CFC PAS HAB, HCS respite, HCS supported employment, HCS employment assistance, TxHmL DH, TxHmL CSS and CFC PAS HAB, TxHmL respite, TxHmL supported employment, and TxHmL employment assistance, for each level of need (LON), HHSC will calculate an attendant compensation rate component for nonparticipating contracts for each service as follows:]

[(A) For each service, for each LON, determine the percent of the fully-funded model rate in effect on August 31, 2010 for that service accruing from attendants. For ICF/IID, the fully-funded model is the model as calculated under §355.456(d) of this chapter (relating to Reimbursement Methodology) before any adjustments made in accordance with §355.101 of this subchapter (relating to Introduction) and §355.109 of this subchapter (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs). For HCS and TxHmL, the fully-funded model is the model as calculated under §355.723(d) of this chapter (relating to Reimbursement Methodology for Home and Community-based Services and Texas Home Living Programs) before any adjustments made in accordance with §355.101 and §355.109 of this subchapter for the rate period.]

[(B) For each service, for each LON, multiply the percent of the fully-funded model rate in effect on August 31, 2010 for that service accruing from attendants from subparagraph (A) of this paragraph by the total adopted reimbursement rate for that service in effect on August 31, 2010. Effective September 1, 2019, the result is multiplied by 1.044 for HCS SHL/CFC PAS HAB, HCS respite, HCS supported employment, HCS employment assistance, TxHmL CSS and CFC/PAS HAB, TxHmL respite, TxHmL supported employment, and TxHmL employment assistance and by 1.07 for HCS SL/RSS, HCS DH, TxHmL DH and ICF Residential and ICF DH. The result is the attendant compensation rate component for that service for nonparticipating contracts.]

[(C) The attendant compensation rate component for nonparticipating contracts will remain constant over time, except in the case of increases to the attendant compensation rate component for nonparticipating contracts explicitly mandated by the Texas legislature; and for adjustments necessitated by increases in the minimum wage. Adjustments necessitated by increases in the minimum wage are limited to ensuring that these rates are adequate to cover mandated minimum wage levels.]

[(D) Effective July 1, 2017, the attendant compensation rate component for nonparticipating contracts for HCS SHL/CFC PAS HAB and TxHmL CSS and CFC PAS HAB is equal to $14.52 per hour.]

[(E) Effective September 1, 2019, the attendant compensation rate component for nonparticipating contracts for HCS SHL/CFC PAS HAB is calculated using cost data from the most recently audited cost report multiplied by 1.044.]

[(F) Effective January 1, 2020, the attendant compensation rate component for nonparticipating contracts for HCS SL/RSS is calculated using cost data from the most recently audited cost report multiplied by 1.07.]

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

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

(i) EA;

(ii) IHR;

(iii) OHR in a camp;

(iv) OHR in a respite facility;

(v) OHR in a setting where host home / companion care (HH/CC) is provided;

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

(vii) SE;

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

(i) individualized skills and socialization services;

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

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

(vi) RSS; and

(v) SL.

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

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

[(3) Effective upon service claims being made billable through the Texas Medicaid & Healthcare Partnership, HHSC will calculate an attendant compensation rate component for nonparticipating contracts for each of the following services per subparagraphs (A) and (B) of this paragraph: HCS in-home DH, HCS out-of-home DH, HCS in-home respite (HCS IHR), HCS out-of-home respite (HCS OHR) in a respite facility, HCS OHR in a setting where HCS SL/RSS is provided, HCS OHR in a setting where host home (HH)/companion care (CC) services are provided, HCS OHR in a camp, HCS OHR in a DH facility, HCS OHR in another setting not listed above, TxHmL in-home DH, TxHmL out-of-home DH, TxHmL IHR, TxHmL OHR in a respite facility, TxHmL OHR in a setting where HCS SL/RSS is provided, TxHmL OHR in a setting where HH/CC services are provided, TxHmL OHR in a camp, TxHmL OHR in a DH facility, and TxHmL out-of-home respite in another setting not listed above.]

[(A) For each service, for each LON, determine the percent of the fully-funded model rate in effect on August 31, 2019 for that service accruing from attendants. For HCS and TxHmL, the fully-funded model is the model as calculated under §355.723(d) of this chapter before any adjustments made in accordance with §355.101 and §355.109 of this subchapter for the rate period.]

[(B) For each service, for each LON, multiply the percent of the fully-funded model rate in effect on August 31, 2019 for that service accruing from attendants from subparagraph (A) of this paragraph by the total adopted reimbursement rate for that service in effect on August 31, 2019.]

[(i) The result is multiplied by 1.044 for HCS in-home DH, HCS IHR, HCS OHR in a respite facility, HCS OHR in a setting where HH/CC services are provided, HCS OHR in a camp, and HCS OHR in another setting.]

[(ii) The result is multiplied by 1.07 for HCS out-of-home DH, HCS OHR in a DH facility, and HCS OHR in a setting where HCS SL/RSS is provided.]

(4) The attendant compensation rate component for nonparticipating contracts will be limited to available levels of appropriated state and federal funds as specified in §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

(n) [(m)] Determination of attendant compensation base rate for participating contracts.

[(1)] For each of the programs identified in subsection (a) of this section [except for CBA AL/RC], the attendant compensation base rate is equal to the attendant compensation rate component for nonparticipating contracts from subsection (m) [(l)] of this section.

[(2) For CBA AL/RC, the attendant compensation base rate will be determined by taking into consideration quality of care, labor market conditions, economic factors, and budget constraints.]

(o) [(n)] Determination of attendant compensation rate enhancements. HHSC will determine a per diem add-on payment for each enhanced attendant compensation level using data from sources such as cost reports, surveys, and/or other relevant sources and taking into consideration quality of care, labor market conditions, economic factors, and budget constraints. The attendant compensation rate enhancement add-ons will be determined on a per-unit-of-service basis applicable to each program or service. Add-on payments may vary by enhancement level.

(p) [(o)] Enhanced attendant compensation. Contracts or component codes desiring to participate in the enhanced attendant compensation rate may request attendant compensation levels from an array of enhanced attendant compensation options and associated add-on payments determined in subsection (o) [(n)] of this section during open enrollment.

(1) ICF/IID providers must select a single attendant compensation level for all contracts within a component code for the day habilitation and/or residential services they have selected for participation.

(2) HCS and TxHmL must select a single attendant compensation level for all contracts within a component code for the non-individualized skills and socialization services and/or individualized skills and socialization services and/or residential services [non-day habilitation and/or day habilitation services] they have selected for participation.

(q) [(p)] Granting attendant compensation rate enhancements. Eligible programs are divided into two populations for purposes of granting attendant compensation rate enhancements. The first population includes the PHC; DAHS; RC; CLASS--DSA; [CBA--HCSS;] and DBMD [; CBA--AL/RC; and ICM AL/RC] programs, and the second population includes the ICF/IID; HCS; and TxHmL programs. Enhancements for the two populations are funded separately; funds intended for enhancements for the first population of programs will never be used for enhancements for the second population, and funds intended for enhancements for the second population of programs will never be used for enhancements for the first population. For each population of programs, HHSC divides all requested enhancements, after applying any enrollment limitations from subsection (v) [(u)] of this section, into two groups: pre-existing enhancements, which providers request to carry over from the prior year, and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by providers who were nonparticipants in the prior year or by providers who were participants in the prior year who seek additional enhancements. Using the process described herein separately for each population of programs, HHSC first determines the distribution of carry-over enhancements. If funds are available after the distribution of carry-over enhancements, HHSC determines the distribution of newly-requested enhancements. HHSC may not distribute newly-requested enhancements to providers owing funds identified for recoupment under subsection (t) [(s)] of this section.

(1) For all programs and levels [except for CBA AL/RC Level 1], HHSC determines projected units of service for contracts and/or component codes requesting each enhancement level and multiplies this number by the enhancement rate add-on amount associated with that enhancement level as determined in subsection (o) [(n)] of this section. [For CBA AL/RC Level 1, HHSC determines projected units of service for CBA AL/RC contracts requesting Level 1 and multiplies this number by the sum of the difference between the base rate and the nonparticipant rate and the enhancement add-on amount associated with enhancement Level 1 as follows: (Base Rate - Nonparticipant Rate) + Level 1 add-on amount.]

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

(A) If the sum of the products is less than or equal to available funds, all requested enhancements are granted.

(B) If the sum of the products is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds. Based upon an examination of existing compensation levels and compensa-

tion needs, HHSC may grant certain enhancement options priority for distribution.

(r) [~~(q)~~] Notification of granting of enhancements. Participating contracts and component codes are notified, in a manner determined by HHSC, as to the disposition of their request for attendant compensation rate enhancements.

(s) [~~(r)~~] Total attendant compensation rate for participating providers. Each participating provider's total attendant compensation rate will be equal to the attendant compensation base rate from subsection (n) [~~(m)~~] of this section plus any add-on payments associated with enhanced attendant compensation levels selected by and awarded to the provider during open enrollment.

(t) [~~(s)~~] Spending requirements for participating contracts and component codes. HHSC will determine from the Attendant Compensation Report or cost report functioning as an Attendant Compensation Report, as specified in subsection (i) [~~(h)~~] of this section and other appropriate data sources, the amount of attendant compensation spending per unit of service delivered. The provider's compliance with the spending requirement is determined based on the total attendant compensation spending as reported on the Attendant Compensation Report or cost report functioning as an Attendant Compensation Report for each participating contract or component code. Compliance with the spending requirement is determined separately for each program specified in subsection (a) of this section, except for [~~providers delivering both RC and CBA AL/RC services in the same facility whose compliance is determined by combining both programs and~~] providers delivering services in both the HCS and TxHmL programs whose compliance is determined by combining both programs. HHSC will calculate recoupment, if any, as follows.

(1) The accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment.

(2) The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts or component codes in subsection (k) [~~(l)~~] of this section.

(3) In cases where more than one enhancement level is in effect during the reporting period, the spending requirement will be based on the weighted average enhancement level in effect during the reporting period calculated as follows. [~~:~~]

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

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

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

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

[~~(4) Effective January 1, 2020, the recoupment for participating providers reporting HCS RSS/SL services will be determined pursuant to §355.727(f) of this chapter (relating to Add-on Payment Methodology for Home and Community-Based Services Supervised Living and Residential Support Services).~~]

(u) [~~(t)~~] Notification of recoupment [~~and request for recalculation~~].

[~~(1)~~] [~~Notification of recoupment.~~] The estimated amount to be recouped is indicated in the State of Texas Automated Information Reporting System (STAIRS), the online application for submitting cost reports and Attendant Compensation reports. STAIRS will generate an email to the entity contact, indicating that the provider's estimated recoupment is available for review. The entity contact is the provider's authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. If a subsequent review by HHSC or audit results in adjustments to the Attendant Compensation Report or cost reporting, as described in subsection (i) [~~(h)~~] of this section, that change the amount to be repaid, the provider will be notified by email to the entity contact that the adjustments and the adjusted amount to be repaid are available in STAIRS for review. HHSC, or its designee, will recoup any amount owed from a provider's vendor payment(s) following the date of the initial or subsequent notification. For the HCS and TxHmL programs, if HHSC, or its designee, is unable to recoup owed funds in an automated fashion, the requirements detailed under subsection (dd) of this section apply.

[~~(2) Request for recalculation. Providers notified of a recoupment based on an Attendant Compensation Report described in subsection (h)(2)(A) or (h)(2)(F) of this section may request that HHSC recalculate their recoupment after combining the Attendant Compensation Report with the provider's most recently available, audited full-year cost report. The request must be received by HHSC Rate Analysis no later than 30 days after the date on the email notification of recoupment. If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day the receipt of the request will be accepted.~~]

[~~(A) The request must be made by email to the email address specified in STAIRS, hand delivery, United States (U.S.) mail, or special mail delivery. An email request must be typed on the provider's letterhead, signed by a person indicated in subparagraph (B) of this paragraph, then scanned and sent by email to HHSC.~~]

[~~(B) The request must be signed by an individual legally responsible for the conduct of the provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable signature authority designation form for the provider at the time of the request, or a legal representative for the provider. The administrator or director of a facility or program is not authorized to sign the request unless the administrator or director holds one of these positions. HHSC will not accept a request that is not signed by an individual responsible for the conduct of the provider.~~]

(v) [~~(u)~~] Enrollment limitations. A provider will not be enrolled in the attendant compensation rate enhancement at a level higher than the level it achieved on its most recently available [~~,~~] audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report. HHSC will notify a provider of its enrollment limitations after HHSC has completed a financial examination of the report in accordance with §355.106 of this title (concerning Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). [~~(if any) prior to the first day of the open enrollment period.~~]

(1) Notification of enrollment limitations. The enrollment limitation level is indicated in STAIRS. STAIRS will generate an

e-mail to the entity contact, indicating that the provider's enrollment limitation level is available for review.

[(2) Requests for revision. A provider may request a revision of its enrollment limitation if the provider's most recently available audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report does not represent its current attendant compensation levels.]

[(A) A request for revision of enrollment limitation must include the documentation specified in subparagraph (B) of this paragraph and must be received by HHSC [Rate Analysis] no later than the deadline indicated in the notification of open enrollment specified in subsection (e) of this section. A request for revision that is not received by the stated deadline will not be accepted, and the enrollment limitation specified in STAIRS will apply.]

[(B) A provider that requests a revision of its enrollment limitation must submit documentation that shows that, for the period beginning September 1 of the current rate year and ending April 30 of the current rate year, the provider met a higher attendant compensation level than STAIRS indicates. In such cases, the provider's enrollment limitation will be established at the level supported by its request for revision documentation. It is the responsibility of the provider to render all required documentation at the time of its request for revision. Requests that fail to support an attendant compensation level different from what is indicated STAIRS will result in a rejection of the request, and the enrollment limitation specified in STAIRS will apply.]

[(C) A request for revision must be signed by an individual legally responsible for the conduct of the provider or legally authorized to bind the provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable DADS signature authority designation form for the interested party on file at the time of the request, or a legal representative for the interested party. A request for revision that is not signed by an individual legally responsible for the conduct of the interested party will not be accepted, and the enrollment limitation specified in STAIRS will apply.]

[(D) If the provider's Attendant Compensation Report or cost report functioning as an Attendant Compensation Report for the rate year that included the open enrollment period described in subsection (e) of this section shows the provider compensated attendants below the level it presented in its request for revision, HHSC will immediately recoup all enhancement payments associated with the request for revision documents, and the provider will be limited to the level supported by the report for the remainder of the rate year.]

(2) [(3)] Informal reviews and formal appeals. The filing of a request for an informal review or formal appeal relating to a provider's most recently available [,] audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report under §355.110 of this title (relating to Informal Reviews and Formal Appeals) does not stay or delay implementation of an enrollment limitation applied in accordance with the requirements of this subsection. If an informal review or formal appeal relating to a provider's most recently available [,] audited Attendant Compensation Report or cost report functioning as an Attendant Compensation Report is pending at the time the enrollment limitation is applied, the result of the informal review or formal appeal shall be applied to the provider's enrollment retroactively to the beginning of the rate year to which the enrollment limitation was originally applied.

(3) [(4)] New owners after a contract assignment or change of ownership that is an ownership change from one legal entity to a different legal entity. Enhancement levels for a new owner after a contract assignment or change of ownership that is an ownership change from one legal entity to a different legal entity will be determined in accordance with subsection (i) [(w)] of this section. A new owner after a contract assignment or change of ownership that is an ownership-change from one legal entity to a different legal entity will not be subject to enrollment limitations based upon the prior owner's performance.

(4) [(5)] New providers. A new provider's enrollment will be determined in accordance with subsection (h) [(g)] of this section.

(w) [(v)] Contract terminations. For contracted providers or component codes required to submit an Attendant Compensation Report due to a termination as described in subsection (i) [(h)] of this section, HHSC, or its designee, will place a vendor hold on the payments of the contracted provider until HHSC receives an acceptable Attendant Compensation Report, as specified in subsection (i) [(h)] of this section, and funds identified for recoupment from subsection (t) [(s)] of this section are repaid to HHSC [,] or its designee. Informal reviews and formal appeals relating to these reports are governed by §355.110 of this title. HHSC, or its designee, will recoup any amount owed from the provider's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (dd) [(cc)] of this section will be jointly and severally liable for any additional payment due to HHSC [,] or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other HHSC [and/or DADS] contracts controlled by the responsible entity, placement of a vendor hold on all HHSC [and/or DADS] contracts controlled by the responsible entity, and will bar the responsible entity from enacting new contracts with HHSC [and/or DADS] until repayment is made in full. The responsible entity for these contracts will be notified as described in subsection (u) [(t)] of this section prior to the recoupment of owed funds, placement of vendor hold on additional contracts, and barring of new contracts.

(x) [(w)] Contract assignments. The following applies to contract assignments.

(1) Definitions. The following words and terms have the following meanings when used in this subsection.

(A) Assignee--A legal entity that assumes a Community Care contract through a legal assignment of the contract from the contracting entity as provided in 40 TAC §49.210 (relating to Contractor Change of Ownership or Legal Entity).

(B) Assignor--A legal entity that assigns its Community Care contract to another legal entity as provided in 40 TAC §49.210.

(C) Contract assignment--The transfer of a contract by one legal entity to another legal entity as provided in 40 TAC §49.210.

(i) Type One Contract Assignment--A contract assignment by which the assignee is an existing Community Care contract.

(ii) Type Two Contract Assignment--A contract assignment by which the assignee is a new Community Care contract.

(2) Participation after a contract assignment. Participation after a contract assignment is determined as follows:

(A) Type One Contract Assignments. For Type One contract assignments, the assignee's level of participation remains the same while the assignor's level of participation changes to the assignee's.

(B) Type Two Contract Assignments. For Type Two contract assignments, the level of participation of the assignor contract(s) will continue unchanged under the assignee contract(s).

(3) Reporting requirements. The assignee is responsible for the reporting requirements in subsection (i) [~~(h)~~] of this section for any reporting period days occurring after the contract assignment effective date. If the contract assignment occurs during an open enrollment period as defined in subsection (f) [~~(e)~~] of this section, the owner recognized by HHSC, or its designee, on the last day of the enrollment period may request to modify the enrollment status of the contract in accordance with subsection (g) [~~(f)~~] of this section.

(4) Vendor holds. For contracted providers required to submit an Attendant Compensation Report due to contract assignment, as described in subsection (i) [~~(h)~~] of this section, HHSC, or its designee, will place a vendor hold on the payments of the existing contracted provider until HHSC receives an acceptable Attendant Compensation Report, as specified in subsection (i) [~~(h)~~] of this section, and until funds identified for recoupment from subsection (t) [~~(s)~~] of this section are repaid to HHSC [~~,~~] or its designee. HHSC, or its designee, will recoup any amount owed from the provider's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (dd) [~~(ee)~~] of this section will be jointly and severally liable for any additional payment due to HHSC [~~,~~] or its designee. Failure to repay the amount due within 60 days of notification will result in the recoupment of the owed funds from other HHSC [~~and/or DADS~~] contracts controlled by the responsible entity, placement of a vendor hold on all HHSC [~~and/or DADS~~] contracts controlled by the responsible entity, and will bar the responsible entity from enacting new contracts with HHSC [~~and/or DADS~~] until repayment is made in full. The responsible entity for these contracts will be notified, as described in subsection (u) [~~(t)~~] of this section, prior to the recoupment of owed funds, placement of vendor hold on additional contracts, and barring of new contract.

(y) [~~(x)~~] Voluntary withdrawal. Participating contracts or component codes wishing to withdraw from the attendant compensation rate enhancement must notify HHSC [~~Rate Analysis~~] in writing by certified mail and the request must be signed by an authorized representative as designated per the HHSC [~~DADS~~] signature authority designation form applicable to the provider's contract or ownership type. The requests will be effective the first of the month following the receipt of the request. Contracts or component codes voluntarily withdrawing must remain nonparticipants for the remainder of the rate year. Providers whose contracts are participating as part of a component code must request withdrawal of all the contracts in the component code.

(z) [~~(y)~~] Adjusting attendant compensation requirements. Providers that determine that they will not be able to meet their attendant compensation requirements may request to reduce their attendant compensation requirements and associated enhancement payment to a lower participation level by submitting a written request to HHSC [~~Rate Analysis~~] by certified mail, and the request must be signed by an authorized representative as designated per the HHSC [~~DADS~~] signature authority designation form applicable to the provider's contract or ownership type. These requests will be effective the first of the month following the receipt of the request. Providers whose contracts are participating as part of a component code must request the same reduction for all of the contracts in the component code.

(aa) [~~(z)~~] All other rate components. All other rate components will continue to be calculated as specified in the program-specific reimbursement methodology and will be uniform for all providers.

(bb) [~~(aa)~~] Failure to document spending. Undocumented attendant compensation expenses will be disallowed and will not be used in the determination of the attendant compensation spending per unit of service in subsection (t) [~~(s)~~] of this section.

(cc) [~~(bb)~~] Appeals. Subject matter of informal reviews and formal appeals is limited as per §355.110 of this title.

(dd) [~~(ee)~~] Responsible entities. The contracted provider, owner, or legal entity which received the attendant compensation rate enhancement is responsible for the repayment of the recoupment amount.

(1) HCS and TxHmL providers required to repay enhancement funds will be jointly and severally liable for any repayment.

(2) Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in placement of a vendor hold on all HHSC [~~or DADS~~] contracts controlled by the responsible entity.

(ee) [~~(dd)~~] Manual Repayment. For the HCS and TxHmL programs, if HHSC, or its designee, is unable to recoup owed funds using an automated system, providers will be required to repay some or all of the enhancement funds to be recouped through a check, money order, or other non-automated method. Providers will be required to submit the required repayment amount within 60 days of notification.

(ff) [~~(ee)~~] Determination of compliance with spending requirements in the aggregate.

(1) Definitions. The following words and terms have the following meanings when used in this subsection.

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

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

(C) Combined entity--one or more commonly owned corporations and one or more limited partnerships where the general partner is controlled by the same identical persons as the commonly owned corporation(s).

(D) Control--greater than 50 percent ownership by the entity.

(2) Aggregation. For an entity, for two or more commonly owned corporations, or for a combined entity that controls more than one participating contract or component code in a program (with [~~RC and CBA AL/RC considered a single program, and~~] HCS and TxHmL considered a single program), compliance with the spending requirements detailed in subsection (t) [~~(s)~~] of this section can be determined in the aggregate for all participating contracts or component codes in the program controlled by the entity, commonly owned corporations, or combined entity at the end of the rate year, the effective date of the change of ownership of its last participating contract or component code in the program, or the effective date of the termination of its last participating contract or component code in the program rather than requiring each contract or component code to meet its spending requirement individually. Corporations that do not meet the definitions under paragraph (1)(A) - (C) of this subsection are not eligible for aggregation to meet spending requirements.

(A) Aggregation Request. To exercise aggregation, the entity, combined entity, or commonly owned corporations must submit an aggregation request [~~,~~] in a manner prescribed by HHSC [~~,~~] at the time each Attendant Compensation Report or cost report is submitted. In limited partnerships in which the same single general partner controls all the limited partnerships, the single general partner must make

this request. Other such aggregation requests will be reviewed on a case-by-case basis.

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

(C) Ownership changes or terminations. For the ICF/IID, HCS, TxHmL, DAHS, RC, and DBMD [, ~~CBA--AL/RC~~] programs, contracts or component codes that change ownership or terminate effective after the end of the applicable reporting period, but prior to the determination of compliance with spending requirements as per subsection (t) [~~(s)~~] of this section, are excluded from all aggregate spending calculations. These contracts' or component codes' compliance with spending requirements will be determined on an individual basis, and the costs and revenues will not be included in the aggregate spending calculation.

(gg) [~~(ff)~~] Conditions of participation for ICF/IID day habilitation and HCS/TxHmL individualized skills and socialization services. The following conditions of participation apply to each ICF/IID, HCS, and TxHmL provider specifying its wish to have day habilitation services or individualized skills and socialization services participate in the attendant compensation rate enhancement.

(1) A provider who provides day habilitation or individualized skills and socialization services in-house or who contracts with a related party to provide day habilitation or individualized skills and socialization services will report job trainer and job coach compensation and hours on the required cost report items (e.g., hours, salaries and wages, payroll taxes, employee benefits/insurance/workers' compensation, contract labor costs, and personal vehicle mileage reimbursement). Day habilitation costs cannot be combined and reported in one cost report item.

(2) A provider who contracts with a non-related party to provide day habilitation or individualized skills and socialization services will report its payments to the contractor in a single cost report item as directed in the instructions for the cost report or Attendant Compensation Report as described in subsection (i)(3) and (4) [~~(h)(2) and (3)~~] of this section. HHSC will allocate 50 percent of reported payments to the attendant compensation cost area for inclusion with other allowable day habilitation or individualized skills and socialization services attendant costs in order to determine the total attendant compensation spending for day habilitation or individualized skills and socialization services as described in subsection (t) [~~(s)~~] of this section.

(3) The provider must ensure access to any and all records necessary to verify information submitted to HHSC on Attendant Compensation Reports and cost reports functioning as an Attendant Compensation Report.

(4) HHSC will require each ICF/IID, HCS, and TxHmL provider specifying their wish to have day habilitation or individualized skills and socialization services participate in the attendant compensation rate enhancement to certify during the enrollment process that it will comply with the requirements of paragraphs (1) - (3) of this subsection.

(hh) [~~(gg)~~] New contracts within existing component codes. For ICF/IID, HCS, and TxHmL, new contracts within existing component codes will be assigned a level of participation equal to the existing component code's level of participation effective on the start date of the contract as recognized by HHSC or its designee.

(ii) [~~(hh)~~] Disclaimer. Nothing in these rules should be construed as preventing providers from compensating attendants at a level above that funded by the enhanced attendant compensation rate.

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

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TRD-202302291
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 867-7817

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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.304, §355.308

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §355.304, concerning Direct Care Staff Spending Requirement on or after September 1, 2023 and proposes an amendment to §355.308, concerning Direct Care Staff Rate Component.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement the 2024-25 General Appropriations Act (GAA), House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 24). Rider 24 provides appropriations for rate increases for nursing facilities. Nursing facilities must report to HHSC on their biennial cost report information regarding the use of these funds, including information related to efforts to improve or maintain client care and quality of services, and to demonstrate that at least 90 percent of the funds were expended for the purpose of direct care staff wages or benefits. This proposed new rule operationalizes the rider requirements to enable nursing facilities to receive increased reimbursement rates.

The proposal also proposes an amendment to §355.308 related to the Direct Care Staff Rate Component. The proposed amendment modifies the spending requirement in the direct care staff enhancement program by changing the direct care spending floor to 90 percent of direct care revenues from the current 85 percent requirement. HHSC proposes to make this change to align spending requirements related to the direct care rate increases in new §355.304 and the direct care staff enhancement program in §355.308. The proposed amendment removes provisions allowing limited providers to submit the request for revision report or request for recalculation. The amendment also removes references to reinvestment as this section is no longer applicable. The proposed amendment makes clarifying edits throughout.

SECTION-BY-SECTION SUMMARY

Proposed new §355.304(a), (b), and (c) introduce the rate increases for direct care reimbursement, including definitions used in the new rule, and outline eligibility criteria for the increases. Subsection (d) specifies the methodology HHSC will use to establish the rate increases. Subsection (e) outlines the spending requirements and circumstances in which payments will be recouped if spending requirements are not met. Subsection (f) details reporting requirements nursing facility providers must comply with to provide direct care revenues and spending information used to demonstrate compliance with spending requirements.

Subsection (g) specifies how HHSC will notify providers of any recoupment, the appeals process, and repayment requirements. Subsection (h) specifies reporting requirements for a provider undergoing a change of ownership. Subsection (i) specifies the circumstances where providers will be placed on vendor hold for failing to meet reporting requirements. Subsection (j) allows a controlling entity to aggregate spending of multiple contracts to meet program requirements.

The proposed amendment to §355.308 updates Texas Administrative Code (TAC) references in Title 40 to Title 26 and updates references to "Department of Aging and Disability Services" to "HHSC." References to "Rate Analysis" are also deleted as the department has been renamed. The proposed amendment deletes §355.308(i)(2) which allows limited providers to submit the request for revision report. Subsection (k) is amended to modify the methodology HHSC uses to calculate the recommended direct care base rate. HHSC proposes to calculate the direct care base rate using from the most recent Medicaid cost report database. The recommended direct care base rate will be inflated using HHSC's inflation methodology from the cost reporting period to the prospective rate period and limited to available levels of state and federal appropriations.

The proposed amendment to subsection (o) modifies the spending requirement for the direct care enhancement program. HHSC proposes to calculate a spending floor by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues (net any staffing recoupments or recoupments associated with new proposed 355.304) by 0.90.

The amendment to subsection (s) deletes subparagraph (2) as HHSC no longer accepts requests for recalculation because the process was made obsolete by technology upgrades. Subsection (cc) is deleted as reinvestment is no longer applicable to the direct care staff enhancement program.

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rules are in effect is an estimated cost of $158,955,883 in General Revenue (GR) ($398,585,464 All Funds (AF)) in fiscal year (FY) 2024, $165,736,789 GR ($413,102,665 AF) in FY 2025, $186,606,102 GR ($468,271,272 AF) in FY 2026, $186,606,102 GR ($468,271,272 AF) in FY 2027, $186,606,102 GR ($468,271,272 AF) in FY 2028.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

Trey Wood has also determined that there could be adverse economic effect on small businesses, micro-businesses, or rural communities. The new rule may impose additional costs on small businesses, micro-businesses, or rural communities; however, these costs may be offset by the rate increases provided.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of the Provider Finance Department, has determined that for each year of the first five years the rules are in effect, the public benefit will be to stabilize the direct care workforce in nursing facilities and increase the quality of resident care.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because rate increases are anticipated to offset any economic costs to comply with the rules.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R041" in the subject line.

STATUTORY AUTHORITY

The amendment and new section are authorized by Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's

duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

The amendment and new section affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32. This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to establish rate increases to the direct care staff component base rate for nursing facility services while limiting the use of funds received by the provider through these increases. This section describes the spending requirements associated with receiving the rate increases and circumstances in which recoupments will be necessary for a provider's failure to meet those requirements.

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

(1) Direct care staff base rate--The direct care staff base rate is calculated in accordance with §355.308(k) of this chapter (relating to Direct Care Staff Rate Component).

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

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

(4) Responsible entity--The contracted provider, owner, or legal entity that received the revenue to be recouped or the new owner following a change of ownership is responsible for the repayment of any recoupment amount.

(c) Eligibility. To receive and retain rate increases under this section, the provider must be contracted with HHSC or a managed care organization (MCO) to provide nursing facility services through the Medicaid program.

(d) Direct Care Staff Base Rate Increase. Effective September 1, 2023, HHSC will increase the direct care staff base rate for nursing facility services for each Resource Utilization Group (RUG), Version III (RUG-III) case-mix group by an amount that is proportional to the level of the direct care staff base rate for each RUG-III case-mix group in effect on August 31, 2023. The direct care staff base rate increases will be limited to available state and federal appropriated amounts provided for the direct care base rate increase. The direct care rate increase will be applied proportionally to the level of each nursing component payer group under the Texas-specific patient driven payment methodology once that methodology is implemented.

(e) Spending Requirements for providers. Providers are subject to a direct care staff cost center spending requirement with recoupment calculated as follows.

(1) At the end of the rate year, HHSC will calculate a direct care staff base rate spending floor by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues proportional to the direct care base rates effective on August 31, 2023, for each provider.

(2) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the base rate spending floor from paragraph (1) of this subsection. If the base rate spending floor is less than the accrued allowable Medicaid direct care staff expenses, HHSC or its designee will notify the provider as specified in subsection (g) of this section. There will be no recoupment associated with a provider's failure to meet the direct care base rate spending floor specified in this paragraph.

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

(4) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the total direct care staff spending floor from paragraph (3) of this subsection. If the direct care spending floor is less than the accrued allowable Medicaid direct care staff expenses, HHSC or its designee will recoup the difference between the direct care spending floor and the accrued allowable Medicaid direct care staff expenses from providers whose Medicaid direct care staff spending is less than their direct care spending floor.

(5) At no time will a provider's direct care rates after recoupment be less than the direct care base rates in effect prior to the direct care staff base rate increase established under this section.

(6) For participants in the direct care staff enhancement program. HHSC will calculate spending requirement as specified under §355.308 of this subchapter.

(f) Reporting Requirements. Providers receiving the direct care rate increases established under this section must report their direct care revenues and spending to HHSC or its designee in a manner and frequency prescribed by HHSC. HHSC will use cost reports or staffing and compensation reports (accountability reports) requested to comply with the direct care staff enhancement program as specified in §355.308 of this subchapter to meet the requirements of this section if applicable. Providers must also report information related to the use of funds, including information related to efforts to improve or maintain client care and quality of services on their biennial cost reports, as specified by HHSC. All reports must be completed in accordance with the provisions of §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this chapter (relating to Revenues), and §355.105 of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). All reports must be completed by preparers who have attended the required nursing facility cost report training, as per §355.102(d) of this chapter.

(g) Notification of recoupment, appeals, and repayment requirements.

(1) The estimated amount to be recouped for a provider's failure to meet spending requirements as specified under subsection (d) of this section will be indicated in the State of Texas Automated Infor-

mation and Reporting System (STAIRS) or successor system. STAIRS will generate an email to the entity contact, indicating that the facility's estimated recoupment is available for review. If a subsequent review by HHSC results in additional adjustments to the report, as described in subsection (e) of this section, that results in a revised recoupment amount, HHSC will notify the provider's entity contact via email of both the report adjustments and revised recoupment amount are available in STAIRS for review.

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

(3) HHSC or its designee will recoup any amount owed from the facility's vendor payments that are being held following the initial or subsequent notification date. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (b) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other Medicaid contracts controlled by the responsible entity, placement of a vendor hold on all Medicaid contracts controlled by the responsible entity, and barring of new contracts. The vendor hold will bar the responsible entity from receiving any new contracts with HHSC or its designees until repayment is made in full. The responsible entity for these contracts will be notified as described in paragraph (1) of this subsection prior to the recoupment of owed funds, placement of vendor hold, and barring of new contracts.

(h) Change of ownership. When there is a change of ownership before the end of a rate year, the new owner may be responsible for the reporting requirements in subsection (f) of this section for any reporting period days after the change as specified by HHSC or its designee.

(i) Vendor hold. HHSC or its designee will place on hold the vendor payments for any participating facility that does not submit a timely report as described in subsection (f) of this section in accordance with §355.403 of this subchapter (relating to Vendor Hold).

(j) Aggregation. For an entity, commonly owned corporation, or combined entity that controls more than one participating nursing facility contract, compliance with the spending requirements detailed in subsection (e) of this section can be determined in the aggregate for all nursing facility contracts controlled by the entity, commonly owned corporations, or combined entity in accordance with aggregation requirements specified in §355.308(aa) of this subchapter.

§355.308. Direct Care Staff Rate Component.

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

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

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

(3) Nurse aides must meet the qualifications enumerated under 26 TAC §556.3 (relating to Nurse Aide Training and Competency Evaluation Program (NATCEP) Requirements) [~~40 TAC §19.1903 (relating to Required Training of Nurse Aides)~~] to be included in this cost center. Nurse aides include certified nurse aides and nurse aides in training [~~as per 40 TAC §94.3(k) (relating to Nurse Aide Training and Competency Evaluation Program (NATCEP) Requirements)~~].

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

(5) For facilities receiving supplemental reimbursement for children with tracheostomies requiring daily care as described in §355.307(b)(3)(F) of this title (relating to Reimbursement Setting Methodology), staff required by 26 TAC §554.901(15)(C)(iii) [~~40 TAC §19.901(14)(C)(iii)~~] (relating to Quality of Care) performing nursing-related duties for Medicaid contracted beds are included in the direct care staff cost center.

(6) For facilities receiving supplemental reimbursement for qualifying ventilator-dependent residents as described in §355.307(b)(3)(E) of this title, Registered Respiratory Therapists and Certified Respiratory Therapy Technicians are included in the direct care staff cost center.

(7) Nursing facility administrators and assistant administrators are not included in the direct care staff cost center.

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

(9) Paid feeding assistants are not included in the direct care staff cost center and are not to be counted toward the staffing requirements described in subsection (j) of this section. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff.

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

(c) Open enrollment. Open enrollment for the enhanced direct care staff rates will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined. HHSC notifies providers of open enrollment by electronic mail (e-mail) to an authorized representative per the signature authority designation form applicable to the provider's contract or ownership type. If open enrollment has been postponed or cancelled, the Texas Health and Human Services Commission (HHSC) will notify providers by e-mail prior to the first day of July. Should conditions warrant, HHSC may conduct additional enrollment periods during a rate year.

(d) Enrollment contract amendment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status (i.e., a nonparticipant can request to become a participant, a

participant can request to become a nonparticipant, a participant can request to change its enhancement level) during any open enrollment period. Nonparticipants and participants requesting to increase their enrollment levels will be limited to requesting increases of three or fewer enhancement levels during any single open enrollment period unless such limits are waived by HHSC. Requests to modify a facility's enrollment status during an open enrollment period must be received by HHSC [~~Rate Analysis~~] by the last day of the open enrollment period as per subsection (c) of this section. If the last day of the open enrollment period falls on a weekend, a national holiday, or a state holiday, then the first business day following the last day of the open enrollment period is the final day the receipt of the enrollment contract amendment will be accepted. An enrollment contract amendment that is not received by the stated deadline will not be accepted. A facility from which HHSC [~~Rate Analysis~~] has not received an acceptable request to modify their enrollment by the last day of the open enrollment period will continue at the level of participation in effect during the open enrollment period within available funds until the facility notifies HHSC in accordance with subsection (r) of this section that it no longer wishes to participate or until the facility's enrollment is limited in accordance with subsection (i) of this section. If HHSC determines that funds are not available to continue participation at the level of participation in effect during the open enrollment period, facilities will be notified as per subsection (dd) [~~(ee)~~] of this section. To be acceptable, an enrollment contract amendment must be completed according to instructions, signed by an authorized representative as per the HHSC [~~Texas Department of Aging and Disabilities Services (DADS)~~] signature authority designation form applicable to the provider's contract or ownership type, and be legible.

(e) New facilities. For purposes of this section, for each rate year a new facility is defined as a facility delivering its first day of service to a Medicaid recipient after the first day of the open enrollment period, as defined in subsection (c) of this section, for that rate year. Facilities that underwent an ownership change are not considered new facilities. For purposes of this subsection, an acceptable enrollment contract amendment is defined as a legible enrollment contract amendment that has been completed according to instructions, signed by an authorized representative as per the HHSC [~~DADS~~] signature authority designation form applicable to the provider's contract or ownership type, and received by HHSC within 30 days of the notification to the facility by HHSC that such an enrollment contract amendment must be submitted. New facilities will receive the direct care staff base rate as determined in subsection (k) of this section with no enhancements. For new facilities specifying their desire to participate on an acceptable enrollment contract amendment, the direct care staff rate is adjusted as specified in subsection (l) of this section, effective on the first day of the month following receipt by HHSC of the acceptable enrollment contract amendment. If the granting of newly requested enhancements was limited as per subsection (j)(3) of this section during the most recent enrollment, enrollment for new facilities will be subject to that same limitation.

(f) Staffing and Compensation Report submittal requirements.

(1) Annual Staffing and Compensation Report. For services delivered on or before August 31, 2009, providers must file Staffing and Compensation Reports as follows. All participating facilities will provide HHSC, in a method specified by HHSC, an Annual Staffing and Compensation Report reflecting the activities of the facility while delivering contracted services from the first day of the rate year through the last day of the rate year. This report will be used as the basis for determining compliance with the staffing requirements and recoupment amounts as described in subsection (n) of this section, and as the basis for determining the spending requirements and recoupment amounts as described in subsection (o) of this section. Participating facilities failing to submit an acceptable Annual Staffing and Compensation Report within 60 days of the end of the rate year will be placed on vendor hold until such time as an acceptable report is received and processed by HHSC.

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

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

(C) Participating facilities who voluntarily withdraw from participation as per subsection (r) of this section must submit a Staffing and Compensation Report within 60 days of the date of withdrawal as determined by HHSC, covering the period from the beginning of the rate year to the date of withdrawal as determined by HHSC. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section.

(D) Participating facilities whose cost report year coincides with the state of Texas fiscal year as per §355.105(b)(5) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures) are exempt from the requirement to submit a separate Annual Staffing and Compensation Report. For these facilities, their cost report will be considered their Annual Staffing and Compensation Report.

(2) For services delivered on September 1, 2009, and thereafter, cost reports as described in §355.105(b) of this title will replace the Staffing and Compensation Report with the following exceptions:

(A) For services delivered from September 1, 2009, to August 31, 2010, participating facilities may be required to submit Transition Staffing and Compensation Reports in addition to required cost reports. The Transition Staffing and Compensation Report reporting period will include those days in calendar years 2009 and 2010 not included in either the 2009 Staffing and Compensation report or the facility's 2010 cost report.

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

(C) Participating facilities whose contracts are terminated either voluntarily or involuntarily must submit a Staffing and Compensation Report covering the period from the beginning of the facility's cost reporting period to the date recognized by HHSC or its

designee as the contract termination date. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section.

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

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

(F) Existing facilities which become participants in the enhancement as a result of the open enrollment process described in subsection (c) of this section on any day other than the first day of their fiscal year are required to submit a Staffing and Compensation Report with a reporting period that begins on their first day of participation in the enhancement and ends on the last day of the facility's fiscal year. This report will be used as the basis for determining any recoupment amounts as described in subsections (n) and (o) of this section. These facilities must still submit a cost report covering the entire cost reporting period. The cost report will not be used for determining any recoupment amounts.

(G) A participating provider that is required to submit a cost report or Attendant Compensation Report under this paragraph will be excused from the requirement to submit a report if the provider did not provide any billable services to DADS recipients during the reporting period.

(3) Other reports. HHSC may require other Staffing and Compensation Reports from all facilities as needed.

(4) Vendor hold. HHSC or its designee will place on hold the vendor payments for any participating facility that does not submit a timely report as described in paragraph (1) of this subsection, or for services delivered on or after September 1, 2009, a timely report as described in paragraph (2) of this subsection completed in accordance with all applicable rules and instructions. This vendor hold will remain in effect until HHSC receives an acceptable report.

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

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

(5) Provider-initiated amended accountability reports and cost reports functioning as Staffing and Compensation Reports. Reports must be received prior to the date the provider is notified of compliance with spending and/or staffing requirements for the report in question as per subsections (n) and/or (o) of this section.

(g) Report contents. Annual Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports will include any information required by HHSC to implement this enhanced direct care staff rate.

(h) Completion of Reports. All Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports must be completed in accordance with the provisions of §§355.102 - 355.105 of this title (relating to General Principles of Allowable and Unallowable Costs; Specifications for Allowable and Unallowable Costs; Revenues; and General Reporting and Documentation Requirements, Methods, and Procedures) and may be reviewed or audited in accordance with §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). Beginning with the state fiscal year 2002 report, all Staffing and Compensation Reports and cost reports functioning as Staffing and Compensation Reports must be completed by preparers who have attended the required nursing facility cost report training as per §355.102(d) of this title.

(i) Enrollment limitations. A facility will not be enrolled in the enhanced direct care staff rate at a level higher than the level it achieved on its most recently available, audited Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report. HHSC will notify a facility of its enrollment limitations (if any) prior to the first day of the open enrollment period.

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

~~[(2) Requests for revision. A facility may request a revision of its enrollment limitation if the facility's most recently available, audited Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report does not represent its current staffing levels.]~~

~~[(A) A request for revision of enrollment limitation must include the documentation specified in subparagraph (B) of this paragraph and must be received by HHSC Rate Analysis no later than the deadline indicated in the notification of open enrollment specified in subsection (c). A request for revision that is not received by the~~

~~stated deadline will not be accepted and the enrollment limitation specified in STAIRS will apply.]~~

~~[(B) A facility that requests a revision of its enrollment limitation must submit documentation that shows that, for the period beginning September 1 of the current rate year and ending April 30 of the current rate year, the facility met a higher staffing level than STAIRS indicates. In such cases, the facility's enrollment limitation will be established at the level supported by its request for revision documentation. It is the responsibility of the provider to render all required documentation at the time of its request for revision. Requests that fail to support a staffing level different than indicated in STAIRS will result in a rejection of the request and the enrollment limitation specified in STAIRS will apply.]~~

~~[(C) A request for revision must be signed by an individual legally responsible for the conduct of the provider or legally authorized to bind the facility, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable DADS signature authority designation form for the interested party on file at the time of the request, or a legal representative for the interested party. A request for revision that is not signed by an individual legally responsible for the conduct of the interested party will not be accepted and the enrollment limitation specified in STAIRS will apply.]~~

~~[(D) If the facility's Staffing and Compensation Report or cost report functioning as its Staffing and Compensation Report for the rate year that included the open enrollment period described in subsection (d) of this section shows the facility staffed below the level it presented in its request for revision, HHSC will immediately recoup all enhancement payments associated with the request for revision documents and the facility will be limited to the level supported by the report for the remainder of the rate year.]~~

(2) [~~(E)~~] At no time will a facility be allowed to enroll in the enhancement program at a level higher than its current level of enrollment plus three additional levels unless otherwise instructed by HHSC [~~Rate Analysis~~].

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

(4) New facilities. A new facility's enrollment will be determined in accordance with subsection (e) of this section.

(j) Determination of staffing requirements for participants. Facilities choosing to participate in the enhanced direct care staff rate agree to maintain certain direct care staffing levels above the minimum staffing levels described in paragraph (1) of this subsection. In order to permit facilities the flexibility to substitute RN, LVN and aide (Medication Aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN equivalent minutes. Conversion factors to convert RN and aide minutes into LVN equivalent minutes are based upon most recently available, reliable relative compensation levels for the different staff types.

(1) Minimum staffing levels. HHSC determines, for each participating facility, minimum LVN equivalent staffing levels as follows.

(A) Determine minimum required LVN equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.

(i) Determine LVN equivalent minutes associated with Medicare residents based on the data sources from this subparagraph adjusted for estimated acuity differences between Medicare and Medicaid residents.

(ii) Determine minimum required LVN equivalent minutes per resident day of service associated with each Resource Utilization Group (RUG-III) case mix group and additional minimum required minutes for Medicaid residents reimbursed under the RUG-III system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care as described in §355.307 of this title (relating to Reimbursement Setting Methodology) based on the data sources from this subparagraph adjusted for acuity differences between Medicare and Medicaid residents and other factors.

(B) Based on most recently available, reliable utilization data, determine for each facility the total days of service by RUG-III group, days of service provided to Medicaid residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents in Medicaid-contracted beds, and total days of service for all other residents in Medicaid-contracted beds.

(C) Multiply the minimum required LVN equivalent minutes for each RUG-III group and supplemental reimbursement group from subparagraph (A) of this paragraph by the facility's Medicaid days of service in each RUG-III group and supplemental reimbursement group from subparagraph (B) of this paragraph and sum the products.

(D) Multiply the minimum required LVN equivalent minutes for Medicare residents by the facility's Medicare Part A days of service in Medicaid-contracted beds.

(E) Divide the sum from subparagraph (C) of this paragraph by the facility's total Medicaid days of service, with a day of service for a Medicaid RUG-III recipient who also qualifies for a supplemental reimbursement counted as one day of service, compare this result to the minimum required LVN-equivalent minutes for a RUG-III PD1 and multiply the lower of the two figures by the facility's other resident days of service in Medicaid-contracted beds.

(F) Sum the results of subparagraphs (C), (D) and (E) of this paragraph, divide the sum by the facility's total days of service in Medicaid-contracted beds, with a day of service for a Medicaid recipient who also qualifies for a supplemental reimbursement counted as one day of service. The results of these calculations are the minimum LVN equivalent minutes per resident day a participating facility must provide.

(G) In cases where the minimum required LVN-equivalent minutes per resident day of service associated with a RUG-III case mix group or supplemental reimbursement group change during the reporting period, the minimum required LVN-equivalent minutes for the RUG-III case mix group or supplemental reimbursement group for the reporting period will be equal to the weighted average LVN-equivalent minutes in effect during the reporting period for that group calculated as follows:

(i) Multiply the first minimum required LVN equivalent minutes per resident day of service associated with the RUG-III case mix group or supplemental reimbursement group in effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the first minimum required LVN equivalent minutes were in effect.

(ii) Multiply the second minimum required LVN equivalent minutes per resident day of service associated with the RUG-III case mix group or supplemental reimbursement group in effect during the reporting period by the most recently available, reliable Medicaid days of service utilization data for the time period the second minimum required LVN equivalent minutes were in effect.

(iii) Sum the products from clauses (i) and (ii) of this subparagraph.

(iv) Divide the sum from clause (iii) of this subparagraph by the sum of the most recently available, reliable Medicaid days of service utilization data for the entire reporting period used in clauses (i) and (ii) of this subparagraph.

(2) Enhanced staffing levels. Facilities desiring to participate in the enhanced direct care staff rate are required to staff above the minimum requirements from paragraph (1) of this subsection. These facilities may request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments during open enrollment under subsection (d) of this section.

(3) Granting of staffing enhancements. HHSC divides all requested enhancements, after applying any enrollment limitations from subsection (i) of this section, into two groups: pre-existing enhancements that facilities request to carry over from the prior year and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, HHSC first determines the distribution of carry-over enhancements. If HHSC determines that funds are not available to carry over some or all pre-existing enhancements, facilities will be notified as per subsection (dd) [~~(ee)~~] of this section. If funds are available after the distribution of carry-over enhancements, HHSC then determines the distribution of newly requested enhancements. HHSC may not distribute newly requested enhancements to facilities owing funds identified for recoupment from subsections (n) and/or (o) of this section.

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

(B) HHSC compares the sum of the products from subparagraph (A) of this paragraph to available funds.

(i) If the product is less than or equal to available funds, all requested enhancements are granted.

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

(4) Notification of granting of enhancements. Participating facilities are notified, in a manner determined by HHSC, as to the disposition of their request for staffing enhancements.

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

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

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

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

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

(k) Determination of direct care staff base rate.

(1) Determine the sum of recipient care costs from the direct care staff cost center in subsection (a) of this section in all nursing facilities included in the most recently available Texas Nursing Facility Cost Report database [~~used to determine the nursing facility rates in effect on January 1, 2000~~] (hereinafter referred to as the initial database).

(2) Adjust the sum from paragraph (1) of this subsection as specified in §355.108 of this title (relating to Determination of Inflation Indices) to inflate the costs to the prospective rate year.

(3) Divide the result from paragraph (2) of this subsection by the sum of recipient days of service in all facilities in the initial database and multiply the result by 1.07. The result is the average direct care staff base rate component for all facilities.

(4) For rates effective September 1, 2009 and thereafter, to calculate the direct care staff per diem base rate component for all facilities for each of the RUG-III case mix groups and for the default groups, divide each RUG-III index from §355.307(b)(3)(C) of this title (relating to Reimbursement Setting Methodology) by 0.9908, which is the weighted average Texas Index for Level of Effort (TILE) case mix index associated with the initial database, and then multiply each of the resulting quotients by the average direct care staff base rate component from paragraph (3) of this subsection.

(5) The direct care staff per diem base rates will be limited to available levels of appropriated state and federal funds as specified in §355.201 of this chapter [~~will remain constant except for adjustments for inflation from paragraph (2) of this subsection~~]. HHSC may also recommend adjustments to the rates in accordance with §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(l) Determine each participating facility's total direct care staff rate. Each participating facility's total direct care staff rate will be equal to the direct care staff base rate from subsection (k) of this section plus any add-on payments associated with enhanced staffing levels selected by and awarded to the facility during open enrollment. HHSC will determine a per diem add-on payment for each enhanced staffing level taking into consideration the most recently available, reliable data relating to LVN equivalent compensation levels.

(m) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN-equivalent minutes equal to those determined in subsection (j) of this section. Each participating facility's adjusted LVN-equivalent minutes maintained during the reporting period will be determined as follows.

(1) Determine unadjusted LVN-equivalent minutes maintained. Upon receipt of the staffing and spending information described in subsection (f) of this section, HHSC will determine the unadjusted

LVN-equivalent minutes maintained by each facility during the reporting period.

(2) Determine adjusted LVN-equivalent minutes maintained. Compare the unadjusted LVN-equivalent minutes maintained by the facility during the reporting period from paragraph (1) of this subsection to the LVN-equivalent minutes required of the facility as determined in subsection (j) of this section. The adjusted LVN-equivalent minutes are determined as follows:

(A) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN-equivalent minutes required for the facility or less than the minimum LVN-equivalent minutes required for participation as determined in subsection (j)(1) of this section; the facility's adjusted LVN-equivalent minutes maintained is equal to its unadjusted LVN-equivalent minutes; or

(B) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is less than the number of LVN-equivalent minutes required of the facility, but greater than or equal to the minimum LVN-equivalent minutes required for participation as determined in subsection (j)(1) of this section, the following steps are performed.

(i) Determine what the facility's accrued Medicaid fee-for-service direct care revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN-equivalent minutes that the facility actually maintained, as defined in subsection (j) of this section.

(ii) Determine the facility's adjusted accrued direct care revenue by multiplying the accrued direct care revenue from clause (i) of this subparagraph by 0.85.

(iii) Determine the facility's accrued allowable Medicaid fee-for-service direct care staff expenses for the rate year.

(iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued direct care revenue from clause (ii) of this subparagraph from the facility's accrued allowable direct care expenses from clause (iii) of this subparagraph.

(v) If the facility's direct care spending surplus from clause (iv) of this subparagraph is less than or equal to zero, the facility's adjusted LVN-equivalent minutes maintained is equal to the unadjusted LVN-equivalent minutes maintained as calculated in paragraph (1) of this subsection.

(vi) If the facility's direct care spending surplus from clause (iv) of this subparagraph is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from clause (iv) of this subparagraph divided by the per diem enhancement add-on as determined in subsection (l) of this section plus the unadjusted LVN-equivalent minutes maintained by the facility during the reporting period from paragraph (1) of this subsection according to the following formula: (Direct Care Spending Surplus/Per Diem Enhancement Add-on for One LVN-equivalent Minute) + Unadjusted LVN-equivalent Minutes.

(C) For adjusted LVN-equivalent minutes calculated on or after March 1, 2004, requirements relating to the minimum LVN-equivalent minutes required for participation in subparagraphs (A) and (B) of this paragraph do not apply.

(n) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in subsection (j) of this section. HHSC will determine the adjusted LVN-equivalent minutes maintained by each facility during the reporting period by the method described in subsection (m) of this section. HHSC or its designee will recoup all direct care staff revenues associated with unmet staffing goals from participating facilities that fail to meet their staffing requirements during the reporting period.

(o) Spending requirements for participants. Participating facilities are subject to a direct care staff spending requirement with recoupment calculated as follows.[:]

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

(2) [~~(1)~~] At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues [~~(net of revenues recouped by HHSC or its designee due to the failure of the facility to meet a staffing requirement as per subsection (n) of this section)~~] by 0.90 [~~0.85~~].

(3) [~~(2)~~] Accrued allowable Medicaid direct care staff fee-for-service expenses for the rate year will be compared to the spending floor from paragraph (2) [~~(1)~~] of this subsection. HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff fee-for-service expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

(4) [~~(3)~~] At no time will a participating facility's direct care rates after spending recoupment be less than the direct care base rates.

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

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

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

(3) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in §355.306(b)(2)(A) of this title (relating to Cost Finding Methodology). If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference between accrued, allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year.

(4) Calculate fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in §355.306(b)(2)(A) of this title. If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year.

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

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

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

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

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

(s) Notification of recoupment based on Annual Staffing and Compensation Report or cost report [~~and request for recalculation~~].

[~~(1)~~] [~~Notification of recoupment.~~] The estimated amount to be recouped is indicated in STAIRS. STAIRS will generate an e-mail to the entity contact, indicating that the facility's estimated recoupment is available for review. If a subsequent review by HHSC or audit results in adjustments to the Annual Staffing and Compensation Report or cost report as described in subsection (f) of this section that changes the amount to be repaid to HHSC or its designee, the facility will be notified by e-mail to the entity contact that the adjustments and the adjusted amount to be repaid are available in STAIRS for review. HHSC or its designee will recoup any amount owed from a facility's vendor payment(s) following the date of the initial or subsequent notification.]

[~~(2) Request for recalculation. Providers notified of a recoupment based on an Annual Staffing and Compensation Report described in subsection (f)(2)(A) or (f)(2)(F) of this section may request that HHSC recalculate their recoupment after combining the Annual Staffing and Compensation Report with the provider's next cost report or Staffing and Compensation Report, as appropriate. The request must be received by HHSC Rate Analysis no later than 30 days after the date on the e-mail notification of recoupment. If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day the receipt of the request will be accepted.~~]

[~~(A) The request must be made by e-mail to the e-mail address specified in STAIRS, by hand delivery, United States (U.S.) mail, or special mail delivery. An e-mail request must be typed on the provider's letterhead, signed by a person indicated in subparagraph (B) of this paragraph, then scanned and sent by e-mail to HHSC.~~]

[~~(B) The request must be signed by an individual legally responsible for the conduct of the provider, such as the sole proprietor, a partner, a corporate officer, an association officer, a governmental official, a limited liability company member, a person authorized by the applicable signature authority designation form for the provider at the time of the request, or a legal representative for the provider. The administrator or director of a facility or program is not authorized to sign the request unless the administrator or director holds one of these positions. HHSC will not accept a request that is not signed by an individual responsible for the conduct of the provider.~~]

(t) Change of ownership and contract terminations. Facilities required to submit a Staffing and Compensation Report due to a change of ownership or contract termination as described in subsection (f) of this section will have funds held as per 26 TAC §554.210 (relating to Change of Ownership and Notice of Changes) [~~40 TAC §19.2308 (relating to Change of Ownership)~~] until an acceptable Staffing and Compensation Report is received by HHSC and funds identified for recoupment from subsections (n) and/or (o) of this section are repaid to HHSC or its designee. Informal reviews and formal appeals relating to these reports are governed by §355.110 of this title (relating to Informal Reviews and Formal Appeals). HHSC or its designee will recoup any amount owed from the facility's vendor payments that are being held. In cases where funds identified for recoupment cannot be repaid from the held vendor payments, the responsible entity from subsection (x) of this section will be jointly and severally liable for any additional payment due to HHSC or its designee. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification will result in the recoupment of the owed funds from other Medicaid contracts controlled by the responsible entity, placement of a vendor hold on all Medicaid contracts controlled by the responsible entity and will bar the responsible entity from receiving any new contracts with HHSC or its designees until repayment is made in full. The responsible entity for these contracts will be notified as described in subsection (s) of this section prior to the recoupment of owed funds, placement of vendor hold and barring of new contracts.

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

(v) All other rate components. All other rate components will be calculated as specified in §355.307 of this title (relating to Reimbursement Setting Methodology) and will be uniform for all providers.

(w) Appeals. Subject matter of informal reviews and formal appeals is limited as per §355.110(a)(3) of this title (relating to Informal Reviews and Formal Appeals).

(x) Responsible entities. The contracted provider, owner, or legal entity that received the revenue to be recouped upon is responsible for the repayment of any recoupment amount.

(y) Change of ownership. Participation in the enhanced direct care staff rate confers to the new owner as defined in 26 TAC §554.210 (relating to Change of Ownership and Notice of Changes) [~~40 TAC §19.2308 (relating to Change of Ownership)~~] when there is a change

of ownership. The new owner is responsible for the reporting requirements in subsection (f) of this section for any reporting period days occurring after the change. If the change of ownership occurs during an open enrollment period as defined in subsection (c) of this section, then the owner recognized by HHSC or its designee on the last day of the enrollment period may request to modify the enrollment status of the facility in accordance with subsection (d) of this section.

(z) Contract cancellations. If a facility's Medicaid contract is cancelled before the first day of an open enrollment period as defined in subsection (c) of this section and the facility is not granted a new contract until after the last day of the open enrollment period, participation in the enhanced direct care staff rate as it existed prior to the date when the facility's contract was cancelled will be reinstated when the facility is granted a new contract, if it remains under the same ownership, subject to the availability of funding. Any enrollment limitations from subsection (i) of this section that would have applied to the cancelled contract will apply to the new contract.

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

(1) Definitions. The following words and terms have the following meanings when used in this subsection.

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

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

(C) Combined entity--one or more commonly owned corporations and one or more limited partnerships where the general partner is controlled by the same person(s) as the commonly owned corporation(s).

(D) Control--greater than 50 percent ownership by the entity.

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

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

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

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

(bb) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient under 26 TAC §554.2326 [~~40 TAC §19.2326~~] (relating to Medicaid Swing Bed Program for Rural Hospitals), HHSC or its designee makes payment to the hospital using the same procedures, the same case-mix methodology, and the same RUG-III rates that HHSC authorizes for reimbursing NFs receiving the direct care staff base rate with no enhancement levels. These hospitals are not subject to the staffing and spending requirements detailed in this section.

~~[(cc) Reinvestment. For services delivered on or before August 31, 2009, HHSC will reinvest recouped funds in the enhanced direct care staff rate program, to the extent that there are qualifying facilities. For services delivered beginning September 1, 2009, and thereafter, HHSC will not reinvest recouped enhanced direct care staff rate funds.]~~

~~[(1) Identify qualifying facilities. Facilities meeting the following criteria during the most recent completed reporting period are qualifying facilities for reinvestment purposes.]~~

~~[(A) The facility was a participant in the enhanced direct care staff rate or, for state fiscal years 2004 and 2005 only, had been a participant at level 0 in state fiscal year 2003 and was reclassified as a nonparticipant due to the elimination of level 0 in state fiscal year 2004.]~~

~~[(B) The facility's unadjusted LVN-equivalent minutes as determined in subsection (m)(1) of this section were greater than the number of LVN-minutes required of the facility as determined in subsection (j) of this section.]~~

~~[(C) The facility met its spending requirement as determined in subsection (o) of this section.]~~

~~[(D) An acceptable Annual Staffing and Compensation Report for the reporting period was received by HHSC Rate Analysis at least 30 days prior to the date distribution of available reinvestment funds was determined.]~~

~~[(E) The Medicaid contract that was in effect for the facility during the reinvestment reporting period is still in effect as an active contract when reinvestment is determined or, in cases where a change of ownership has occurred, HHSC or its designee has approved a Successor Liability Agreement between the contract in effect during the reinvestment reporting period and the contract in effect when reinvestment is determined.]~~

~~[(2) Distribution of available reinvestment funds. Available funds are distributed as described below.]~~

~~[(A) HHSC determines units of service provided during the most recent completed reporting period by each qualifying facility achieving, with unadjusted LVN-equivalent minutes as determined in subsection (m)(1) of this section, each enhancement option above the enhancement option awarded to the facility during the reporting period and multiplies this number by the rate add-on associated with that enhancement in effect during the reporting period.]~~

~~[(B) HHSC compares the sum of the products from subparagraph (A) of this paragraph to funds available for reinvestment.]~~

~~*[(i)* If the product is less than or equal to available funds, all achieved enhancements for qualifying facilities are retroactively awarded for the reporting period.]~~

~~*[(ii)* If the product is greater than available funds, retroactive enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until achieved enhancements are granted within available funds.]~~

~~[(3) All retroactive enhancements are subject to spending requirements detailed in subsection (o) of this section. Revenue from retroactive enhancements is not eligible for mitigation of spending recoupment as described in subsection (p) of this section.]~~

~~[(4) Retroactively awarded enhancements do not qualify as pre-existing enhancements for enrollment purposes.]~~

~~[(5) Notification of reinvested enhancements. Qualifying facilities are notified in a manner determined by HHSC, as to the award of reinvested enhancements.]~~

(cc) [~~(dd)~~] Disclaimer. Nothing in these rules should be construed as preventing facilities from adding direct care staff in addition to those funded by the enhanced direct care staff rate.

(dd) [~~(ee)~~] Notification of lack of available funds. If HHSC determines that funds are not available to continue participation for facilities from which it has not received an acceptable request to modify their enrollment by the last day of an enrollment period as per subsection (d) of this section or to fund carry-over enhancements as per subsection (j)(3) of this section, HHSC will notify providers in a manner determined by HHSC that such funds are not available.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 867-7817

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SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

1 TAC §355.513

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.513, concerning Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program.

BACKGROUND AND PURPOSE

Title 42, Code of Federal Regulations, §441.301(c)(4)(i) - (v), requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules in Title 26 Texas Administrative Code (TAC) Chapter 260 to implement individualized skills and socialization effective January 1, 2023.

The 2022 - 2023 General Appropriations Act (GAA), Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-Based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities (DBMD) Programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023.

The purpose of the proposal is to amend the reimbursement methodology for the DBMD Program to remove day habilitation services and establish rate methodologies for individualized skills and socialization services. The proposal also clarifies the rate methodology for residential habilitation transportation, chore, and intervener services by replacing the "other direct care" cost area with an administration and facility cost area to align waiver rate methodology with other similar services.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.513(c)(4) replaces day habilitation with individualized skills and socialization services.

The proposed amendment to §355.513(c)(7) clarifies the rate methodology for residential habilitation transportation, chore, and intervener services by replacing the "other direct care" cost area with an administration and facility cost area to align waiver rate methodology with other similar services.

The proposed amendment to §355.513 adds new subsection (d) establishing the methodology for individualized skills and socialization services in the DBMD program to equal the individualized skills and socialization payment rate for individuals with a level of need 9 in the HCS waiver program as specified in 1 TAC §355.723, concerning Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs.

The proposed amendment to §355.513 also renumbers current subsections (d) - (f) to subsections (e) - (g).

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rule is in effect is an estimated cost of $20,665 in General Revenue (GR) ($59,434 All Funds (AF)) in fiscal year (FY) 2023, $35,544 GR ($89,149 AF) in FY 2024, $35,526 GR ($89,149 AF) in FY 2025, $35,526 GR ($89,149 AF) in FY 2026, $35,526 GR ($89,149 AF) in FY 2027. This fiscal note represents only costs associated with non-direct care rate components, including facility, operations, indirect care, and administrative cost areas. The attendant portion of the rate is discussed in 1 TAC §355.112, concerning Attendant Compensation Rate Enhancement.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The proposed rule establishes the rate methodology for individualized skills and socialization services in the DBMD program. Individualized skills and socialization services are supported by appropriations by the 2022 - 2023 GAA, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23).

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated persons and the rule is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be establishing the rate methodology for individualized skills and socialization services in Deaf-Blind with Multiple Disabilities Waiver Program.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule does not impose costs on regulated persons.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R042" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; 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; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

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

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

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

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

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

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

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

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

surance (WCI), the Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

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

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

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

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

(A) The attendant cost area, which includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).

(B) An administration and facility [~~"other direct care"~~] cost area, which includes costs for services not included in subparagraph (A) of this paragraph as determined in paragraphs (1) - (4) of this subsection. An allowable cost per unit of service is determined for each contracted provider cost report for the administration and facility [~~other direct care~~] cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed. The units of service for each contracted provider cost report in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and is multiplied by 1.044.

(C) The attendant cost area, and the administration and facility [~~other direct care~~] cost area are summed to determine the cost per unit of service.

(8) For Interveners I, II, and III, payment rates are developed based on rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma approach in accordance with §355.105(h) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). Interveners I, II, and III are not considered attendants for purposes of the Attendant Compensation Rate Enhancement described in §355.112 of this title, and providers are not eligible to receive direct care add-ons to the Intervener I, II, or III rates.

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

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

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

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

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

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

(f) [~~(e)~~] Reporting of cost.

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

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

(3) Reporting and verification of allowable cost.

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

(B) Individual cost reports may not be included in the database used for reimbursement determination if:

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

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

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

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

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

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

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

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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SUBCHAPTER F. REIMBURSEMENT METHODOLOGY FOR PROGRAMS SERVING PERSONS WITH MENTAL ILLNESS OR INTELLECTUAL OR DEVELOPMENTAL DISABILITY

1 TAC §355.723

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.723, concerning Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs.

BACKGROUND AND PURPOSE

Title 42, Code of Federal Regulations, §441.301(c)(4)(i) - (v), requires home and community-based settings in programs authorized by §1915(c) of the Social Security Act to have certain qualities, including being integrated into and supporting full access of individuals to the greater community. HHSC adopted rules in Title 26 Texas Administrative Code (TAC) Chapters 262 and 263 to implement individualized skills and socialization effective January 1, 2023.

The 2022-2023 General Appropriations Act (GAA), Senate Bill (S.B.) 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23) authorized funding for the provision of individualized skills and socialization in the Home and Community-Based Services (HCS), Texas Home Living (TxHmL), and Deaf-Blind with Multiple Disabilities Programs. HHSC adopted rates for individualized skills and socialization based on the available appropriations, effective January 1, 2023.

The purpose of the proposal is to amend the reimbursement methodology for the HCS and TxHmL Programs to remove day habilitation and establish rate methodologies for individualized skills and socialization. The proposal also clarifies the rate methodology for each HCS and TxHmL waiver service and implements some recommendations in HHSC's legislative report, *Rates: Intermediate Care Facilities and Certain Waiver Providers,* required by the 2022-2023 GAA, S.B. 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30).

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.723 makes changes in subsection (b)(1) to replace day habilitation with individualized skills and socialization in the list of rates that are variable by level of need (LON).

The proposed amendment to §355.723 makes changes in subsection (b)(2) to add in-home and out-of-home respite, as these service rates do not vary by LON, and deletes references to high medical needs, as these are not currently waiver services. The proposed amendment also removes TxHmL day habilitation from the list of rates that do not vary by LON.

The proposed amendment to §355.723 removes subsection (c)(1) and (2) and replaces them with proposed new subsection (c)(1) - (6) to describe each of the cost areas HHSC calculates to support recommended methodological rates for HCS and TxHmL services. Proposed new subsection (c)(1) describes the methodology used to calculate the attendant compensation cost area. Proposed new subsection (c)(2) describes the methodology used to calculate the other direct care cost area. Proposed new subsection (c)(3) incorporates the methodology used to calculate the administration and operations cost area currently in subsection (d)(1). The proposed amendment to subsection (c)(5) and (6) describes the methodology used to calculate the facility cost area.

The proposed amendment to §355.723 removes subsection (d) and replaces it with a new proposed subsection (d) to detail the methodology HHSC uses to calculate recommended rates for each waiver service.

The proposed amendment to §355.723 adds a new subsection (e) to clarify that HHSC uses a pro forma modeling approach to calculate recommended rates for any waiver service where reliable provider cost data is unavailable.

The proposed amendment to §355.723 reformats subsection (e) to subsection (f) due to other formatting changes and adds new language to clarify that recommended rates are limited to available appropriations.

The proposed amendment to §355.723 removes current subsection (f) related to the total Medicaid spending requirement as this provision is no longer applicable.

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rule is in effect is an estimated cost of $1,885,286 in General Revenue (GR) ($5,422,163 All Funds (AF)) in fiscal year (FY) 2023, $3,432,219 GR ($8,608,525 AF) in FY 2024, $3,431,350 GR ($8,610,665 AF) in FY 2025, $3,431,350 GR ($8,610,665 AF) in FY 2026, $3,431,350 GR ($8,610,665 AF) in FY 2027. This fiscal note represents only costs associated with non-direct care rate components, including facility, operations, transportation, indirect care, and administrative cost areas. The attendant portion of the rate is discussed in 1 TAC §355.112.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

The rule establishes rate methodology for individualized skills and socialization services in HCS and TxHmL programs. Individualized skills and socialization services are supported by appropriations by the 2022-2023 GAA, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 23).

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule does not impose a cost on regulated people and the rule is necessary to receive a source of federal funds or comply with federal law.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be establishing rate methodology for individualized skills and socialization services in the HCS and TxHmL Programs and clarifying the rate methodologies for other waiver services.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule does not impose costs on regulated persons.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R043" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; 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; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32.

The amendment affects Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32. This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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

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

(b) Levels of need.

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

~~[(A) HCS day habilitation (DH);]~~

(A) [~~(B)~~] host home/companion care (HH/CC) [~~host home (HH)/companion care (CC)~~];

(B) individualized skills and socialization;

(C) residential support services (RSS); and

(D) supervised living (SL).[~~; and~~]

~~[(E) effective upon service claims being made billable through the Texas Medicaid & Healthcare Partnership (TMHP).]~~

~~*[(i)* HCS in-home DH;]~~

~~*[(ii)* HCS out-of-home DH;]~~

~~*[(iii)* HCS out-of-home respite (HCS OHR) in a DH facility;]~~

~~*[(iv)* HCS OHR in a setting where SL or RSS is provided; and]~~

~~*[(v)* HCS OHR in a setting where HH/CC is provided.]~~

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

(A) audiology;

(B) behavioral support;

(C) cognitive rehabilitative therapy (CRT);

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

(E) [~~(D)~~] community support services transportation (CSS);

(F) [~~(E)~~] dietary;

(G) [~~(F)~~] employment assistance (EA);

~~[(G) high medical needs licensed vocational nurse (LVN);]~~

~~[(H) high medical needs registered nurse (RN);]~~

~~[(I) high medical needs support;]~~

(H) in-home respite;

(I) [~~(J)~~] licensed vocational nurse (LVN) [~~LVN~~];

(J) [~~(K)~~] occupational therapy (OT);

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

(L) physical therapy (PT);

(M) registered nurse (RN) [~~RN~~];

~~[(N) respite;]~~

(N) [~~(O)~~] social work;

(O) [~~(P)~~] speech therapy;

(P) [~~(Q)~~] supported employment (SE); and

(Q) [~~(R)~~] supported home living transportation (SHL).[~~; and~~]

~~[(S) effective upon service claims being made billable through TMHP:]~~

~~*[(i)* HCS in-home respite (IHR);]~~

~~*[(ii)* HCS OHR in a camp;]~~

~~*[(iii)* HCS OHR in a respite facility;]~~

~~*[(iv)* TxHmL in-home DH;]~~

~~*[(v)* TxHmL out-of-home DH;]~~

~~*[(vi)* TxHmL OHR in a DH facility;]~~

~~*[(vii)* TxHmL OHR in a setting where HH/CC is provided;]~~

~~*[(viii)* TxHmL OHR in a setting where SL or RSS is provided; and]~~

~~*[(ix)* HCS and TxHmL OHR in a setting that is not listed above.]~~

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

(1) Attendant compensation cost area. The determination of the attendant compensation cost area is calculated as specified in §355.112 of this chapter (relating to Attendant Compensation Rate Enhancement). The attendant compensation cost area includes personal attendant staffing costs (wages, benefits, modeled staffing ratios for attendant staff, direct care trainers, and job coaches).

(2) Other direct care cost area. The other direct care cost area includes other direct service staffing costs (wages and benefits for direct care and attendant supervisors). The other direct care cost area is determined by calculating a median from allowable other direct care costs for each service, weighed by units of service for the applicable service from the most recently examined HCS/TxHmL cost report adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter (relating to Determination of Inflation Indices).

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

(i) EA;

(ii) in-home respite;

(iii) OHR in a camp;

(iv) OHR in a respite facility;

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

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

(vii) SE.

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

(i) individualized skills and socialization;

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

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

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

(v) RSS; and

(vi) SL.

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

(A) administration and operation costs; and

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

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

(ii) service-specific transportation costs.

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

(A) Step 1. Determine total projected administration and operation costs and projected units of service by service type using cost reports submitted by HCS and TxHmL providers in accordance with §355.722 of this subchapter (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(G) Step 7. Calculate the percent of total administration and operation costs to be allocated to the service type by dividing the projected weighted units for the service type from subparagraph (E) of this paragraph by the total projected weighted units of service from subparagraph (F) of this paragraph.

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

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

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

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

(I) CFC PAS/HAB;

(II) CSS;

(III) EA;

(IV) in-home individualized skills and socialization;

(V) in-home respite;

(VI) OHR in a camp;

(VII) OHR in a respite facility;

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

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

(X) SE; and

(XI) SHL.

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

(I) individualized skills and socialization;

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

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

(IV) RSS; and

(V) SL.

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

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

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

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

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

(i) HH/CC;

(ii) OHR in a camp;

(iii) OHR in a respite facility; and

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

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

(i) individualized skills and socialization;

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

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

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

(v) RSS; and

(vi) SL.

~~[(c) Recommended rates.~~

~~[(1) Rate models. The recommended modeled rates are determined for each HCS and TxHmL service listed in subsection (b)(1) - (2) of this section by type and, for services listed in subsection (b)(1) of this section, by LON to include the following cost components: direct care worker staffing costs (wages, benefits, modeled staffing ratios for direct care workers, direct care trainers and job coaches), other direct service staffing costs (wages for direct care supervisors, benefits, modeled staffing ratios); facility costs (for respite care only); room and board costs for overnight, OHR care; administration and operation costs; and professional consultation and program support costs. The determination of all components except for the direct care worker staffing costs component is based on cost reports submitted by HCS and TxHmL providers in accordance with §355.722 of this subchapter (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers). The determination of the direct care worker staffing costs component is calculated as specified in §355.112 of this chapter (relating to Attendant Compensation Rate Enhancement).~~]

~~[(2) SHL and CSS.~~]

~~[(A) Effective July 1, 2017, the recommended modeled rates for HCS SHL and TxHmL CSS include the following cost components: direct care worker staffing costs, and administration and operation costs. The modeled rates for these two services do not include a cost component for other direct service staffing costs. The determination of the administration and operation cost component is calculated as specified in subsection (d)(10) of this section. The determination of the direct care worker staffing costs component is calculated as specified in §355.112 of this chapter.~~]

~~[(B) Effective September 1, 2019, the recommended modeled rate for HCS SHL is calculated as specified in subsection (c)(1) and subsection (d) of this section.~~]

~~[(C) Effective September 1, 2019, the recommended modeled rate for TxHmL CSS is equal to the rate that was in effect for these services on August 31, 2019.~~]

~~[(3) High medical needs support. Payment rates for high medical needs support are developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures).~~]

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

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

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

(3) HH/CC. The recommended payment rate is determined by summing the direct care worker component, HH/CC coordinator

cost area, administration and operations component, and facility cost area. The direct care worker component is calculated using the median of allowable direct care worker costs, weighted by HH/CC units of service from the most recently examined cost report database. The result is adjusted for each LON. The HH/CC coordinator cost area and administration and operations components are calculated as determined in subsection (c) of this section. The facility cost area is calculated as determined in subsection (c) of this section but does not include room and board costs as defined in subparagraph (c)(5)(A) of this section. If HHSC lacks reliable cost report data, the rate is developed based on payment rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma analysis in accordance with §355.105(h) of this chapter.

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

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

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

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

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

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

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

~~[(d) Administration and operation cost component. The administration and operation cost component included in the recommended rates described in subsection (c) of this section for each HCS and TxHmL service type is determined as follows.]~~

~~[(1) Step 1. Determine total projected administration and operation costs and projected units of service by service type using cost reports submitted by HCS and TxHmL providers in accordance with §355.722 of this subchapter.]~~

~~[(2) Step 2. Determine the HH/CC coordinator component of the HH/CC rate as follows:]~~

~~[(A) For fiscal years 2010 through 2013, the HH/CC coordinator component of the HH/CC rate was modeled using the weighted average HH/CC coordinator wage as reported on the most recently available and reliable audited HCS cost report plus 10.25 percent for payroll taxes and benefits inflated to the rate period and a consumer to HH/CC coordinator ratio of 1:15.]~~

~~[(B) For fiscal years 2012 and 2013, the HH/CC coordinator component of the HH/CC rate was remodeled using a consumer to HH/CC coordinator ratio of 1:20.]~~

~~[(C) For fiscal years 2014 and thereafter, this] component is determined by summing total reported HH/CC coordinator wages and allocated payroll taxes and benefits from the most recently available audited HCS cost report, inflating those costs to the rate period, and dividing the resulting product by the total number of host home units of service reported on that cost report.]~~

~~[(3) Step 3. Determine total HH/CC coordinator dollars as follows. Multiply the HH/CC coordinator component of the HH/CC rate from paragraph (2) of this subsection by the total number of HH/CC units of service reported on the most recently available, reliable audited HCS cost report database.]~~

~~[(4) Step 4. Determine total projected administration and operation costs after offsetting total HH/CC coordinator dollars as follows. Subtract the total HH/CC coordinator dollars from paragraph (3) of this subsection from the total projected administration and operation costs from paragraph (1) of this subsection.]~~

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

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

~~[(B) DH in HCS and TxHmL. Projected weighted units of service for DH equal projected DH units of service times a weight of 0.25.]~~

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

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

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

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

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

[(H) Audiology, CRT, OT, PT, and speech therapy in HCS and TxHmL. Projected weighted units of service for audiology, CRT, OT, PT, and speech therapy equal projected audiology, CRT, OT, PT, and speech therapy units of service times a weight of 0.18.]

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

[(J) Nursing in HCS and TxHmL and high medical needs nursing in HCS. Projected weighted units of service for nursing and high medical needs nursing equal projected nursing and high medical needs nursing units of service times a weight of 0.25.]

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

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

[(6) Step 6. Calculate total projected weighted units of service by summing the projected weighted units of service from paragraph (5)(A) - (L) of this subsection.]

[(7) Step 7. Calculate the percent of total administration and operation costs to be allocated to the service type by dividing the projected weighted units for the service type from paragraph (5) of this subsection by the total projected weighted units of service from paragraph (6) of this subsection.]

[(8) Step 8. Calculate the total administration and operation cost to be allocated to that service type by multiplying the percent of total administration and operation costs allocated to the service type from paragraph (7) of this subsection by the total administration and operation costs after offsetting total host home/companion care coordinator dollars from paragraph (4) of this subsection.]

[(9) Step 9. Calculate the administration and operation cost component per unit of service for each HCS and TxHmL service type by dividing the total administration and operation cost to be allocated to that service type from paragraph (8) of this subsection by the projected units of service for that service type from paragraph (1) of this subsection.]

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

[(A) For the following services, multiply the administration and operation cost component from paragraph (9) of this subsection by 1.044:]

[(i) CSS;]

[(ii) EA;]

[(iii) SE;]

[(iv) SHL; and]

[(v) effective upon service claims being made billable through TMHP:]

[(I) in-home DH;]

[(II) HCS OHR in a camp;]

[(III) HCS OHR in a respite facility;]

[(IV) HCS OHR in a setting where HH/CC is provided; and]

[(V) HCS OHR in a setting that is not listed.]

[(B) For the following services, multiply the administration and operation cost component from paragraph (9) of this subsection by 1.07:]

[(i) RSS;]

[(ii) SL; and]

[(iii) effective upon service claims being made billable through TMHP:]

[(I) out-of-home DH;]

[(II) HCS OHR in a DH facility; and]

[(III) HCS OHR in a setting where SL or RSS is provided.]

[(11) Step 11. Effective July 1, 2017, the final recommended administration and operation cost component per unit of service for SHL in HCS, CSS in TxHmL, and high medical needs support in HCS is equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services program as specified in §355.505 of this chapter (relating to Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program).]

[(12) Step 12. Effective September 1, 2019, the recommended modeled rates for all TxHmL services except TxHmL CSS are equal to the rates that were in effect for these services on August 31, 2019. The recommended modeled rate for TxHmL CSS is calculated as specified in subsection (e)(2)(C) of this section.]

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

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

[(f) Total Medicaid Spending Requirement. Effective for costs and revenues accrued on or after September 1, 2015, through August 31, 2017, all HCS and TxHmL providers are required to spend at least 90 percent of revenues received through the HCS and TxHmL waiver

programs' Medicaid payment rates on Medicaid allowable costs under these programs.]

[(1) Compliance with the total Medicaid spending requirement will be determined in the aggregate for all component codes controlled by the same entity across the HCS, TxHmL and Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) programs within the same cost report year.]

[(2) Compliance with the spending requirement is determined on an annual basis using cost reports as described in Chapter 355, Subchapter A, of this title (relating to Cost Determination Process) and this subchapter.]

[(A) When a provider changes ownership through a contract assignment, the prior owner must submit a report covering the period from the beginning of the provider's fiscal year to the effective date of the contract assignment as determined by HHSC or its designee. This report is used as the basis for determining compliance with the spending requirement.]

[(B) Providers whose contracts are terminated voluntarily or involuntarily must submit a report covering the period from the beginning of the provider's fiscal year to the date recognized by HHSC or its designee as the contract termination date. This report is used as the basis for determining compliance with the spending requirement.]

[(C) When part of a cost reporting period is subject to spending accountability and part is not subject to spending accountability, a provider may choose to have HHSC divide their costs for the entire cost reporting period between the part of the period subject to spending accountability and the part of the period not subject to spending accountability on a pro-rata basis (i.e., pro-rata allocation). For example, if six months of a twelve month cost reporting period are subject to spending accountability, HHSC would divide the provider's costs for the entire cost reporting period by two to determine the costs subject to spending accountability. Providers who do not choose to have HHSC divide their costs on a pro-rata basis must report their costs for the period subject to spending accountability separately from their costs for the period not subject to spending accountability (i.e., direct reporting). Once a provider indicates to HHSC their choice between a pro-rata allocation and direct reporting for a specific cost reporting period, that choice is irrevocable for that cost reporting period.]

[(3) Allowable costs are those described in Chapter 355, Subchapter A, and this subchapter.]

[(4) The total Medicaid revenue for an HCS or TxHmL provider participating in the attendant compensation rate enhancement is offset by any recoupment made under §355.112(s) of this title prior to determining compliance with the spending requirement.]

[(5) Revenue and costs for the HCS and TxHmL waiver programs are combined for a component code for determination of compliance with the spending requirement.]

[(6) Providers who fail to meet the 90 percent spending requirement are subject to a recoupment of the difference between the 90 percent spending requirement and their actual Medicaid allowable HCS and TxHmL costs. Recoupments for each rate period under this subsection are limited to the difference between the provider's Medicaid revenues for services provided at the rates subject to spending accountability and what the provider's Medicaid revenues would have been for services provided at the Medicaid rates in effect on August 31, 2015.]

[(7) The contracted provider, owner, or legal entity which received the Medicaid payment is responsible for the repayment of the recoupment amount. Failure to repay the amount due or submit an acceptable payment plan within 60 days of notification results in placement of a vendor hold on all HHSC and Texas Department of Aging and Disability Services contracts controlled by the responsible entity.]

[(8) If HHSC, or its designee, is unable to recoup owed funds using an automated system, providers are required to repay some or all of the funds to be recouped through a check, money order or other non-automated method. Providers are required to submit the required repayment amount within 60 days of notification.]

[(9) Prior to each rate period through August 31, 2017, providers will be given the option of receiving the Medicaid rates adopted by HHSC for the rate period and the Medicaid rates that were in effect on August 31, 2015. Providers who choose to receive the Medicaid rates that were in effect on August 31, 2015, will not be subject to the spending accountability requirements described in this subsection.]

[(10) For rate periods beginning on or after September 1, 2017, the Total Medicaid Spending Requirement described in this subsection will no longer apply. Additionally, providers who chose to receive the Medicaid rates that were in effect on August 31, 2015, will receive the rates that were adopted effective September 1, 2015.]

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 June 26, 2023.

TRD-202302290
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 867-7817

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SUBCHAPTER H. BASE WAGE REQUIREMENTS FOR PERSONAL ATTENDANTS

1 TAC §355.7051

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.7051, concerning Base Wage for a Personal Attendant.

BACKGROUND AND PURPOSE

The purpose of the proposed amendment is to implement Rider 30(a) of the 2024-25 General Appropriations Act, Article II, HHSC, House Bill 1, 88th Legislature, Regular Session, 2023 (Rider 30(a)). Rider 30(a) appropriates funds to HHSC to increase the minimum base wage paid to "personal attendants" from $8.11 to $10.60 per hour. In response to Rider 30(a), HHSC must update its program requirements to require service providers to pay this updated minimum base wage. To ensure consistency and clarity, the proposed amendment also adds additional services to the definition of "personal attendant," including services in the Home and Community-based Services 1915(c) waiver program, the Texas Home Living 1915(c) waiver program, and the Home and Community-based Services--Adult Mental Health program. In addition, the proposed amendment replaces day habilitation with individualized skills and socialization services.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.7051 updates all references to the current minimum wage for personal attendants from $8.11 to $10.60.

The proposed amendment to §355.7051(a) replaces "day habilitation" with "individualized skills and socialization services" in the Deaf-Blind with Multiple Disabilities Waiver (DBMD), Home and Community-Based Services Waiver (HCS) and Texas Home Living Waiver (TxHmL) programs. The proposed amendment also adds supervised living and residential support services in the HCS program; and assisted living services, in-home respite, and supervised living and residential support services in the Home and Community-Based Service--Adult Mental Health program to the list of services subject to minimum wage requirements for personal attendant services.

Minor editorial revisions were made for formatting and to add references.

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rule is in effect is an estimated cost of $373,894,831 in General Revenue (GR) ($942,988,224 All Funds (AF)) in fiscal year (FY) 2024, $393,686,869 GR ($992,905,091 AF) in FY 2025, $492,405,833 GR ($1,235,648,264 AF) in FY 2026, $492,405,833 GR ($1,235,648,264 AF) in FY 2027, $492,405,833 GR ($1,235,648,264 AF) in FY 2028.

The fiscal impact above excludes the impact of increasing wages in Intermediate Care Facilities (ICF) because those are not covered in the rule.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed rule will expand an existing rule;

(7) the proposed rule will increase the number of individuals subject to the rule; and

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

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

Trey Wood has also determined that there could be an adverse economic effect on small businesses, micro-businesses, or rural communities because the proposed rule requires some businesses to pay a higher wage to personal attendants than currently. HHSC lacks sufficient information to provide an estimate of the economic impact.

However, because Rider 30(a) appropriated funds to HHSC for the purpose of increasing the payment rate to providers required to comply with the proposed rule, the increased payment rates may offset any adverse economic effect incurred by such providers.

HHSC determined that alternative methods to achieve the purpose of the proposed rules for small businesses, micro-businesses, or rural communities would not be consistent with ensuring the health and safety of the citizens of Texas.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule is necessary to protect the health, safety, and welfare of the residents of Texas and to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public benefit will be an improvement in the stability and quality of the attendant workforce due to higher wages.

Trey Wood has also determined that for the first five years the rule is in effect, persons who are required to comply with the proposed rule may incur economic costs if they are currently paying an average base wage of less than $10.60 per hour for a service listed in the proposed rule. However, the increased payment rates may address most, if not all, of the increased wages for attendant services for those providers currently paying less than the required base wage. HHSC lacks sufficient data to estimate the cost to persons required to comply with the proposed rule.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R045" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the Health and Human Services agencies; 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; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance (Medicaid) payments under Texas Human Resources Code Chapter 32.

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

§355.7051. Base Wage for a Personal Attendant.

(a) The following words and terms, when used in this subchapter, have the following meanings[,] unless the context clearly indicates otherwise.[:]

(1) HHSC contractor--A person who has a written agreement with the Texas Health and Human Services Commission (HHSC) to provide a service to an individual in exchange for payment from HHSC.

(2) Managed care organization or MCO--Has the meaning assigned in §353.2 of this title (relating to Definitions).

(3) Personal attendant--

(A) An employee or subcontractor of an HHSC contractor, or an employee of an employer in the consumer directed services (CDS) option, who provides the following services, as described in 40 TAC §49.101 (relating to Application):

(i) services in the Community Attendant Services program;

(ii) services in the Family Care program;

(iii) services in the Primary Home Care program;

(iv) day activity and health services;

(v) residential care;

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

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

(II) habilitation (transportation); or

(III) in-home respite;

(vii) in the Deaf-Blind Multiple Disabilities Program:

(I) CFC PAS/HAB;

(II) residential habilitation (transportation);

(III) in-home respite;

(IV) licensed assisted living;

(V) licensed home health assisted living; or

(VI) individualized skills and socialization services [~~day habilitation~~];

(viii) in the Home and Community-based Services Program:

(I) CFC PAS/HAB;

(II) supported home living (transportation); [~~or~~]

(III) in-home respite; [~~and~~]

(IV) individualized skills and socialization services;

(V) supervised living; or

(VI) residential support services; and

(ix) in the Texas Home Living Program:

(I) CFC PAS/HAB;

(II) community support services (transportation); [~~or~~]

(III) in-home respite; or

(IV) individualized skills and socialization services.

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

(i) assisted living services;

(ii) in-home respite;

(iii) supervised living services; and

(iv) supported home living services.

(C) [~~(B)~~] An [~~an~~] employee or subcontractor of an HHSC contractor[,] or an employee of an employer in the CDS option who provides:

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

(ii) CFC habilitation (CFC HAB) or CFC personal assistance services (CFC PAS), as described in Chapter 354, Subchapter A, Division 27 (relating to Community First Choice).[;]

(D) [~~(C)~~] An [~~an~~] employee or subcontractor of an HHSC contractor, or an employee of an employer in the CDS option or in the block grant option, who provides consumer managed personal attendant services as described in 26 [~~40~~] TAC Chapter 275 [44] (relating to Consumer Managed Personal Attendant Services (CMPAS) Program).[; ~~or~~]

(E) [~~(D)~~] A [~~a~~] provider or an employee of an employer in the CDS option who provides:

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

(I) assisted living;

(II) CFC PAS;

(III) CFC HAB;

(IV) day activity and health services;

(V) in-home respite care;

(VI) personal assistance services; or

(VII) protective supervision;

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

(I) day activity and health services;

(II) CFC PAS;

(III) CFC HAB;

(IV) flexible family support;

(V) in-home respite; or

(VI) personal care services; or

(iii) in the STAR Kids program and MDCP:

(I) CFC PAS;

(II) CFC HAB;

(III) personal care services;

(IV) day activity and health services;

(V) flexible family support services; or

(VI) in-home respite.

(4) Provider--Has the meaning assigned in §353.2 of this title.

(b) An HHSC contractor, other than an HHSC contractor described in subsection (c) or (d) of this section, must pay a personal attendant a base wage of at least $10.60 [~~$8.11~~] per hour.

(c) An HHSC contractor that has a contract for financial management services (FMS) must ensure that an employer in the CDS option, or designated representative, pays a personal attendant a base wage of at least $10.60 [~~$8.11~~] per hour.

(d) An HHSC contractor that has a CMPAS contract must:

(1) pay a personal attendant who is an employee or subcontractor of the contractor in the traditional service option or block grant option a base wage of at least $10.60 [~~$8.11~~] per hour; and

(2) ensure that an individual employer of a personal attendant under the block grant option or CDS option, or the individual's representative, pays a personal attendant a base wage of at least $10.60 [~~$8.11~~] per hour.

(e) An MCO must require an MCO contractor, other than an MCO contractor described in subsection (f) of this section, to pay a personal attendant a base wage of at least $10.60 [~~$8.11~~] per hour.

(f) An MCO must require that an MCO contractor that has a contract for FMS ensures that an employer in the CDS option or designated representative pays a personal attendant a base wage of at least $10.60 [~~$8.11~~] per hour.

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 June 26, 2023.

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 867-7817

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SUBCHAPTER J. PURCHASED HEALTH SERVICES
DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8052

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §355.8052, concerning Inpatient Hospital Reimbursement.

BACKGROUND AND PURPOSE

The purpose of this proposal is to comply with House Bill (H.B.) 1 Rider 8 and Rider 16, 88th Legislature, Regular Session 2023. HHSC is required by H.B. 1, to the extent allowed by law, to increase Medicaid inpatient rural hospital labor and delivery rates. Additionally, the rural hospital definition is modified to reflect the population updates in the 2020 U.S. Census. In compliance with Senate Bill 170 (S.B. 170), 86th Legislature, Regular Session 2019, to the extent allowed by law, HHSC will calculate Medicaid rural hospital inpatient rates using a cost-based prospective reimbursement methodology. HHSC must calculate rates for rural hospitals once every two years, using the most recent cost information available. HHSC previously published proposed rates to be effective September 1, 2023, and, with this legislative direction, will account for the updates in this proposed rule and republish rates.

SECTION-BY-SECTION SUMMARY

The proposed amendment modifies §355.8052(b)(32)(A) by changing the U.S. Census year from "2010" to "2020" and population from "60,000" to "68,750".

The proposed amendment modifies §355.8052(e)(2) by changing the effective date from "September 1, 2019" to "September 1, 2023" and to change the labor and delivery Standard Dollar Amount add-on payment from "no less than $500" to "no less than $1,500".

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does have foreseeable implications relating to costs or revenues of state government.

The effect on local government for each year of the first five years that the rule is in effect, enforcing or administering the rule has implications relating to revenues of local governments. The effect is projected to be a net increase to revenues of local governments of approximately $9,230,429 General Revenue (GR) and $23,493,073 All Funds (AF) for State Fiscal Year (SFY) 2024 and $9,361,990 GR and 23,493,073 AF for SFY 2025. No estimate of the impact during SFYs 2026 - 2028 is available because the rural hospital rates will be recalculated for SFY 2026.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed rule will not expand an existing rule;

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

(8) the proposed rule will positively affect the state's economy.

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules do not impose any additional costs on small businesses, micro-businesses, or rural communities that are required to comply with the rules.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of the Provider Finance Department, has determined that for each year of the first five years the rule is in effect, the public benefit will be updated data, increased transparency as well as increased Medicaid inpatient rates for rural hospitals.

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

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

Please contact Provider Finance Department Hospital Finance section at pfd_hospitals@hhsc.state.tx.us if you have questions.

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Valerie Lesak in the HHSC Provider Finance for Hospitals department at pfd_hospitals@hhsc.state.tx.us in the HHSC Provider Finance Hospital section.

Written comments on the proposal may be submitted to HHSC, Mail Code 400, 4601 W. Guadalupe Street, Austin, Texas 78751, or by email to pfd_hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 21 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R046" in the subject line.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code, Chapter 32; and Texas Government Code §531.02194, which requires adoption of a prospective reimbursement methodology for the payment of rural hospitals.

The amendment affects Texas Government Code §531.0055, Chapter 531 and Texas Human Resources Code Chapter 32.

§355.8052. Inpatient Hospital Reimbursement.

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate reimbursement for a covered inpatient hospital service.

(b) Definitions.

(1) Add-on--An amount that is added to the base Standard Dollar Amount (SDA) to reflect high-cost functions and services or regional cost differences.

(2) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsections (c) and (d) of this section, for the costs incurred by prospectively paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year--For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.

(5) Base year claims--For the purposes of rate setting (including Diagnosis-related group (DRG) relative weights, Mean length of stay (MLOS) and Days Thresholds, and rebasing or realignment of base rates) effective September 1, 2021, and after HHSC includes Medicaid inpatient fee-for-service (FFS) and Managed Care Organization (MCO) encounters that meet the criteria in subparagraphs (A) - (F) of this paragraph in the Base Year claims data. For base rates set prior to September 1, 2021, individual sets of base year claims are compiled for children's hospitals and urban hospitals for the purposes of rate setting and realignment. All Medicaid inpatient fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by an urban or children's hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;

(C) were not claims for patients who are covered by Medicare;

(D) were not Medicaid spend-down claims;

(E) were not claims associated with military hospitals, out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals; and

(F) individual sets of base year claims are compiled for children's hospitals and urban hospitals for the purposes of rate setting and rebasing.

(6) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital and exempted by Centers for Medicare and Medicaid Services (CMS) from the Medicare prospective payment system.

(7) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(8) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(9) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(11) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC. Each DRG has four digits. The last digit of the Diagnosis-Related Group is the Severity of Illness (SOI). SOI indicates the seriousness of the condition on a scale of one to four: minor, moderate, major, or extreme. SOI may increase if secondary diagnoses are present, in addition to the primary diagnosis.

(12) Final settlement--Reconciliation of Medicaid cost in the CMS form 2552-10 hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary, or HHSC.

(13) Final standard dollar amount (final SDA)--The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(14) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

(15) HHSC--The Texas Health and Human Services Commission, or its designee.

(16) Impact file--The Inpatient Prospective Payment System (IPPS) Final Rule Impact File that contains data elements by provider used by the CMS in calculating Medicare rates and impacts. The impact file is publicly available on the CMS website.

(17) Inflation update factor--Cost of living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.

(18) Inpatient Ratio of cost-to-charge (RCC)--A ratio that covers all applicable Medicaid hospital costs and charges relating to inpatient care.

(19) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(20) Interim payment--An initial payment made to a hospital that is later settled to Medicaid-allowable costs, for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(21) Interim rate--The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.

(22) Managed Care Organization (MCO) Adjustment Factor--Factor used to estimate managed care premium tax, risk margin, and administrative costs related to contracting with HHSC. The estimated amounts are subtracted from appropriations.

(23) Mean length of stay (MLOS)--One factor used in determining the payment amount calculated for each DRG; the average number of inpatient days per DRG.

(24) Medical education add-on--An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.

(25) Military hospital--A hospital operated by the armed forces of the United States.

(26) New Hospital--A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.

(27) Out-of-state children's hospital--A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(28) Realignment--Recalculation of the base SDA and add-ons using current RCCs, inflation factors, and base year claims as specified by HHSC, or its designee, for one or more hospital types. Realignment will occur based on legislative direction.

(29) Rebasing--Calculation of all SDAs and add-ons, DRG relative weights, MLOS, and day outlier thresholds for all hospitals using a base period as specified by HHSC, or its designee. Rebasing will occur based on legislative direction.

(30) Relative weight--The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(31) Rural base year stays--An individual set of base year stays is compiled for rural hospitals for the purposes of rate setting and realignment. All inpatient FFS claims and inpatient managed care encounters for reimbursement filed by a rural hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year or the six-month period that immediately followed the base year, except for such stays that had zero inpatient days;

(C) were not stays for patients who are covered by Medicare; and

(D) were not Medicaid spend-down stays; and were not stays associated with military hospitals, out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals.

(32) Rural hospital--A hospital enrolled as a Medicaid provider that:

(A) is located in a county with 68,750 [~~60,000~~] or fewer persons according to the 2020 [~~2010~~] U.S. Census;

(B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or

(C) meets all of the following:

(i) has 100 or fewer beds;

(ii) is designated by Medicare as a CAH, a SCH, or a RRC; and

(iii) is located in an MSA.

(33) Safety-Net add-on--An adjustment to the base SDA for a safety-net hospital to reflect the higher costs of providing Medicaid inpatient services in a hospital that provides a significant percentage of its services to Medicaid and/or uninsured patients.

(34) Safety-Net hospital--An urban or children's hospital that meets the eligibility and qualification requirements described in §355.8065 of this division (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

(35) Standard Dollar Amount (SDA)--A standardized payment amount calculated by HHSC for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(36) State-owned teaching hospital--Acute care hospitals owned and operated by the state of Texas.

(37) Teaching hospital--A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(38) Teaching medical education add-on--An adjustment to the base SDA for a children's teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children's hospitals.

(39) TEFRA target cap--A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to a hospital's cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.

(40) Tentative settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(41) Texas provider identifier (TPI)--A unique number assigned to a provider of Medicaid services in Texas.

(42) Trauma add-on--An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations. To be eligible for the trauma add-on, a hospital must be eligible to receive an allocation from the trauma facilities and emergency medical services account under Texas Health and Safety Code Chapter 780.

(43) Trauma hospital--An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation under 25 Texas Administrative Code §157.125 (relating to Requirements for Trauma Facility Designation).

(44) Universal mean--Average base year cost per claim for all urban hospitals.

(45) Urban hospital--Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children's hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.

(c) Base children's hospitals SDA calculations. HHSC will use the methodologies described in this subsection to determine average statewide base SDA and a final SDA for each children's hospital.

(1) HHSC calculates the average base year cost per claim as follows.

(A) To calculate the total inpatient base year cost per children's hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and

(ii) multiply clause (i) of this subparagraph by the hospital's inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount of all hospitals' base year costs from subparagraph (A) of this paragraph.

(C) Subtract an amount equal to the estimated outlier payment amount for the base year claims for all children's hospitals from subparagraph (B) of this paragraph.

(D) To derive the average base year cost per claim, divide the result from subparagraph (C) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base children's SDA as follows.

(A) From the amount determined in paragraph (1)(C) of this subsection, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(C) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the sum of the relative weights for all children's base year claims to derive the base SDA.

(3) A children's hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

(i) Impact files.

(I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

(II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

(ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

(iii) Teaching medical education add-on during the fiscal year. If a hospital becomes eligible for the teaching medical education add-on, the hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(iv) Safety-net add-on during the fiscal year. The hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(v) New children's hospital teaching medical education add-on. If an eligible children's hospital is new to the Medicaid program and a cost report is not available, the teaching medical education add-on will be calculated at the beginning of the state fiscal year after a cost report is received.

(B) Geographic wage add-on.

(i) CBSA assignment. For claims with dates of admission beginning September 1, 2013, and continuing until the next realignment, the geographic wage add-on for children's hospitals will be calculated based on the corresponding CBSA in the impact file in effect on September 1, 2011.

(ii) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(iii) Wage index. To determine a children's hospital geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas.

(II) HHSC identifies the lowest Medicare wage index factor in Texas.

(III) HHSC divides the Medicare wage index factor in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iv) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (E) of this paragraph.

(v) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

(vi) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (c)(2)(B) of this section, the wage index calculated in clause (iii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (v) of this subparagraph.

(C) Teaching medical education add-on.

(i) Eligibility. A teaching hospital that is a children's hospital is eligible for the teaching medical education add-on. Each children's hospital is required to confirm, under the process described in subparagraph (E) of this paragraph, that HHSC's determination of the hospital's eligibility for the add-on is correct.

(ii) Teaching medical education add-on calculation.

(I) For each children's hospital, identify the total hospital medical education cost from each hospital cost report or reports that cross over the base year.

(II) For each children's hospital, sum the amounts identified in subclause (I) of this clause to calculate the total medical education cost.

(III) For each children's hospital, calculate the average medical education cost by dividing the amount from subclause (II) of this clause by the number of cost reports that cross over the base year.

(IV) Sum the average medical education cost per hospital to determine a total average medical education cost for all hospitals.

(V) For each children's hospital, divide the average medical education cost for the hospital from subclause (III) of this clause by the total average medical education cost for all hospitals from subclause (IV) of this clause to calculate a percentage for the hospital.

(VI) Divide the total average medical education cost for all hospitals from subclause (IV) of this clause by the total base year cost for all children's hospitals from subsection (c)(1)(B) of this section to determine the overall teaching percentage of Medicaid cost.

(VII) For each children's hospital, multiply the percentage from subclause (V) of this clause by the percentage from subclause (VI) of this clause to determine the teaching percentage for the hospital.

(VIII) For each children's hospital, multiply the hospital's teaching percentage by the base SDA amount to determine the teaching medical education add-on amount.

(D) Safety-Net add-on.

(i) Eligibility. If a children's hospital meets the definition of a "safety-net hospital" as defined in subsection (b) of this section, it is eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(-d-) total relative weights for managed care encounters.

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of this subclause.

(III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of this subclause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(E) Add-on status verification.

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file at the time of realignment, Medicaid days, and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare teaching hospital designation for children's hospitals as applicable, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to hospital associations to disseminate to their member hospitals.

(ii) Rate realignment. HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different teaching medical education add-on or teaching hospital designation;

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annual SDA calculation. HHSC will calculate a hospital's final SDA annually using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of a new teaching program or new teaching hospital designation; or

(II) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iv) Failure to notify. If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Final children's hospital SDA calculations. HHSC calculates a children's hospital's final SDA as follows.

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) For labor and delivery services provided to adults age 18 or older in a children's hospital, the final SDA is equal to the base SDA for urban hospitals without add-ons, calculated as described in subsection (d)(4)(E)(i) of this section plus the urban hospital geographic wage add-on for an urban hospital located in the same CBSA as the children's hospital providing the service.

(C) For new children's hospitals that are not teaching hospitals, for which HHSC has no base year claim data, the final SDA is the base SDA plus the hospital's geographic wage add-on. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(D) For new children's hospitals that qualify for the teaching medical education add-on, as defined in subsection (b) of this section, for which HHSC has no base year claim data, the final SDA is calculated based on one of the following options until realignment is performed with base year claim data for the hospital. A new children's hospital must notify the HHSC Provider Finance Department of its selected option within 60 days from the date the hospital is notified of its provider activation by HHSC's fiscal intermediary. If the HHSC Provider Finance Department does not receive timely notice of the option, HHSC will assign the hospital the SDA calculated as described in clause (i) of this subparagraph. The SDA calculated based on the selected option will be effective retroactive to the first day of the provider's enrollment.

(i) Children's hospital base SDA plus the applicable geographic wage add-on and the minimum teaching add-on for existing children's hospitals. No settlement of costs is required for services reimbursed under this option. The SDA will be in effect until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(ii) Children's base SDA plus the applicable geographic wage add-on and the maximum teaching add-on for existing children's hospitals. A cost settlement is required for services reimbursed under this option. The SDA will be in effect for the hospital until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(d) Base urban hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the average statewide base SDA and the final SDA for each urban hospital.

(1) HHSC calculates the average base year cost per claim (the universal mean) as follows.

(A) To calculate the total inpatient base year cost per urban hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and

(ii) multiply clause (i) of this subparagraph by the hospital's inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount for all hospitals' base year costs from subparagraph (A) of this paragraph.

(C) To derive the average base year cost per claim, divide the result from subparagraph (B) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base urban SDA as follows.

(A) From the amount determined in paragraph (1)(B) of this subsection for urban hospitals, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(B) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the total number of base year claims to derive the base SDA.

(3) An urban hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

(i) Impact files.

(I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

(II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

(ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

(iii) Medical education add-on during fiscal year. If an existing hospital has a change in its medical education operating adjustment factor under Medicare, the hospital will become eligible for the adjustment to its medical education add-on upon the next realignment.

(iv) New medical education add-on. If a hospital becomes eligible for the medical education add-on after the most recent realignment:

(I) the hospital will receive a medical education add-on, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year; and

(II) HHSC will calculate the add-on using the impact file in effect at the time the hospital initially claims eligibility for the medical education add-on; and

(III) this amount will remain fixed until the next realignment.

(B) Geographic wage add-on.

(i) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(ii) Wage index. To determine an urban geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas;

(II) HHSC identifies the lowest Medicare wage index factor in Texas;

(III) HHSC divides the Medicare wage index factor identified in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iii) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (F) of this paragraph.

(iv) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

(v) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (d)(2)(B) of this section, the wage index calculated in clause (ii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (iv) of this subparagraph.

(C) Medical education add-on.

(i) Eligibility. If an urban hospital meets the definition of a teaching hospital, as defined in subsection (b) of this section, it is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in subparagraph (F) of this paragraph, that HHSC's determination of the hospital's eligibility and medical education operating adjustment factor under Medicare for the add-on is correct.

(ii) Add-on amount. HHSC multiplies the base SDA calculated in subsection (d)(2)(B) of this section by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(D) Trauma add-on.

(i) Eligibility.

(I) If an urban hospital meets the definition of a trauma hospital, as defined in subsection (b) of this section, it is eligible for a trauma add-on.

(II) HHSC initially uses the trauma level designation associated with the physical address of a hospital's TPI. A hospital may request that HHSC, under the process described in subparagraph (F) of this paragraph use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

(ii) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(I) by 28.3 percent for hospitals with Level 1 trauma designation;

(II) by 18.1 percent for hospitals with Level 2 trauma designation;

(III) by 3.1 percent for hospitals with Level 3 trauma designation; or

(IV) by 2.0 percent for hospitals with Level 4 trauma designation.

(iii) Reconciliation with other reimbursement for uncompensated trauma care. Subject to General Appropriations Act and other applicable law:

(I) if a hospital's allocation from the trauma facilities and emergency medical services account administered under Texas Health and Safety Code Chapter 780, is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at the time funds are disbursed from that account to eligible trauma hospitals; and

(II) if a hospital's allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(E) Safety-Net add-on.

(i) Eligibility. If an urban hospital meets the definition of a safety-net hospital as defined in subsection (b) of this section, it is eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(-d-) total relative weights for managed care encounters.

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of this subclause.

(III) Determine the hospital's percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital's portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of this subclause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(F) Add-on status verification.

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file available at the time of realignment or at the time of eligibility for a new medical education add-on as described in subparagraph (A)(iv) of this paragraph; the Texas Department of State Health Services' list of trauma-designated hospitals; and Medicaid days and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital for urban hospitals, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.

(ii) During realignment, HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, the HHSC Provider Finance Department receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different medical education add-on or teaching hospital designation;

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA;

(III) the hospital provides documentation of its eligibility for a different trauma designation; or

(IV) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annually, HHSC will calculate a hospital's final SDA using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of a new teaching program or new teaching hospital designation; or

(II) the hospital provides documentation of its eligibility for a different trauma designation; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iv) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Urban hospital final SDA calculations. HHSC calculates an urban hospital's final SDA as follows.

(A) Add all add-on amounts for which the hospital is eligible to the base SDA. These are the fully funded final SDAs.

(B) Multiply the final SDA determined in subparagraph (A) of this paragraph by each urban hospital's total relative weight of the base year claims.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all urban hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient urban hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) To determine the budget-neutral final SDA:

(i) multiply the base SDA in paragraph (2) of this subsection by the percentage determined in subparagraph (D) of this paragraph;

(ii) multiply each of the add-ons described in paragraph (3)(B) - (E) by the percentage determined in subparagraph (D) of this paragraph; and

(iii) sum the results of clauses (i) and (ii) of this subparagraph.

(F) For new urban hospitals for which HHSC has no base year claim data, the final SDA is a base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in subparagraph (D) of this paragraph.

(e) Rural hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the final SDA for each rural hospital.

(1) HHSC calculates the rural final SDA as follows.

(A) Base year cost. Calculate the total inpatient base year cost per rural hospital.

(i) Total the inpatient charges by hospital for the rural base year stays.

(ii) Multiply clause (i) by the hospital's inpatient RCC and the inflation update factors to inflate the rural base year stays to the current year of the realignment.

(B) Full-cost SDA. Calculate a hospital-specific full-cost SDA by dividing each hospital's base year cost, calculated as described in subparagraph (A) of this paragraph, by the sum of the relative weights for the rural base year stays.

(C) Calculating the SDA floor and ceiling.

(i) Calculate the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(ii) Calculate the standard deviation of the hospital-specific SDAs identified in subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(iii) Calculate an SDA floor as clause (i) minus clause (ii) multiplied by a factor, determined by HHSC to maintain budget neutrality.

(iv) Calculate an SDA ceiling as clause (i) plus clause (ii) multiplied by a factor, determined by HHSC to maintain budget neutrality.

(D) Assigning a final hospital-specific SDA.

(i) If the adjusted hospital-specific SDA from subparagraph (B) is less than the SDA floor in subparagraph (C)(iii) of this paragraph, the hospital is assigned the SDA floor amount as the final SDA.

(ii) If the adjusted hospital-specific SDA from subparagraph (B) is more than the SDA ceiling in subparagraph (C)(iv), the hospital is assigned the SDA ceiling amount as the final SDA.

(iii) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in clauses (i) and (ii) of this subparagraph.

(2) Alternate SDA for labor and delivery. For labor and delivery services provided by rural hospitals on or after September 1, 2023 [~~2019~~], the final SDA is the alternate SDA for labor and delivery stays, which is equal to the final SDA determined in paragraph (1)(D) of this subsection plus an SDA add-on sufficient to increase paid claims by no less than $1,500 [~~$500~~].

(3) HHSC calculates a new rural hospital's final SDA as follows.

(A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA in paragraph (1)(C)(i) of this subsection.

(B) The mean rural SDA assigned in subparagraph (A) of this paragraph remains in effect until the next realignment.

(4) Minimum Fee Schedule. Effective March 1, 2021, MCOs are required to reimburse rural hospitals based on a minimum fee schedule. The minimum fee schedule is the rate schedule as described above.

(5) Biennial review of rural rates. Every two years, HHSC will calculate new rural SDAs using the methodology in this subsection to the extent allowed by federal law and subject to limitations on appropriations.

(f) Final SDA for military and out-of-state. The final SDA for military and out-of-state hospitals is the urban hospital base SDA multiplied by the percentage determined in subsection (d)(4)(D) of this section.

(g) DRG statistical calculations. HHSC rebases the relative weights, MLOS, and day outlier threshold whenever the base SDAs for urban hospitals are recalculated. The relative weights, MLOS, and day outlier thresholds are calculated using data from urban hospitals and apply to all hospitals. The relative weights that were implemented for urban hospitals on September 1, 2012, apply to all hospitals until the next realignment.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows.

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the base year costs per DRG as determined in subsection (d) of this section;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG.

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.

(F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(5) Adjust the MLOS, day outlier, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(h) DRG grouper logic changes. Beginning September 1, 2021, HHSC may adjust DRG statistical calculations to align with annual grouper logic changes. The changes will remain budget neutral unless rates are rebased, and additional funding is appropriated by the legislature. The adjusted relative weights, MLOS, and day outlier threshold apply to all hospitals until the next adjustment or rebasing described in subsection (g) of this section.

(1) Base year claim data and rural base year stays are regrouped, using the latest grouping software version to determine DRG assignment changes by comparing the newly assigned DRG to the DRG assignment from the previous grouper version.

(2) For DRGs impacted by the grouping logic changes, relative weights must be adjusted. HHSC adjusts a relative weight for each impacted DRG as follows.

(A) Divide the total cost for all claims in the base year by the number of claims in the base year.

(B) Base year claims and rural base year stays are grouped by DRG, and for each DRG, HHSC:

(i) sums the base year costs for all claims in each DRG;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in each DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the amount determined in subparagraph (A) of this paragraph, resulting in the relative weight for the DRG.

(3) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

(A) Base year claims and rural base year stays are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(4) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (3) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph and multiply by two.

(F) Add the result of subparagraph (E) of this paragraph to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(5) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(6) Adjust the MLOS, day outliers, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(i) Reimbursements.

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsections (c) - (f) of this section as applicable, by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

(2) Full payment. The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.

(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are

included in calculating the amount of any day outlier or cost outlier payment adjustment.

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows.

(i) Determine whether the number of medically necessary days allowed for a claim exceeds:

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.

(ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim.

(iii) Multiply the DRG relative weight by the final SDA.

(iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsections (g)(2) or (h)(3) of this section to arrive at the DRG per diem amount.

(v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.

(vi) Multiply the result in clause (v) of this subparagraph by 60 percent.

(vii) Multiply the allowed charges by the current interim rate to determine the cost.

(viii) Subtract the DRG payment amount calculated in clause (iii) of this subparagraph from the cost calculated in clause (vii) of this subparagraph.

(ix) The day outlier amount is the lesser of the amount in clause (vi) of this subparagraph or the amount in clause (viii) of this subparagraph.

(x) For urban and rural hospitals, multiply the amount in clause (ix) of this subparagraph by 90 percent to determine the final day outlier amount. For children's hospitals the amount in clause (ix) of this subparagraph is the final day outlier amount.

(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows.

(i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims and rural base year stays multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.

(ii) Multiply the full DRG prospective payment by 1.5.

(iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.

(iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment.

(vi) For urban and rural hospitals, multiply the amount in clause (v) of this subparagraph by 90 percent to determine the final cost outlier amount. For children's hospitals the amount in clause (v) of this subparagraph is the final cost outlier amount.

(C) Final outlier determination.

(i) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero, HHSC pays the higher of the two amounts.

(ii) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is less than or equal to zero, HHSC pays the day outlier amount.

(iii) If the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero and the amount calculated in subparagraph (A)(ix) of this paragraph is less than or equal to zero, HHSC pays the cost outlier amount.

(iv) If the amount calculated in subparagraph (A)(ix) of this paragraph and the amount calculated in subparagraph (B)(vi) of this paragraph are both less than or equal to zero HHSC will not pay an outlier for the admission.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

(4) Interim bill. A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged, and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows.

(i) Multiply the DRG relative weight by the final SDA.

(ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsections (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:

(I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or

(II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.

(j) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports when realigning or rebasing to calculate base SDAs, DRG statistics, and interim rates and to complete cost settlements.

(k) Cost Settlement.

(1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) for children's and state-owned teaching hospitals.

(2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.

(4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

(6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(l) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows:

(1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:

(A) summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and

(B) dividing the result in subparagraph (A) of this paragraph by the number of in-state children's hospitals' base year claims.

(2) HHSC determines the average relative weight for all in-state children's hospitals' base year claims by:

(A) assigning a relative weight to each claim pursuant to subsections (g)(1)(B)(iii) or (h)(2)(B)(iii) of this section;

(B) summing the relative weights for all claims; and

(C) dividing by the number of claims.

(3) The result in paragraph (1) of this subsection is divided by the result in paragraph (2) of this subsection to arrive at the adjusted cost per discharge.

(4) The adjusted cost per discharge in paragraph (3) of this subsection is the payment rate used for payment of claims.

(5) HHSC reimburses each out-of-state children's hospital a prospective payment for covered inpatient hospital services. The payment amount is determined by multiplying the result in paragraph (4) of this subsection by the relative weight for the DRG assigned to the adjudicated claim.

(m) Merged hospitals.

(1) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.

(2) The merged entity receives the final SDA of the hospital associated with the surviving TPI. HHSC will reprocess all claims for the merged entity back to the effective date of the merger or the first day of the fiscal year, whichever is later.

(3) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.

(4) When Medicare requires a merged hospital to maintain two Medicare provider numbers because they are in different CBSAs, HHSC assigns one base TPI with a separate suffix for each facility. Both suffixes receive the SDA of the primary hospital TPI which remains active.

(n) Adjustments. HHSC may adjust a hospital's final SDA in accordance with §355.201 of this chapter (relating to Establishment and Adjustment of Reimbursement Rates for Medicaid).

(o) Additional data. HHSC may require a hospital to provide additional data in a format and at a time specified by HHSC. Failure to submit additional data as specified by HHSC may result in a provider vendor hold until the requested information is provided.

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

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Karen Ray
Chief Counsel
Texas Health and Human Services Commission
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For further information, please call: (512) 487-3480

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TITLE 19. EDUCATION

PART 1. TEXAS HIGHER EDUCATION COORDINATING BOARD

CHAPTER 17. RESOURCE PLANNING
SUBCHAPTER B. REPORTING REQUIREMENTS

19 TAC §17.20

The Texas Higher Education Coordinating Board (Coordinating Board) proposes amendments to Texas Administrative Code, Title 19, Part 1, Chapter 17, Subchapter B, §17.20, concerning Resource Planning. Specifically, the amendment will modify naming nomenclature from "tuition revenue bonds" to "Capital Construction Assistance Projects."

The Coordinating Board proposes modifying the nomenclature of Chapter 17, Subchapter B, §17.20, to reflect legislative changes to the program title pursuant to the Capital Construction Assistance Projects definition as found in Texas Education Code, Chapter 55.

Emily Cormier, Assistant Commissioner for Funding, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Emily Cormier, Assistant Commissioner for Funding, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section is to match legislatively approved nomenclature changes found in Texas Education Code, Chapter 55. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

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

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

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

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Emily Cormier, Assistant Commissioner for Funding, P.O. Box 12788, Austin, Texas 78711-2788, or via email at funding@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

The amendment is proposed under Texas Education Code, Sections 61.0572 and 61.058, which provide the Coordinating Board with the authority to conduct the facilities programs governed by Chapter 17.

The proposed amendment affects Texas Administrative Code, Chapter 17, Subchapter B, §17.20.

§17.20. Facility Projects to Be Submitted to the Board.

(a) Institutions shall submit data on the following projects to the Board:

(1) New construction of building and facilities and/or additions to buildings and facilities having an E&G project cost of $10 million or greater;

(2) Repair and renovation projects for buildings and facilities having an E&G project cost of $10 million or greater;

(3) Improved real property purchases that the institution intends to include in the E&G buildings and facilities inventory if the purchase price is more than $1,000,000;

(4) Energy Savings Performance Contract projects; and

(5) Projects financed by Capital Construction Assistance Projects [~~tuition revenue bonds~~] pursuant to Education Code §61.0572 and §61.058.

(b) Projects not specifically described in this rule, including but not limited to the following types of projects, are EXEMPT from Board submission.

(1) Projects at The University of Texas at Austin, Texas A&M University, and Prairie View A&M University financed more than 50 percent with Permanent University Fund bond proceeds or Available University Fund funds;

(2) New Construction, repair, or rehabilitation of privately-owned buildings and facilities on land leased from an institution if the new construction, repair, or rehabilitation is financed entirely from funds not under the control of the institution;

(3) Gifts, grants, or lease-purchase arrangements intended for clinical or research facilities;

(4) New construction, repair, or rehabilitation projects to be undertaken pursuant to specific legislative authority;

(5) Lease of property or facilities;

(6) Acquisitions of unimproved real property;

(7) Acquisitions of improved real property that the institution does not intend to include in its E&G buildings and facilities inventory;

(8) New Construction, repair, renovation, or acquisition of buildings and facilities that are to be used exclusively for auxiliary enterprises and will not require appropriations from the legislature for operations, maintenance, or repair; and

(9) All gifts and grants of improved real property.

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

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Nichole Bunker-Henderson
General Counsel
Texas Higher Education Coordinating Board
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For further information, please call: (512) 427-6548

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SUBCHAPTER F. FACILITIES AUDIT

19 TAC §17.112

The Texas Higher Education Coordinating Board (Coordinating Board) proposes amendments to Texas Administrative Code, Title 19, Part 1, Chapter 17, Subchapter F, §17.112, concerning Facilities Audit. Specifically, this amendment will update data sources used in the facilities audit process.

The Coordinating Board proposes modifying the nomenclature to change the text of Chapter 17, Subchapter F, §17.112, from mandatory direction to permissive direction. Currently §17.112 states, "At a minimum, Board shall use the following data sources in the course of the audit." The proposed amendment will change the term "shall" to "may."

Emily Cormier, Assistant Commissioner for Funding, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Emily Cormier, Assistant Commissioner for Funding, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section is reduced administrative burden and clarity for the Coordinating Board and the institutions as it pertains to facilities programs. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

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

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

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

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

(6) the rules will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Emily Cormier, Assistant Commissioner for Funding, P.O. Box 12788, Austin, Texas 78711-2788, or via email at funding@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

The amendment is proposed under Texas Education Code, Section 61.0583, which requires the Coordinating Board to conduct a comprehensive audit of all educational and general facilities.

The amendment affects Texas Administrative Code, Chapter 17, Subchapter F, §17.112.

§17.112. Data Sources.

The [~~At a minimum,~~] Board may [~~shall~~] use the following data sources in the course of the audit:

(1) Institutional Capital Expenditure Plans (MP1);

(2) Campus Condition Report as submitted to the governing board;

(3) Space Model Projection Reports;

(4) Reports required by the Educational Data Center;

(5) Facilities Inventory Reports;

(6) Facilities Development and Improvement Applications and Reviews;

(7) Classroom and Class Laboratory Utilization Reports;

(8) Energy Savings Performance Contracts;

(9) Governing Board facilities approvals; and

(10) Any other institutional data deemed appropriate by the Coordinating Board staff.

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

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Nichole Bunker-Henderson
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CHAPTER 22. STUDENT FINANCIAL AID PROGRAMS

SUBCHAPTER J. FUTURE OCCUPATIONS & RESKILLING WORKFORCE ADVANCEMENT TO REACH DEMAND (FORWARD) LOAN PROGRAM

19 TAC §22.186

The Texas Higher Education Coordinating Board (Coordinating Board) proposes amendments to Texas Administrative Code, Title 19, Part 1, Chapter 22, Subchapter J, §22.186, concerning Future Occupations & Reskilling Workforce Advancement to Reach Demand (FORWARD) Loan Program. Specifically, this amendment removes unnecessary words.

Texas Education Code, Section 52.54, provides the Coordinating Board with the authority to adopt rules and regulations to effectuate the purpose of the state's student loan programs. The Coordinating Board is proposing this rule amendment to provide clarity on how the Coordinating Board will implement the FORWARD loan program's repayment process.

Charles Contéro-Puls, Assistant Commissioner for Student Financial Aid Programs, has determined that for each of the first five years the sections are in effect there would be no fiscal implications for state or local governments as a result of enforcing or administering the rules. There are no estimated reductions in costs to the state and to local governments as a result of enforcing or administering the rule. There are no estimated losses or increases in revenue to the state or to local governments as a result of enforcing or administering the rule.

There is no impact on small businesses, micro businesses, and rural communities. There is no anticipated impact on local employment.

Charles Contéro-Puls, Assistant Commissioner for Student Financial Aid Programs, has also determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of administering the section will be the clarification of how the Coordinating Board will implement the loan program's repayment process. There are no anticipated economic costs to persons who are required to comply with the sections as proposed.

Government Growth Impact Statement

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

(2) implementation of the rule will not require the creation or elimination of employee positions;

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

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

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

(6) the rule will not limit an existing rule;

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

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

Comments on the proposal may be submitted to Charles Contéro-Puls, Assistant Commissioner for Student Financial Aid Programs, P.O. Box 12788, Austin, Texas 78711-2788, or via email at Charles.Contero-Puls@highered.texas.gov. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

The amendment is proposed under Texas Education Code, Section 52.54, which provides the Coordinating Board with the authority to adopt rules and regulations to effectuate the purpose of the state's student loan programs.

The proposed amendment affects Texas Administrative Code, Title 19, Part 1, Chapter 22, Subchapter J, §§22.175 - 22.189.

§22.186. Repayment of Loans.

(a) Period of loan repayment. The repayment period shall be 10 years.

(b) The repayment period shall begin no earlier than six months after:

(1) the date on which the student ceases to be enrolled at least half-time at an eligible institution, for borrowers enrolled in credential programs measured in semester credit hours; or

(2) the anticipated graduation date certified by the institution of higher education [~~on the loan application,~~] for borrowers enrolled in programs that are not measured in semester credit hours.

(c) Monthly repayment amount. The method for calculating the monthly repayment amount for loans through this Program shall be determined annually by the Commissioner, and shall be calculated annually based on:

(1) the borrower's income, as demonstrated through federal income tax returns or other documentation determined to be acceptable by Board staff;

(2) the borrower's monthly accrued interest on loans through the Program; and

(3) the borrower's cumulative outstanding student loan [~~principal~~] balance.

(d) Income threshold. Borrowers may be automatically placed in forbearance when the demonstrated income is below a threshold established by Board staff in consultation with the Texas Workforce Commission.

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

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Nichole Bunker-Henderson
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Texas Higher Education Coordinating Board
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TITLE 22. EXAMINING BOARDS

PART 3. TEXAS BOARD OF CHIROPRACTIC EXAMINERS

CHAPTER 80. COMPLAINTS

22 TAC §80.5

The Texas Board of Chiropractic Examiners (Board) proposes repealing 22 TAC §80.5 (Expert Review Process). The Board will propose a new §80.5 in a separate rulemaking. This rulemaking action will clarify language relating to the Board's authority to conduct standard of care reviews during complaint investigations.

The Board's Executive Director, Patrick Fortner, has determined that for the first five-year period the proposed repeal is in effect

there will be no fiscal implications for state or local government. There will be no adverse effect on small businesses or rural communities, micro-businesses, or local or state employment. There will be no additional economic costs to persons required to comply with the repeal as proposed. An Economic Impact Statement and Regulatory Flexibility Analysis is not required because the proposed repeal will not have an adverse economic effect on small businesses or rural communities as defined in Texas Government Code §2006.001(1-a) and (2).

Mr. Fortner has determined that for each year of the first five years the proposed repeal will be in effect the public benefit is to clarify language relating to the Board's authority to conduct standard of care reviews during complaint investigations.

The Board provides this Government Growth Impact Statement, pursuant to Texas Government Code §2001.0221, for the proposed repeal of 22 TAC §80.5. For each year of the first five years the proposed repeal is in effect, Mr. Fortner has determined:

(1) The proposed repeal does not create or eliminate a government program.

(2) Implementation of the proposed repeal does not require the creation of new employee positions or the elimination of existing employee positions.

(3) Implementation of the proposed repeal does not require an increase or decrease in future legislative appropriations to the Board.

(4) The proposed repeal does not require a decrease or increase in fees paid to the Board.

(5) The proposed repeal does not create a new regulation.

(6) The proposal repeals existing Board rules for an administrative process.

(7) The proposed repeal does not decrease the number of individuals subject to the rule's applicability.

(8) The proposed repeal does not positively or adversely affect the state economy.

Comments on the proposed repeal or a request for a public hearing may be submitted to Christopher Burnett, General Counsel, Texas Board of Chiropractic Examiners, 1801 North Congress Avenue, Suite 10.500, Austin, Texas 78701-1319, via email: rules@tbce.state.tx.us; or fax: (512) 305-6705, no later than 30 days from the date that this proposed repeal is published in the *Texas Register.* Please include the rule name and number in the subject line of any comments submitted by email.

The repeal is proposed under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic), and 201.210 (which authorizes the Board to adopt rules to develop a review process for complaints requiring additional chiropractic expertise).

No other statutes or rules are affected by this proposed repeal.

§80.5. Expert Review Process.

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 June 23, 2023.

TRD-202302262
Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 305-6700

22 TAC §80.5

The Texas Board of Chiropractic Examiners (Board) proposes new 22 TAC §80.5 (Peer Review Process). The current §80.5 is being repealed in a separate rulemaking action.

Texas Occupations Code §201.210 requires the Board to set up a system where the Board may draw on outside chiropractic expertise (an "expert" reviewer of patient records) to help in investigations involving standard of care allegations. The Board adopted such a system through §80.5.

However, the use of the term "expert" in both the statute and the Board's current rule has caused confusion for some complainants as to the exact role and authority of the reviewer. Some complainants have thought that the reviewer's job is to assign legal liability for any injury the complainant may have suffered as the result of a licensee's failure to meet the profession's standard of care; in effect, some complainants believe that the reviewer is the same as an expert witness in a trial court who is called upon to render an opinion as to causation (and thus assign legal liability). That is not the case with the Board's reviewers.

Unlike an expert witness, a Board reviewer does not examine any patient; the reviewer only performs a review of records. Also, a Board reviewer is not statutorily authorized to render an opinion as to causation, only whether the standard of care for chiropractic was met; those are different standards. An opinion on causation is within the purview of the courts, not the Board.

The proposed new §80.5 keeps the Board's current system of outside standard of care review, but clarifies to both reviewers hired by the Board and complainants that the reviewer is not authorized to make a legal opinion as to any violation of statutes or rules under the Board's jurisdiction, nor authorized to make a legal opinion as to the liability for any injury possibly sustained by the complainant. To that end, the rule will be retitled as "Peer Review Process" to eliminate the perception that a Board reviewer is the same as an expert witness.

The Board's Executive Director, Patrick Fortner, has determined that for the first five-year period the proposed rule is in effect there will be no fiscal implications for state or local government. There will be no adverse effect on small businesses or rural communities, micro-businesses, or local or state employment. There will be no additional economic costs to persons required to comply with the rule as proposed. An Economic Impact Statement and Regulatory Flexibility Analysis is not required because the proposed rule will not have an adverse economic effect on small businesses or rural communities as defined in Texas Government Code §2006.001(1-a) and (2).

Mr. Fortner has determined that for each year of the first five years the proposed rule will be in effect the public benefit is a more accurate description of the role and limitations of individuals selected by the Board to perform standard of care reviews in complaints filed with the Board.

The Board provides this Government Growth Impact Statement, pursuant to Texas Government Code §2001.0221, for the proposed new 22 TAC §80.5. For each year of the first five years the proposed rule is in effect, Mr. Fortner has determined:

(1) The proposed rule does not create or eliminate a government program.

(2) Implementation of the proposed rule does not require the creation of new employee positions or the elimination of existing employee positions.

(3) Implementation of the proposed rule does not require an increase or decrease in future legislative appropriations to the Board.

(4) The proposed rule does not require a decrease or increase in fees paid to the Board.

(5) The proposed rule does not create a new regulation.

(6) The proposal does repeal existing Board rules for an administrative process.

(7) The proposed rule does not decrease the number of individuals subject to the rule's applicability.

(8) The proposed rule does not positively or adversely affect the state economy.

Comments on the proposed rule or a request for a public hearing may be submitted to Christopher Burnett, General Counsel, Texas Board of Chiropractic Examiners, 1801 North Congress Avenue, Suite 10.500, Austin, Texas 78701, via email: rules@tbce.state.tx.us; or fax: (512) 305-6705, no later than 30 days from the date that this proposed rule is published in the *Texas Register.* Please include the rule name and number in the subject line of any comments submitted by email.

The rule is proposed under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic), and §201.210 (which requires the Board to develop a review process of complaints filed with the Board that require additional chiropractic expertise).

No other statutes or rules are affected by this proposed rule.

§80.5. Peer Review Process.

(a) During the investigation of a complaint, the Enforcement Committee may order the outside peer review of a licensee's standard of patient care or billing practices.

(b) To qualify as a peer reviewer, a person shall:

(1) have an active license with the Board or appropriate professional credentials;

(2) have no prior violations of Board statutes or rules;

(3) have no open complaints;

(4) have no felony convictions or misdemeanor convictions for a crime of moral turpitude;

(5) show sufficient training or experience to offer an informed opinion;

(6) show knowledge of accepted standards of chiropractic care in Texas or other professional standards related to the alleged violation; and

(7) have an acceptable malpractice complaint history.

(c) A peer reviewer may not review a complaint if the peer reviewer has:

(1) a direct financial interest or relationship with any party or witness to the complaint that gives the appearance of a conflict of interest;

(2) a familial relationship within the third degree of affinity with any party or witness;

(3) personal knowledge of any information about any party or witness related to the complaint; or

(4) any other reason where the peer reviewer could not fairly and impartially consider the complaint.

(d) The Board shall maintain a list of peer reviewers and shall periodically audit the list to confirm their qualifications.

(e) Board staff shall select a peer reviewer when an investigator identifies a standard of care or other professional standard beyond the expertise of staff in the complaint.

(f) Board staff shall randomly select a peer reviewer from the list based on the peer reviewer's qualifications to review the type of complaint.

(g) The executive director shall remove a peer reviewer from the list for:

(1) failure to maintain the required qualifications;

(2) failure to timely complete reports;

(3) failure to inform the Board of potential or apparent conflicts of interest; or

(4) failure to maintain the confidentiality of any matter.

(h) The Board shall provide to the peer reviewer:

(1) the complaint;

(2) the investigator's report;

(3) the Board's peer review report form; and

(4) a contract for services.

(i) The peer reviewer shall review all relevant information to determine if a licensee violated the applicable standard of care in Texas or other professional standard and prepare a written report.

(j) The peer reviewer's report shall include:

(1) the peer reviewer's qualifications;

(2) the relevant facts of the complaint;

(3) the applicable standard of care or other professional standard;

(4) an application of the standard of care in Texas or other professional standard to the facts;

(5) a finding of whether the standard of care or other professional standard was met; and

(6) the clinical basis for the findings, including the use of any peer-reviewed journals, studies, or reports.

(k) A peer reviewer may not offer a legal opinion as to whether a particular statute, Board rule, or other law was violated.

(l) A peer reviewer may not offer an opinion on the legal liability of any individual for an injury sustained by a patient.

(m) The peer reviewer shall complete and return the review to the Board within 30 days, unless the peer reviewer requests more time due to the complaint's complexity.

(n) The Board shall give the peer reviewer's report to the licensee within 30 days of receipt.

(o) The Enforcement Committee shall consider the report and the licensee's response in determining if a violation occurred.

(p) The Enforcement Committee may order additional peer reviews if necessary.

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 June 23, 2023.

TRD-202302263
Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 305-6700

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22 TAC §80.8

The Texas Board of Chiropractic Examiners (Board) proposes new 22 TAC §80.8 (Board Member and Staff Initiated Complaints). This proposed action puts into rule the Board's current policy for processing complaints initiated by Board members and staff.

As practicing chiropractors, Board members interact with other licensees. On occasion, a Board (or staff) member may become aware of facts that indicate that another licensee may be in violation of the statutes and rules under the Board's jurisdiction and thus need to file a formal complaint. The proposed new rule formalizes the Board's procedures for processing those complaints.

The intent behind the new rule is transparency: the licensee who is the subject of a complaint under this rule will know the identity of the Board or staff member making the complaint; know that the allegations were considered independently by the Board's executive director before the complaint is forwarded to the Board's enforcement director; and know that any Board member filing a complaint will be prohibited from voting on or considering the results of any investigation or subsequent administrative action taken by the Board on the complaint.

The Board's Executive Director, Patrick Fortner, has determined that for the first five-year period the proposed rule is in effect there will be no fiscal implications for state or local government. There will be no adverse effect on small businesses or rural communities, micro-businesses, or local or state employment. There will be no additional economic costs to persons required to comply with the rule as proposed. An Economic Impact Statement and Regulatory Flexibility Analysis is not required because the proposed rule will not have an adverse economic effect on small businesses or rural communities as defined in Texas Government Code §2006.001(1-a) and (2).

Mr. Fortner has determined that for each year of the first five years the proposed rule will be in effect the public benefit is greater formal transparency in the Board's procedures for processing complaints initiated by Board members and staff.

The Board provides this Government Growth Impact Statement, pursuant to Texas Government Code §2001.0221, for the proposed new 22 TAC §80.8. For each year of the first five years the proposed rule is in effect, Mr. Fortner has determined:

(1) The proposed rule does not create or eliminate a government program.

(2) Implementation of the proposed rule does not require the creation of new employee positions or the elimination of existing employee positions.

(3) Implementation of the proposed rule does not require an increase or decrease in future legislative appropriations to the Board.

(4) The proposed rule does not require a decrease or increase in fees paid to the Board.

(5) The proposed rule does not create a new regulation.

(6) The proposal does repeal existing Board rules for an administrative process.

(7) The proposed rule does not decrease the number of individuals subject to the rule's applicability.

(8) The proposed rule does not positively or adversely affect the state economy.

Comments on the proposed rule or a request for a public hearing may be submitted to Christopher Burnett, General Counsel, Texas Board of Chiropractic Examiners, 1801 North Congress Avenue, Suite 10.500, Austin, Texas 78701, via email: rules@tbce.state.tx.us; or fax: (512) 305-6705, no later than 30 days from the date that this proposed rule is published in the *Texas Register.* Please include the rule name and number in the subject line of any comments submitted by email.

The rule is proposed under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic), §201.2205 (which requires the Board to adopt rules concerning the investigation of a complaint), and §201.2065 (which prohibits the Board from accepting anonymous complaints).

No other statutes or rules are affected by this proposed rule.

§80.8. Board Member and Staff Initiated Complaints.

(a) A Board member or staff shall notify the Board's executive director in writing of any potential violation by an individual of a statute or rule under the Board's jurisdiction.

(b) The executive director shall evaluate the written statement (and any supporting evidence) of the Board member or staff about the potential violation within five days of receipt.

(c) If the executive director determines there is sufficient grounds to begin a formal complaint, the executive director shall forward the written statement (and any supporting evidence) to the Board's director of enforcement with instructions to open an investigation.

(d) The director of enforcement shall name both the executive director and the Board member or staff as the complainant in an investigation opened under this section.

(e) A Board member who initiates a complaint under this section shall recuse himself from any consideration of the complaint by the Board.

(f) A Board member or staff who initiated a complaint under this section shall respond to a request for additional information by a Board investigator or the Enforcement Committee only in writing.

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 June 23, 2023.

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Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 305-6700

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CHAPTER 82. INTERNAL BOARD PROCEDURES

22 TAC §82.7

The Texas Board of Chiropractic Examiners (Board) proposes new 22 TAC §82.7 (Employee Equity Salary Adjustments). The General Appropriations Act (GAA) authorizes an agency executive director to make employee equity salary adjustments only if the agency has adopted a rule permitting that action. This proposed rule, which is compliant with the terms of the GAA (Article IX, §3.07, 87th Legislature - Regular Session, 2021 (or successor provisions), permits the agency executive director to make such adjustments if necessary.

The Board's Executive Director, Patrick Fortner, has determined that for the first five-year period the proposed rule is in effect there will be no fiscal implications for state or local government. There will be no adverse effect on small businesses or rural communities, micro-businesses, or local or state employment. There will be no additional economic costs to persons required to comply with the rule as proposed. An Economic Impact Statement and Regulatory Flexibility Analysis is not required because the proposed rule will not have an adverse economic effect on small businesses or rural communities as defined in Texas Government Code §2006.001(1-a) and (2).

Mr. Fortner has determined that for each year of the first five years the proposed rule will be in effect the public benefit is to permit the Board's executive director to make employee equity salary adjustments, if needed, in compliance with the requirements of the General Appropriations Act.

The Board provides this Government Growth Impact Statement, pursuant to Texas Government Code §2001.0221, for the proposed new 22 TAC §82.7. For each year of the first five years the proposed rule is in effect, Mr. Fortner has determined:

(1) The proposed rule does not create or eliminate a government program.

(2) Implementation of the proposed rule does not require the creation of new employee positions or the elimination of existing employee positions.

(3) Implementation of the proposed rule does not require an increase or decrease in future legislative appropriations to the Board.

(4) The proposed rule does not require a decrease or increase in fees paid to the Board.

(5) The proposed rule does not create a new regulation.

(6) The proposal does repeal existing Board rules for an administrative process.

(7) The proposed rule does not decrease the number of individuals subject to the rule's applicability.

(8) The proposed rule does not positively or adversely affect the state economy.

Comments on the proposed rule or a request for a public hearing may be submitted to Christopher Burnett, General Counsel, Texas Board of Chiropractic Examiners, 1801 North Congress Avenue, Suite 10.500, Austin, Texas 78701, via email: rules@tbce.state.tx.us; or fax: (512) 305-6705, no later than 30 days from the date that this proposed rule is published in the *Texas Register.* Please include the rule name and number in the subject line of any comments submitted by email.

The rule is proposed under Texas Occupations Code §201.152 (which authorizes the Board to adopt rules necessary to perform the Board's duties and to regulate the practice of chiropractic) and the General Appropriations Act, Article IX, §3.07 (87th Legislature - Regular Session, 2021) or successor provisions (which authorizes the Board to adopt rules concerning employee equity salary adjustments).

No other statutes or rules are affected by this proposed rule.

§82.7. Employee Equity Salary Adjustments.

(a) Pursuant to Senate Bill 1 (General Appropriations Act), Article IX, Section 3.07 (87th Legislature - Regular Session, 2021) or successor provisions, the Board's executive director may adjust the salary rate of an employee whose position is classified under the position classification plan to any rate within the employee's salary group range as necessary to maintain desirable salary relationships:

(1) between and among employees of the Board; or

(2) between employees of the Board and employees who hold similar positions in the relevant labor market.

(b) In determining desirable salary relationships under subsection (a) of this section, the executive director shall consider the education, skills, related work experience, length of service, and job performance of Board employees and similar employees in the relevant labor market.

(c) The executive director may award an equity adjustment to an employee under this section only if the adjustment does not conflict with other law.

(d) The executive director's analysis under subsection (b) of this section shall be in writing.

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 June 23, 2023.

TRD-202302265
Christopher Burnett
General Counsel
Texas Board of Chiropractic Examiners
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 305-6700

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PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 102. FEES

22 TAC §102.1

The State Board of Dental Examiners (Board) proposes this amendment to 22 TAC §102.1, concerning fees. The proposed amendment reflects the fees required to submit the following applications to the Board: Registered Dental Assistant (RDA) Course Provider Application, and Continuing Education (CE) Provider Application.

FISCAL NOTE: Casey Nichols, Executive Director, has determined that for the first five-year period the proposed rule is in effect, the proposed rule does not have foreseeable implications relating to cost or revenues of the state or local governments.

PUBLIC BENEFIT-COST NOTE: Casey Nichols has also determined that for the first five-year period the proposed rule is in effect, the public benefit anticipated as a result of this rule will be the protection of public safety and welfare.

LOCAL EMPLOYMENT IMPACT STATEMENT: Casey Nichols has also determined that the proposed rule does not affect local economies and employment.

SMALL AND MICRO-BUSINESS, RURAL COMMUNITY IMPACT STATEMENT: Casey Nichols has determined that no economic impact statement and regulatory flexibility analysis for small businesses, micro-businesses, and rural communities is necessary for this rule.

GOVERNMENT GROWTH IMPACT STATEMENT: The Board has determined that for the first five-year period the proposed rule is in effect, the following government growth effects apply: (1) the rule does not create or eliminate a government program; (2) implementation of the proposed rule does not require the creation or elimination of employee positions; (3) the implementation of the proposed rule does not require an increase or decrease in future appropriations; (4) the proposed rule does require an increase in fees paid to the agency for the applications pertaining to RDA course providers and CE providers; (5) the proposed rule does not create a new regulation; (6) the proposed rule does not expand an existing regulation; (7) the proposed rule does not increase or decrease the number of individuals subject to it; and (8) the proposed rule does not positively or adversely affect the state's economy.

COST TO REGULATED PERSONS: This proposed rule does not impose a cost on a regulated person and, therefore, is not subject to Tex. Gov't. Code §2001.0045.

Comments on the proposed amendment may be submitted to Casey Nichols, Executive Director, 1801 Congress Avenue, Suite 8.600, Austin, Texas 78701, by fax to (512) 649-2482, or by email to official_rules_comments@tsbde.texas.gov for 30 days following the date that the proposed rule is published in the *Texas Register.* To be considered for purposes of this rulemaking, comments must be: (1) postmarked or shipped by the last day of the comment period; or (2) faxed or e-mailed by midnight on the last day of the comment period.

This rule is proposed under Texas Occupations Code §254.001(a), which gives the Board authority to adopt rules necessary to perform its duties and ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety, and Texas Occupations Code §254.004, which directs the Board to establish reasonable and necessary fees sufficient to cover the cost of administering the Board's duties.

No statutes are affected by this proposed rule.

§102.1. Fees.

(a) Effective September 1, 2023 [~~October 1, 2020~~], the Board has established the following reasonable and necessary fees for the administration of its function. Upon initial licensure or registration, and at each renewal, the fees provided in subsections (b) - (d) of this section shall be due and payable to the Board.
Figure; 22 TAC §102.1(a)
[~~Figure; 22 TAC §102.1(a)~~]

(b) - (f) (No change.)

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 June 26, 2023.

TRD-202302271
Lauren Studdard
General Counsel
State Board of Dental Examiners
Earliest possible date of adoption: August 6, 2023
For further information, please call: (512) 305-8910

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CHAPTER 110. SEDATION AND ANESTHESIA

22 TAC §110.18

The State Board of Dental Examiners (Board) proposes this amendment to 22 TAC §110.18, concerning inspection of sedation/anesthesia providers. The proposed amendment gives the Board discretion on whether to pursue revocation of a dental license if a permit holder who is in an inactive status is found to have administered or delegated the administration of level 2, 3, or 4 sedation/anesthesia while in inactive status. The proposed amendment also gives the Board discretion on whether to pursue revocation of a dental license if a permit holder who is an exempt location status is found to have administered or delegated the administration of level 2, 3, or 4 sedation/anesthesia in a non-exempt location.

FISCAL NOTE: Casey Nichols, Executive Director, has determined that for the first five-year period the proposed rule is in effect, the proposed rule does not have foreseeable implications relating to cost or revenues of the state or local governments.

PUBLIC BENEFIT-COST NOTE: Casey Nichols has also determined that for the first five-year period the proposed rule is in effect, the public benefit anticipated as a result of this rule will be the protection of public safety and welfare.

LOCAL EMPLOYMENT IMPACT STATEMENT: Casey Nichols has also determined that the proposed rule does not affect local economies and employment.

SMALL AND MICRO-BUSINESS, RURAL COMMUNITY IMPACT STATEMENT: Casey Nichols has determined that no economic impact statement and regulatory flexibility analysis for small businesses, micro-businesses, and rural communities is necessary for this rule.

GOVERNMENT GROWTH IMPACT STATEMENT: The Board has determined that for the first five-year period the proposed rule is in effect, the following government growth effects apply: (1) the rule does not create or eliminate a government program; (2) implementation of the proposed rule does not require the creation or elimination of employee positions; (3) the implementation of the proposed rule does not require an increase or decrease in future appropriations; (4) the proposed rule does not require an increase in fees paid to the agency; (5) the proposed rule does not create a new regulation; (6) the proposed rule does not expand an existing regulation; (7) the proposed rule does not increase or decrease the number of individuals subject to it; and (8) the proposed rule does not positively or adversely affect the state's economy.

COST TO REGULATED PERSONS: This proposed rule does not impose a cost on a regulated person and, therefore, is not subject to Tex. Gov't. Code §2001.0045.

Comments on the proposed amendment may be submitted to Casey Nichols, Executive Director, 1801 Congress Avenue, Suite 8.600, Austin, Texas 78701, by fax to (512) 649-2482, or by email to official_rules_comments@tsbde.texas.gov for 30 days following the date that the proposed rule is published in the *Texas Register.* To be considered for purposes of this rulemaking, comments must be: (1) postmarked or shipped by the last day of the comment period; or (2) faxed or e-mailed by midnight on the last day of the comment period.

This rule is proposed under Texas Occupations Code §254.001(a), which gives the Board authority to adopt rules necessary to perform its duties and ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

No statutes are affected by this proposed rule.

§110.18. Inspection of Sedation/Anesthesia Providers.

(a) The Board may conduct inspections to enforce Chapter 110 of this title (relating to Sedation and Anesthesia), including inspections of a licensee, an office site, equipment, a facility, and any document required by Board rules. The inspections shall not identify violations outside the applicable sedation/anesthesia rules in effect for each permit level at the time of the inspection. The Board may employ Board staff or contract with another state agency or qualified person to conduct these inspections.

(b) Unless it would jeopardize an ongoing investigation, the Board shall provide at least ten business days' notice before conducting an on-site inspection under this section.

(c) Regardless of issue date, all level 2, 3 and 4 permit holders will be subject to at least one inspection prior to September 1, 2022. All level 2, 3, and 4 permit holders who received their initial permit after March 1, 2018, must be inspected within a year of receiving their permit.

(d) Compliance/Tier 1 inspections: The initial inspection will be a compliance inspection, in which a Board staff member will evaluate the permit holder's compliance with the Board's rules through completing a checklist and auditing one sedation/anesthesia record of the inspector's choosing that was completed prior to the date the Board notified the licensee of the inspection. The record shall be of treatment for the highest level of sedation/anesthesia permit held by the permit holder, and will apply the Board rules in effect at the time the patient was treated. The inspector shall be a member of Board staff and will receive training in recognizing the checklist requirements and in evaluating sedation/anesthesia records. If the inspection results in the identification of a violation of the Board's rules found in Chapter 110, the permit holder must immediately cease providing sedation/anesthesia services until satisfactory proof is provided to Board staff that the violation has been corrected. Board staff shall provide contact information for both an inspector and supervisor of the inspector so that the permit holder may provide proof of remediation as soon as possible. Any violation of this cease and desist requirement shall represent grounds for disciplinary action. A failure by Board staff to respond within two business days to permit holder's satisfactory proof of remediation shall represent an affirmative defense to disciplinary action. Additionally, the permit holder shall pay an amount of not more than five hundred dollars ($500.00) as necessary to cover the expenses of additional review and inspection by Board staff as a result of any violations identified during the initial inspection. If, after a completed Compliance/Tier 1 inspection, the only violation(s) identified by Board staff relate to the time-interval recording requirements contained in the inspection items numbered 3 and 4 of the "Patient Record Audit" portion of the attached graphic "Anesthesia Levels 2-4 Inspection Form" for this section, then the violation(s) may be remedied by the Respondent through the execution of a sworn affidavit provided by Board staff. The Respondent's affidavit must attest that the Respondent shall observe the requirements of the applicable sedation/anesthesia rule sections requiring time interval recording for each permit level the Respondent holds. The inspection checklist can be previewed here:
Figure: 22 TAC §110.18(d) (No change.)

(e) Risk-based/Tier 2 inspections: A permit holder with a violation on a compliance/tier 1 inspection that is not remedied within thirty (30) days shall be referred to a risk-based inspection. Additionally, a Board member sitting on an informal settlement conference panel pursuant to Tex. Occ. Code §263.0072 may refer a permit holder to a risk-based inspection. The risk-based inspection will include the same factors as a compliance inspection, as well as a competency evaluation consisting of an audit of five sedation/anesthesia records of the inspector's choosing. The records shall be of treatment records for the highest level of sedation/anesthesia permit held by the permit holder, and shall apply the Board rules in effect at the time the patient was treated. Review of the five sedation/anesthesia records shall be performed by members of the Board's dental review panel process pursuant to Tex. Occ. Code §255.0065 who currently hold the same or higher level of sedation/anesthesia permit. The dental review panel reviewer shall prepare a report and note any violations or concerns with the permit holder's competency, and the report shall be reviewed following the procedure described in Tex. Occ. Code §255.0067. Any violation found during the risk-based inspection may result in the filing of a complaint and complaint resolution pursuant to the Board's informal disposition process in §107.63 of this title (relating to Informal Disposition and Mediation). The Executive Committee of the Board may order the emergency temporary suspension of a permit if the risk-based inspection reveals evidence of a clear, imminent, or continuing threat to the health or well-being of the public.

(f) Inactive status: A permit holder may forego an inspection if they submit a notarized, Board-issued affidavit that they will not administer levels 2, 3, or 4 sedation/anesthesia until first notifying the Board in writing that they wish to resume those activities. A permit holder must complete a compliance/Tier 1 inspection prior to resuming the administration of sedation/anesthesia at the inactive permit level. The permit holder must comply with continuing education and any other permit requirements during this time. During the period of inactive status, a permit holder may not delegate any inactive-status level of sedation/anesthesia to a certified registered nurse anesthetist or any other dental or medical professional except a dentist with a permit issued by the Board for the procedure being performed or a physician anesthesiologist licensed by the Texas Medical Board. If the permit

holder is later found to have administered or delegated the administration of level 2, 3, or 4 sedation/anesthesia while in inactive status, the Board may [~~shall~~] pursue revocation of their dental license.

(g) Exempt-location status: The Board shall not inspect a level 2, 3, or 4 permit holder who provides those services exclusively in a state-licensed hospital or state-licensed ambulatory surgery center. The permit holder must attest to that fact with a notarized, Board-issued affidavit and may not provide those services at a non-exempt location until first notifying the Board in writing and successfully completing a compliance/Tier 1 inspection. During the period of exempt-location status, a permit holder may not delegate the administration of any level of sedation/anesthesia to a dental or medical professional outside a state-licensed hospital or state-licensed ambulatory surgery center. If they are later found to have administered or delegated the administration of level 2, 3, or 4 sedation/anesthesia in a non-exempt location, the Board may [~~shall~~] pursue revocation of their dental license.

(h) Group practice inspections. The Board shall permit group practices to request an inspection of all permit holders in a single location during one inspection visit. Permit holders shall inform Board staff upon receiving notice of an inspection their wish to receive a combined group practice inspection, and Board staff shall accommodate this request as feasible while ensuring a group inspection shall not jeopardize an ongoing investigation. Board staff shall ensure that group practice inspection requests do not create unnecessary delays to the completion of the inspection process and may decline the request as needed to ensure timely completion of all scheduled inspections.

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 June 26, 2023.

TRD-202302273
Lauren Studdard
General Counsel
State Board of Dental Examiners
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For further information, please call: (512) 305-8910

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER M. FILING REQUIREMENTS

The Texas Department of Insurance (TDI) proposes to amend 28 TAC §§5.9310, 5.9312, 5.9321, 5.9323, 5.9327, 5.9332, 5.9334, 5.9342, 5.9355, 5.9357, 5.9361, 5.9372, and 5.9373, and add new §5.9313, concerning filing requirements for property and casualty insurance. Among other changes, this rule proposal reflects the enactment of Senate Bills 965 and 1367, 87th Legislature, 2021.

EXPLANATION. SB 965 repealed the law authorizing the commissioner to establish different filing requirements for certain personal automobile insurers with low market shares. SB 1367 eliminated rate, rule, and form filing requirements for numerous commercial lines of insurance. The proposed amendments conform Subchapter M with the statutory changes.

In addition, the proposal makes other amendments throughout Subchapter M. The proposed amendments require that provisions in mandatory endorsements be incorporated into personal automobile and residential property policy forms (for policy forms filed on or after January 1, 2025); prohibit inapplicable provisions in personal automobile and residential property endorsements (for endorsements filed on or after January 1, 2025); require that insurers file application forms along with personal automobile policy forms; prohibit scanned documents and scanned text in filed property and casualty policy forms, endorsements, and form usage tables; prohibit password-protected or otherwise encrypted documents in filings; clarify the information used to establish an insurer exemption under Insurance Code §2251.252(a); distinguish the filing requirements applicable to advisory organizations; require submission of new categories of supporting information on third-party data and models in rate, rule, and underwriting guideline filings; change underwriting guideline filing requirements to require a complete set of underwriting guidelines with each filing; and replace TDI mailing addresses with TDI's website, where appropriate.

The following summary describes the proposed changes to specific sections of the Filings Made Easy rules (FME Rules) found in 28 TAC Chapter 5, Subchapter M, Divisions 4, 5, 6, 7, 9, 10, and 11. TDI posted an informal working draft of the revised FME Rules on the TDI website on April 14, 2022. TDI received 10 comment letters on the informal draft. TDI considered those comments when drafting this proposal. The detailed section-by-section summary is organized by division.

Amendments throughout the entire proposal make minor grammatical, punctuation, and format changes to reflect current TDI drafting style and plain-language preferences.

Division 4. Filings Made Easy - Transmittal Information and General Filing Requirements for Property and Casualty Form, Rate, Underwriting Guideline, and Credit Scoring Model Filings.

Section 5.9310. Property and Casualty Transmittal Information and General Filing Requirements. The proposed amendments to §5.9310 add text specifying that a filing submitted for one line of insurance (a monoline filing) may also be used in multi-peril insurance. Accordingly, amendments to this section delete references to dual filings, including transmittal information requirements for dual filings. Neither the new multi-peril text nor the deletion of dual filings text will require a separate multi-peril filing. When a filer makes a monoline filing under Insurance Code Chapters 2251 or 2301, the filing may be used for multi-peril insurance without making an additional, separate multi-peril filing.

Amendments implement SB 1367 by changing the definition of multi-peril insurance to exclude a combination of coverages as described in Insurance Code §2251.0031 and §2301.0031, which were added by the bill. These sections list insurance lines that are exempted from certain filing and approval requirements in Insurance Code Chapters 2251 and 2301.

Amendments also add the option to use the National Association of Insurance Commissioners System for Electronic Rate and Form Filing (SERFF) tracking number as an alternative to the TDI file number for certain required transmittal information.

Amendments also renumber subsections, paragraphs, and subparagraphs as appropriate to reflect the other amendments in the section, and they insert the titles of cited Insurance Code

and Administrative Code provisions for consistency with current TDI rule drafting style.

Section 5.9312. Personally Identifiable Information. Proposed amendments make two nonsubstantive clarifying changes to descriptions of personally identifiable information, changing "phone" to "phone number" and "email" to "email address."

Section 5.9313. Filing Format Requirements. Proposed new §5.9313 specifies filing format requirements. The section prohibits encrypted or password-protected documents in filings. No changes are made to a filer's ability to mark documents as confidential or protect documents from public view in SERFF.

The rule text also specifies that property and casualty policy forms, endorsements, and form usage tables must not be scanned documents; may not include any scanned text or images with text that will be part of the insurance contract; must be in a format that is selectable and searchable; and must be in portrait, rather than landscape, orientation.

These new requirements streamline the filing process by ensuring that policy forms, endorsements, and form usage tables are more readily accessible to TDI staff and compatible with text search tools in SERFF and TDI's form review technology that relies on word recognition software.

Division 5. Filings Made Easy - Requirements for Property and Casualty Policy Form and Endorsement Filings.

Section 5.9321. General Filing Requirements. Proposed amendments specify that unless requested by TDI, filings made by advisory organizations do not need to include proposed effective dates or form usage tables. Proposed amendments allow filers to use a SERFF tracking number instead of a TDI file number to identify previously approved filings. Amendments also make several nonsubstantive wording changes to text and reorganize existing requirements on conditional mandatory addendums within the section for clarity.

Proposed amendments also delete plain-language requirements for personal automobile and residential property insurance as addressed within this section. These requirements are deleted here and added to proposed §5.9327 to clarify that the plain-language requirements only apply to personal automobile and residential property forms.

Section 5.9323. Requirements for Reference Filings. The proposed amendment allows the SERFF tracking number to be used as an alternative identifier to the TDI file number for reference filings.

Section 5.9327. Additional Requirements for Personal Automobile and Residential Property Forms. The section heading is amended to address the proposed provisions included in the section.

Proposed amendments add new subsection (a), which specifies requirements for personal automobile and residential property insurance forms. The amendments include new requirements applicable to filings submitted to TDI on or after January 1, 2025. One of the amendments requires that when an insurer files new or revised policy forms on or after January 1, 2025, the insurer must incorporate the provisions of all associated mandatory endorsements that it uses or plans to use at the time of the filing. Policy forms filed on or after January 1, 2025, should not have any mandatory endorsement forms at the time the policy form is approved. This amendment does not prohibit companies from including new mandatory endorsements in subsequent filings that do not include the related policy form.

The proposed text also requires that when filing an endorsement with provisions that do not apply to every policy to which the endorsement will be attached, the provisions must be enclosed with brackets to reflect that the provisions are variable text. Proposed text requires filings to indicate that when the endorsement is attached to a policyholder's specific policy, the endorsement will not include any provisions that are inapplicable to that specific policy. The proposed text provides an example of how this requirement will operate. The requirement is effective for endorsements filed on or after January 1, 2025.

These changes are intended to increase consumers' understanding of their insurance policies by reducing or eliminating inapplicable provisions and by decreasing the need for consumers to cross-reference endorsements because applicable provisions will be integrated into the policy. The delayed implementation date for these requirements is intended to allow insurers lead time to incorporate these requirements into their business practices.

The amendments also add new subsection (c), which requires that when making a new automobile insurance policy form filing, insurers must file for informational purposes automobile insurance applications that are not part of the insurance policy. The new subsection also clarifies that insurers must file personal automobile insurance applications for approval if they are part of the insurance policy.

Current TDI practice is to ask insurers to file all personal automobile insurance applications when the associated policy is initially filed for review. For applications that are part of the policy, filing for approval is required by Insurance Code §2301.006, which prohibits insurer use of any form subject to Insurance Code Chapter 2301 until it is filed with and approved by the commissioner. For applications that are not part of the policy, TDI currently asks insurers to file them for informational purposes, which enables TDI to verify that the application does not contain policy terms or conditions and that the application and policy do not conflict.

Plain-language requirements for personal automobile and residential property insurance are deleted in proposed §5.9321 but added back in proposed §5.9327 to clarify that the plain-language requirements apply only to personal automobile and residential property forms. In addition, amendments redesignate and renumber subsequent provisions as appropriate to reflect the new text.

Division 6. Filings Made Easy - Requirements for Rate and Rule Filings.

Section 5.9332. Categories of Supporting Information. Proposed amendments add new categories of supporting information for third-party data and model information. These amendments are intended to modernize the FME Rules to address insurers' increasing use of third-party data and models. The amendments specify that the following information be filed for third-party data: the name of the data vendor or source; a description of the data; a description of how the data is used; and a list of the rating variables that reflect the use of the data. Similarly, amendments require that the following information be filed for third-party models: the name of the model vendor or source; the model name and version number; a description of the model; a description of the model input; a description of how the model

output is used; and a list of the rating variables that depend on the model's output.

Amendments also allow filers the option of using the SERFF tracking number instead of the TDI file number when providing loss cost information for reference filings.

In addition, amendments renumber a paragraph to reflect addition of the new categories of supporting information, and they insert the titles of cited Insurance Code provisions and make nonsubstantive language changes for consistency with current TDI rule drafting style.

Section 5.9334. Requirements for Rate and Rule Filing Submissions. Proposed amendments distinguish which filing requirements apply to advisory organization rate and rule filings. The proposed text specifies that advisory organization filings do not need to include proposed effective dates; written premium and policyholder information; policyholder impact information; historical premium and loss information; expense information; or profit provision information.

Amendments also add third-party data and model information to the list of required elements of rate and rule filing submissions.

In addition, amendments redesignate existing subsections as appropriate to reflect addition of the new provisions, and they insert the titles of cited Insurance Code provisions and make nonsubstantive language changes for consistency with current TDI rule drafting style.

Division 7. Filings Made Easy - Requirements for Underwriting Guideline Filings.

Section 5.9342. Filing Requirements. Proposed amendments revise underwriting guideline filing requirements. Proposed amendments remove the requirement to file a comprehensive set of underwriting guidelines every three years. Instead, the proposed amendments require, not later than 10 days after use, a comprehensive set of underwriting guidelines with each underwriting guideline filing. The proposed amendments also require that each underwriting guideline filing include a mark-up or redline version of the guideline, clearly indicating any changes. These proposed amendments reduce the number of underwriting guideline filings and streamline TDI's review of these filings.

The amendments also require that for each third-party data set used in underwriting, the following information be filed: the name of the data vendor or source; a description of the data; a description of how the data is used; and a list of the underwriting guidelines that reflect the use of the data. Similarly, amendments specify that the following information be filed for third-party models: the name of the model vendor or source; the model name and version number; a description of the model; a description of the model input; a description of how the model output is used; and a list of the underwriting guidelines that depend on the model's output.

The proposed text specifies that filings must clearly indicate any changes in the underwriting guidelines resulting from a change in third-party data and modeling information, and that no filing is necessary for a change in third-party data and modeling information that does not result in a change to underwriting guidelines. Adding the filing requirement for third-party data and model information modernizes the FME Rules to include information that insurers are increasingly using in their underwriting guideline filings.

In addition, amendments redesignate existing subsections and update references to subsections within the section as appropriate to reflect the new provisions, and they insert the titles of cited Insurance Code provisions for consistency with current TDI rule drafting style.

Division 9. Filings Made Easy - Reduced Filing Requirements for Certain Residential Property Insurers.

A proposed amendment to the title of Division 9 clarifies that the division now only applies to residential property insurers for consistency with SB 965, which repealed Insurance Code §2251.1025, concerning Filing Requirements for Certain Personal Automobile Insurers with Less Than 3.5 Percent of Market.

Section 5.9355. Purpose. A proposed amendment implements SB 965 by eliminating a reference to Chapter 2251, Subchapter C, which previously contained §2251.1025. In addition, an amendment inserts the title of Insurance Code Chapter 2251, Subchapter F for consistency with current TDI rule drafting style.

Section 5.9357. Filing Requirements. Proposed amendments implement SB 965 by eliminating references to personal automobile insurers and making conforming changes throughout the section. To increase clarity, proposed amendments revise the rule text related to certain insurers exempted from filing and approval requirements. The proposed amendments also include third-party data and model information in the list of supporting information that insurers subject to §5.9357 are not required to file.

Division 10. Filings Made Easy - Additional Filing Requirements for Certain County Mutual Insurance Companies.

Section 5.9361. Additional Requirements. Proposed amendments add the option to use a SERFF tracking number as an alternative to the TDI file number for certain required filing information, and they also insert the title of Insurance Code Chapter 2301 for consistency with current TDI rule drafting style.

Division 11. Filings Made Easy - Certificates of Property and Casualty Insurance.

Section 5.9372. Preparation and Submission of Certificate of Insurance Form Filings. Proposed amendments restructure rule text addressing how TDI will accept filings. The amendments improve clarity; eliminate obsolete physical and mailing addresses; remove an email address; and specify that mailing addresses and other contact information are available on the Property and Casualty Certificates of Insurance web page on TDI's website. An amendment also inserts the title of Insurance Code Chapter 1811 for consistency with current TDI rule drafting style.

Section 5.9373. Certificate of Insurance Form Filing Transmittal Information. Proposed amendments remove request by mail as an option for filers to obtain the Certificate of Insurance Form Filing Transmittal Form. The request by mail option is removed because TDI no longer receives such requests by mail and the form remains available on TDI's website.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. J'ne Byckovski, chief actuary and director of the Property and Casualty Actuarial Office of the Property and Casualty Division, has determined that during each year of the first five years the amendments and new sections are in effect, there will be no fiscal impact on state or local government because of enforcing or administering the sections. The proposal will have no measurable effect on local employment or the local economy.

PUBLIC BENEFIT AND COST NOTE. For each of the first five years the proposed amendments and new sections are in effect, Ms. Byckovski expects that the proposed amendments and new sections will have the public benefits of ensuring that TDI's rules properly implement SB 965 and SB 1367, increasing consumer understanding of insurance policies, reducing certain costs imposed on filing entities, conserving agency resources, and increasing government efficiency.

Ms. Byckovski expects that several of the proposed amendments will impose a cost on regulated entities, but that these costs will be offset by savings for regulated entities.

Costs

TDI anticipates that requiring the incorporation of mandatory endorsement form provisions into policies as described in §5.9327(a)(2) will result in costs for some insurers as they revise their forms. While it is not feasible to determine the actual time required or the cost of employees needed to comply with the requirements, TDI estimates that the incorporation of such an endorsement into a policy form would take a range of one to two hours to complete for each amended form and would likely require both software programming and clerical staff. According to the May 2021 Bureau of Labor Statistics Occupational and Employment Wage Statistics at www.bls.gov/oes/current/oes_nat.htm, the national mean hourly wage for software and web developers, programmers, and testers in the "Management of Companies and Enterprises" classification is $54.68, and the national mean hourly wage for the "Secretaries and Administrative Assistants, Except Legal, Medical, and Executive" classification is $19.75.

TDI also anticipates that the bracketing of variable text in endorsement forms as described in §5.9327(a)(3) will result in costs for some insurers. While actual costs for each insurer will depend on the language that must be bracketed and the underlying form, TDI estimates that bracketing variable text and preparing the forms to remove any inapplicable text when the endorsements are issued will take a range of one to five hours to complete for each amended form and would likely require both software programming and clerical staff. The national mean hourly wages discussed above in the mandatory endorsement cost analysis are also applicable for these costs.

TDI believes these potential costs are significantly mitigated by the delayed implementation of these requirements until January 1, 2025. Even more significantly, the rule proposal does not prohibit the use of separate mandatory endorsements or unbracketed variable text on January 1, 2025, but rather specifies that filings an insurer chooses to make after that date must conform to the new standards. Insurers can choose when to file policy forms and endorsements that will be subject to the requirements in §5.9327(a)(2) and §5.9327(a)(3). As a result, insurers will have the opportunity to integrate any necessary software programming and administrative activities into related activities the insurer will already be undertaking to develop and begin using the filed policy forms or endorsements. Insurers that do not use policy forms that have mandatory endorsements as described in §5.9327(a)(2), or that do not use endorsements forms with inapplicable text as described in §5.9327(a)(3), will have no costs resulting from these amendments.

Insurers may also experience minor costs relating to the requirement in §5.9327(c)(2) that automobile insurance applications that are not part of the insurance policy must be filed for informational purposes when the insurer files a new personal automobile policy form. According to May 2021 National Occupational and Wage Statistics as published by the Bureau of Labor Statistics at www.bls.gov/oes/current/oes_nat.htm, the national mean hourly wage for the "Secretaries and Administrative Assistants, Except Legal, Medical, and Executive" classification is $19.75. TDI estimates that filing an automobile insurance application will take less than one hour given that the insurer will already be filing a policy form. TDI regularly requests a copy of automobile insurance applications when a new policy is filed because it is needed for TDI's review of the policy. Therefore, compliance with the requirement will not result in a cost that is not already present.

Proposed new §5.9313 specifies filing format requirements. Although most insurers currently comply with the proposed requirements, the amendments may result in minor costs for a very small number of insurers. The requirements ensure that filings are compatible with text search tools in SERFF and TDI's form review technology that relies on word recognition software. TDI believes that insurers ordinarily draft or otherwise develop policy forms, endorsements, and form usage tables in a format that is selectable and searchable and can easily be converted to portrait orientation if needed. The existing requirement in §5.9310 that filings be made in SERFF sometimes results in TDI requesting that filers submit in a compatible format. Therefore, compliance with these formatting requirements will not result in costs that are not already present under existing requirements.

Proposed amendments in §§5.9332, 5.9334, and 5.9342 on third-party data and model information may result in time and filing costs for some insurers. These amendments are intended to address insurers' increasing use of modeling and data provided by third parties. The third-party information required by the proposed amendments consists of basic identifying and descriptive information and is not expected to impose a significant cost. Insurers that do not use third-party data or models will not have any costs resulting from these amendments.

Because of the number of factors impacting potential insurer costs, it is not feasible for TDI to estimate the range of all potential costs of the proposed amendments. Any potential insurer costs resulting from the proposal will be specific to each filing entity and their unique circumstances.

Savings

TDI believes that the costs previously discussed will be offset by time, effort, and cost savings for filing entities, and that as a result of these offsetting savings the proposal will result in an overall net savings for impacted entities. TDI expects that filing entities will have savings resulting from streamlining the filing process by formalizing current practices, clarifying filing requirements for advisory organizations, allowing monoline filings to be used in multi-peril insurance, and allowing the use of a SERFF tracking number instead of a TDI filing number. TDI also believes that the requirements for incorporating mandatory endorsements into policies and bracketing variable text will significantly reduce misunderstanding and increase transparency for consumers, which will result in less insurer time and expense responding to customer complaints and TDI inquiries.

The following proposed amendments streamline the filing and review process by formalizing current TDI practice and clarifying filing requirements: specifying current filing format requirements in §5.9313; clarifying advisory organization filing requirements in §5.9321 and §5.9334; formalizing the current practice of requesting that automobile insurance applications accompany the

underlying policy when filed in §5.9327; and providing specificity in §§5.9332, 5.9334, and 5.9342 on third-party data and model information in rate, rule, and underwriting guideline filings. In addition, proposed amendments in §§5.9310, 5.9321, 5.9323, 5.9332, and 5.9361 allow filers to use a SERFF tracking number in lieu of a TDI file number.

TDI anticipates that streamlining the filing process by formalizing these practices will result in time, effort, and cost savings for filing entities because it will decrease the necessity of follow-up by TDI staff during the review process. Currently, when TDI receives a filing that needs additional supporting information, or that must be resubmitted without password-protected or scanned documents, TDI staff must pause review of the filing and initiate correspondence with the filing entity. Ongoing dialogue regarding a filing is inefficient and delays the review process. Clearly specifying requirements in the FME Rules increases the likelihood of an efficient and timely review process. Submitting form filings in accordance with the requirements in proposed §5.9313 will also enable TDI to use its form review technology that relies on word recognition software. Using the technology helps TDI review filings more quickly and efficiently.

Filers may also save time and expense when preparing a filing because they can use a SERFF tracking number instead of a TDI file number. For some filers, the SERFF tracking number may be easier to find or maintain than the TDI file number.

TDI expects that proposed amendments in §5.9310 that permit a filing submitted for one line of insurance to also be used in multi-peril insurance will result in savings. Insurers that file for one line of insurance will not have to file again if they later decide to use the form in a multi-peril insurance product.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed amendments will not have an adverse economic impact on small or micro businesses, or on rural communities. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal results in a net savings for regulated entities. No additional rule amendments are required under Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT. Ms. Byckovski has determined that for each year of the first five years that the proposed amendments and new sections are in effect, the proposed rule:

- will not create or eliminate a government program;

- will not require the creation of new employee positions or the elimination of existing employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not require an increase or decrease in fees paid to the agency;

- will create a new regulation;

- will expand and limit existing regulations;

- will decrease the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on August 7, 2023. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a request before the end of the comment period to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030. The request for public hearing must be separate from any comments and received by the department no later than 5:00 p.m., central time, on August 7, 2023. If TDI holds a public hearing, TDI will consider comments both written and those presented at the hearing.

DIVISION 4. FILINGS MADE EASY - TRANSMITTAL INFORMATION AND GENERAL FILING REQUIREMENTS FOR PROPERTY AND CASUALTY FORM, RATE, UNDERWRITING GUIDELINE, AND CREDIT SCORING MODEL FILINGS

28 TAC §§5.9310, 5.9312, 5.9313

STATUTORY AUTHORITY. The amendments to §5.9310 and §5.9312 and new §5.9313 are proposed under Insurance Code §§36.002(1)(C), 36.002(1)(F), 36.002(2)(E), 2251.101, 2301.055, 559.004, and 36.001.

Insurance Code §36.002(1)(C) authorizes the commissioner to adopt reasonable rules that are necessary to effect the purposes of a provision of Insurance Code Chapter 2301, Subchapter A. Insurance Code §2301.001 states that the purpose of Insurance Code Chapter 2301, Subchapter A, includes regulating insurance forms to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive, and to provide regulatory procedures for the maintenance of appropriate information reporting systems.

Insurance Code §36.002(1)(F) authorizes the commissioner to adopt reasonable rules necessary to effect the purposes of a provision of Insurance Code Chapter 2251.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

Insurance Code §2251.101 provides that each insurer must file its rates, rating manuals, supplementary rating information, and additional information with TDI as required by the commissioner. It also provides that the commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

Insurance Code §2301.055 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 2301, Subchapter B.

Insurance Code §559.004 authorizes the commissioner to adopt rules necessary to implement Insurance Code Chapter 559.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9310 and §5.9312 and new §5.9313 implement Insurance Code §§38.002, 38.003, 559.151, 2052.002, 2053.003, 2053.034, 2171.003, 2251.101, 2301.001, 2301.006, 3502.101, and 3502.104.

§5.9310. Property and Casualty Transmittal Information and General Filing Requirements.

(a) Purpose. The purpose of this division is to specify the transmittal information and general filing requirements for property and casualty form, rate, [~~and~~] rule, underwriting guideline, and credit scoring model filings.

(b) Definitions. Terms not defined in this division may be defined in Insurance Code Chapters 2053, concerning Rates for Workers' Compensation Insurance; 2251, concerning Rates; and 2301, concerning Policy Forms and have the same meaning when used in this division. The following terms when used in this division have the following meanings unless the context indicates otherwise:

[~~(1) Dual filing--A filing submitted for one line of insurance that may also be used in multi-peril insurance.~~]

(1) [~~(2)~~] Interline filing--A filing that may be used for more than one line of insurance submitted for:

(A) a policy jacket, declarations page, signature page, notice of cancellation, disclosure, schedule, general change form, company name change, or policyholder notice filed under Division 5 of this subchapter, relating to Filings Made Easy - Requirements for Property and Casualty Policy Form and Endorsement Filings; or

(B) policy fees, service fees, and other fees that are charged or collected by the insurer under Insurance Code §550.001, concerning Solicitation or Collection of Certain Payments, or §4005.003, concerning Fees, filed under Division 6 of this subchapter (relating to Filings Made Easy - Requirements for Rate and Rule Filings).

(2) [~~(3)~~] Multi-peril insurance--Policies and rates for two or more lines of insurance that are subject to regulation under Insurance Code Chapters 2251 and 2301. This definition does not include a combination of coverages described in:

(A) Insurance Code §2251.002, concerning Definitions, and §2301.002, concerning Definitions, and filed as commercial property insurance; or[~~.~~]

(B) Insurance Code §2251.0031, concerning Exceptions for Certain Lines, and §2301.0031, concerning Exceptions for Certain Lines.

(3) [~~(4)~~] NAIC--The National Association of Insurance Commissioners.

(4) [~~(5)~~] Reference filing--A filing that references the use of policy forms, endorsements, rules, loss costs, rating manuals, other supplementary rating information, or credit scoring models that TDI has adopted, approved, or accepted.

(5) [~~(6)~~] SERFF--The NAIC System for Electronic Rate and Form Filing.

(6) [~~(7)~~] TDI--Texas Department of Insurance.

(7) [~~(8)~~] TDI file number--The number TDI assigns to a filing.

(c) Transmittal information. Each filing must contain the following transmittal information:

(1) company name as used for financial reporting to the NAIC and company number assigned by the NAIC;

(2) company group name and group NAIC number;

(3) whether the filing is new, or revises or replaces an existing filing;

(4) TDI file number or SERFF tracking number of the revised or replaced filing;

(5) TDI file number or SERFF tracking number for the previously approved policy that the proposed form will be attached to;

(6) TDI file number or SERFF tracking number of associated or companion filings of other filing types;

(7) line of insurance:

(A) all filings must specify the line of insurance; and

(B) interline filings must specify all lines of insurance to which the filing applies.[~~; and~~]

[~~(C) dual filings must indicate the line of insurance to which the filing applies and the TDI file numbers for the applicable monoline and multi-peril filings;~~]

(8) type of filing;

(9) proposed effective date; and

(10) contact person, including name, telephone number, and mailing address.

(d) Multi-peril use. A filing submitted for a line of insurance that is subject to regulation under Insurance Code Chapters 2251 and 2301 may also be used in multi-peril insurance.

(e) [~~(d)~~] Filings Made Easy Guide. TDI maintains the Filings Made Easy Guide to help insurers submit filings and comply with statutory requirements. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

(f) [~~(e)~~] Letter of authorization. A third-party representing an insurer on a filing must provide a letter of authorization signed by the insurer on the insurer's letterhead. A letter of authorization applies only to the filing with which it is submitted.

(g) [~~(f)~~] Submission of filing. Filings under Divisions 5, 6, 7, 8, and 9 of this subchapter (relating to Filings Made Easy - Requirements for Property and Casualty Policy Form and Endorsement Filings; Filings Made Easy - Requirements for Rate and Rule Filings; Filings Made Easy - Requirements for Underwriting Guideline Filings; Filings Made Easy - Requirements for Credit Scoring Model Filings for Personal Insurance; and Filings Made Easy - Reduced Filing Requirements for Certain Insurers) must be submitted through SERFF.

(h) [~~(g)~~] Public disclosure of contact information. To the extent that a filing includes company contact information, by submitting a filing the company affirmatively consents to the release and disclosure of its company contact information, including any email addresses. The filer also certifies that each person associated with an email address

that appears in the filing has affirmatively consented to the release and disclosure of that email address.

§5.9312. Personally Identifiable Information.

Filings must not include any policyholders' personally identifiable information. Filings that include this type of information may be rejected. As used in this subchapter, personally identifiable information means information that can be used either alone or in combination to distinguish an individual's identity. Examples of personally identifiable information include:

(1) any individual policyholder identification, including name, address, phone number, or email address;

(2) social security numbers;

(3) insurance policy numbers;

(4) drivers' license, identification card, vehicle identification, and license plate numbers;

(5) debit card, credit card, bank account, and routing numbers; and

(6) health information about a specific individual.

§5.9313. Filing Format Requirements.

(a) Documents included in filings may not be encrypted or password protected. TDI staff must be able to fully process and review the documents without a password or other decryption process.

(b) The policy forms, endorsements, and form usage tables submitted in a filing under Division 5 of this subchapter (relating to Filings Made Easy - Requirements for Property and Casualty Policy Form and Endorsement Filings) must:

(1) not be scanned documents;

(2) not include any scanned text, or scanned images with text, that will be part of the insurance contract;

(3) be in a format that is selectable and searchable; and

(4) be in portrait, not landscape, orientation.

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

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Texas Department of Insurance
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DIVISION 5. FILINGS MADE EASY - REQUIREMENTS FOR PROPERTY AND CASUALTY POLICY FORM AND ENDORSEMENT FILINGS

28 TAC §§5.9321, 5.9323, 5.9327

STATUTORY AUTHORITY. The amendments to §§5.9321, 5.9323, and 5.9327 are proposed under Insurance Code §§36.002(1)(C), 36.002(2)(E), 541.401, 2301.053, 2301.055, Article 5.35(f), 2051.201, and 36.001.

Insurance Code §36.002(1)(C) authorizes the commissioner to adopt reasonable rules that are necessary to effect the purposes of a provision of Insurance Code Chapter 2301, Subchapter A. Insurance Code §2301.001 states that the purpose of Insurance Code Chapter 2301, Subchapter A, includes regulating insurance forms to ensure that they are not unjust, unfair, inequitable, misleading, or deceptive, and to provide regulatory procedures for the maintenance of appropriate information reporting systems.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

Insurance Code §541.401 specifies that the commissioner may adopt and enforce reasonable rules the commissioner determines necessary to accomplish the purposes of Insurance Code Chapter 541. Insurance Code §541.001 states that the purpose of Insurance Code Chapter 541 is to regulate insurance trade practices by defining or providing for the determination of trade practices that are unfair methods of competition or unfair or deceptive acts or practices and prohibiting those trade practices.

Insurance Code §2301.053 provides that a form may not be used unless it is written in plain language.

Insurance Code §2301.055 provides that the commissioner may adopt reasonable and necessary rules to implement Insurance Code Chapter 2301, Subchapter B.

Insurance Code Article 5.35(f) specifies timelines for commissioner form and endorsement approval, and states that for good cause shown the commissioner may withdraw approval of a form or endorsement at any time.

Insurance Code §2051.201 authorizes the commissioner to adopt and enforce all reasonable rules necessary to carry out the provisions of a law referenced in Insurance Code §2051.002(1), (2), or (3).

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §§5.9321, 5.9323, and 5.9327 implement Insurance Code §§541.001, 2052.002, 2171.003, 2301.001, 2301.006, 2301.053, 2301.056, and 3502.104.

§5.9321. General Filing Requirements.

(a) Filings must be submitted for [~~only~~] one line of insurance only, except for multi-peril and interline filings.

(b) Filings submitted under this division may not be combined with any other filing types submitted under this subchapter.

(c) Filings must contain the following:

(1) the transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements);

(2) a copy of the proposed policy forms or endorsements;

(3) a form number for each proposed form;

(4) an edition date for each proposed form, if applicable;

(5) the TDI file number or SERFF tracking number for the previously approved policy to which the proposed form will be attached, if applicable;

(6) a form usage table that includes:

(A) the form name and form number for each proposed form;

(B) information indicating whether each proposed form is optional, mandatory, or conditional mandatory; and[. ~~For conditional mandatory forms, the filer must submit an addendum that describes the conditions that make each form mandatory. For filings other than personal automobile, residential property, or personal multi-peril, the filer may describe the conditions elsewhere in the filing; and~~]

(C) for conditional mandatory forms, an addendum to the form usage table describes the conditions that make each form mandatory. For filings other than personal automobile, residential property, or personal multi-peril, the filer may describe the conditions elsewhere in the filing;

(7) a memorandum that [~~contains~~]:

(A) explains in detail [~~a detailed explanation of~~] the reasons for the filing;

(B) describes each [~~a description of the~~] proposed policy form [~~forms~~] or endorsement [~~endorsements~~]; and

(C) details [~~an explanation of~~] each policy form or [~~and~~] endorsement's use, including [~~which may include for example,~~] the type of risk or risks for which the forms or endorsements will be used.

(d) Filings must also meet the following requirements.

(1) [~~(8)~~] Filings must include all [~~All~~] provisions required by statute, administrative rule, or Commissioner's order. Filers may add the required provisions to a policy form by including a Texas amendatory endorsement. The filing must include the amendatory endorsement, or the filing may reference an approved amendatory endorsement that applies to the policy forms in the filing.

(2) [~~(9)~~] For amended policy forms or endorsements, copies of the previously approved or adopted policy forms or endorsements indicating the differences between the approved or adopted policy forms or endorsements and the filed policy forms or endorsements must be included. New text must be underlined, and deleted text must be in brackets with a strikethrough. Alternatively, the changes can be indicated by other clearly identified or highlighted editorial notations referencing new and replaced text. The marked changes must be in a separate single document for each filed form.

~~[(10) For personal automobile and residential property insurance, a filing must meet the statutory requirements for plain language in policies required by Commissioner's Order No. 92-0573, or any superseding Commissioner's order. The filing must also include the Flesch Reading Ease Test readability score for the filed forms or endorsements.]~~

(e) Unless requested by TDI, filings made by advisory organizations do not need to include:

(1) the proposed effective date specified in §5.9310(c)(9) of this title; or

(2) the form usage table specified in subsection (c)(6) of this section.

§5.9323. Requirements for Reference Filings.

(a) Reference filings for policy forms and endorsements should not include a copy of the referenced material.

(b) In addition to the transmittal information, a reference filing must include:

(1) the name of the insurance company or advisory organization whose filing is being referenced; and

(2) the TDI file number or SERFF tracking number of the filing being referenced.

(c) For personal automobile, residential property, and personal multi-peril insurance, the filing must also include:

(1) a list of each form and endorsement that the insurer will use from each referenced filing; and

(2) a form usage table, as described in §5.9321(c)(6) of this title (relating to General Filing Requirements), that includes each form and endorsement that the insurer will use from each referenced filing.

(d) If a filer wants to change a form or endorsement approved for another insurer or an advisory organization, the filer may not submit the form as a reference filing. The filer must submit the amended form for approval with the information required by §5.9321 and §5.9322 of this title (relating to [~~General Filing Requirements and~~] Additional Information).

§5.9327. Additional Requirements for Personal Automobile and Residential Property [~~Declarations Page~~] Forms.

(a) Personal automobile and residential property insurance forms are subject to this subsection.

(1) Filed forms must meet the plain-language requirements described in Insurance Code §2301.053, concerning Requirements for Forms; Plain-Language Requirement; and Commissioner's Order No. 92-0573. Filings must also include the Flesch Reading Ease Test readability score for the forms.

(2) For policy forms filed on or after January 1, 2025:

(A) Amended policy forms must incorporate the provisions of all mandatory endorsement forms the insurer uses with the policy form at the time of filing. Amended policy forms must not have any mandatory endorsement forms at the time the policy form is approved.

(B) New policy forms must not have any mandatory endorsement forms at the time the policy form is filed and approved.

(C) Subject to subparagraphs (A) and (B) of this paragraph, an insurer may file mandatory endorsement forms in a filing that does not include the related policy form.

(3) When filing an endorsement form with provisions that do not apply to every policy to which the endorsement will be attached, the provisions must be enclosed with brackets to reflect that the provisions are variable text. The filing must also indicate that when the endorsement is attached to a policyholder's specific policy, the endorsement will not include any provisions that are inapplicable to that specific policy. For example, an insurer may file an endorsement with provisions that amend an HO-3 policy and an HO-5 policy. If certain provisions apply only to the HO-5, those must be bracketed in the filed form, and must not be visible to the policyholder when the form is used to endorse the HO-3. This paragraph applies to new or amended endorsements filed on or after January 1, 2025.

(b) [~~(a)~~] Insurers must file residential property [~~insurance~~] policy declarations page forms for approval [~~under this division~~].

(1) Declarations pages include renewal declarations pages, renewal certificates, amended declarations pages, and separate disclosure pages allowed under §5.9700 of this title (relating to Residential Property Declarations Pages and Deductible Disclosures).

(2) [~~(b)~~] Filed declarations page forms must be completed with sample--not actual--policyholder information sufficient to demonstrate how the insurer will comply with this rule and Insurance Code §2301.056, concerning Requirement for Forms; Declarations Page Requirement.

(c) Insurers must file personal automobile insurance application forms as follows:

(1) new or amended application forms that are part of the insurance policy must be filed for approval; and

(2) application forms that are not part of the insurance policy must be filed for informational purposes when an insurer files a new personal automobile policy form.

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

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Texas Department of Insurance
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DIVISION 6. FILINGS MADE EASY - REQUIREMENTS FOR RATE AND RULE FILINGS

28 TAC §5.9332, §5.9334

STATUTORY AUTHORITY. The amendments to §5.9332 and §5.9334 are proposed under Insurance Code §§36.002(1)(F), 36.002(2)(E), 912.056, 2251.101, and 36.001.

Insurance Code §36.002(1)(F) authorizes the commissioner to adopt reasonable rules necessary to effect the purposes of a provision of Insurance Code Chapter 2251.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

Insurance Code §912.056 provides that certain county mutual insurance companies that have appointed managing general agents, created districts, or organized local chapters to manage a portion of their business must, for each managing general agent, district, or local chapter program, file the rating information that the commissioner requires by rule.

Insurance Code §2251.101 provides that each insurer must file its rates, rating manuals, supplementary rating information, and additional information with TDI as required by the commissioner. It also provides that the commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9332 and §5.9334 implement Insurance Code §§912.056, 2053.003, 2053.034, 2251.101, 3502.101, and 3502.104.

§5.9332. Categories of Supporting Information.

The categories of supporting information addressed in this section describe the different items that may be required or requested in a rate and rule filing. Section 5.9334 of this title (relating to Requirements for Rate and Rule Filing Submissions) lists the categories of supporting information that different rate and rule filings require. Categories of supporting information include:

(1) Rate filing checklists. These are found in the Filings Made Easy Guide and show the information filers need to include with the filing.

(2) Actuarial memorandum. This memorandum describes the methodologies for determining each component used in developing the actuarial support, and a qualitative discussion on the selections for each component. It includes an explanation for any changes in methodologies or any changes to the component selections from the previous analysis.

(3) Actuarial support. This type of support consists of sufficient documentation and analysis to allow a qualified actuary to understand and evaluate the rates, each component used in developing the rates, and the appropriateness of each material assumption. Actuarial support is divided into the following subcategories:

(A) Rate indications consist of the analyses the insurer relies on to support its filed rates, each component used to develop the rate indications, and support for each of these components, including the data and methodologies used by the insurer. Rate indications may be on an overall basis or by coverage, class, form, or peril when appropriate. Rate indications must include each of the following with documentation in support of each, to the extent applicable:

(i) premiums, on-level factors, and premiums at current rate level;

(ii) incurred and paid losses;

(iii) loss and claim development factors;

(iv) premium and loss trend factors;

(v) hurricane and nonhurricane catastrophe factors or loss provisions, including the definition of a catastrophe and how the definition has changed over the experience period used to calculate the provisions;

(vi) off-balance factors if there are changes in relativities, for example: discounts, surcharges, or territorial definitions;

(vii) the measure of credibility, the complement of credibility, the criteria for full credibility, and the method for determining partial credibility;

(viii) expenses, including: general expenses; other acquisition expenses; commissions and brokerage expenses; taxes, licenses, and fees; loss adjustment expenses; and expense offsets from fee income;

(ix) the net cost of reinsurance;

(x) for rates filed under Insurance Code Chapter 2251, concerning Rates, profit provisions, including risk loads;

(xi) for rates filed under Insurance Code Chapters 2053, concerning Rates for Workers' Compensation Insurance, and

3502, concerning Mortgage Guaranty Insurance, profit and contingency provisions, including risk loads;

(xii) the effect on premiums of individual risk variations based on loss or expense considerations; and

(xiii) any other component used in developing a rate indication.

(B) Relativity analysis consists of both the analysis and support for the selected rating factors, including the loss experience and methodologies used by the insurer to derive the indicated rating factors. Supporting information must include:

(i) the current relativity;

(ii) the indicated relativity;

(iii) support for the indicated relativities, including the loss experience and methodologies used by the insurer to derive the indications;

(iv) the selected relativity;

(v) support for the selected relativities if they differ from the indicated relativities; and

(vi) the percent change from current to selected relativity.

(C) Other actuarial support consists of both the analysis and support for the selected rates, including the loss experience and methodologies used by the insurer to derive them. The support must clearly demonstrate why the proposed rates are not excessive, inadequate, or unfairly discriminatory. A rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer. These costs include claims, claim settlement expenses, operational and administrative expenses, and the cost of capital.

(4) SERFF rate data. This data consists of all information necessary to complete the company rate information fields in SERFF.

(5) Policyholder impact information. Policyholder impact information must reflect the changes for all policyholders. This information consists of the following provided separately by form or coverage:

(A) a histogram that graphically depicts the impact of the filed changes to policyholders in 5 percentage point intervals;

(B) the policy counts in each interval displayed in either the histogram or a separate table;

(C) the minimum and maximum policyholder impact; and

(D) a description of the changes that contributed to the minimum and maximum policyholder impact.

(6) Average rate change by county. This is the average impact of all changes included in a filing by county, provided separately by form or coverage.

(7) Rate change information. Rate change information must reflect the changes for all policyholders.

(A) For loss cost reference filings, rate change information consists of:

(i) the proposed percentage change in the underlying loss costs;

(ii) the change in the insurer's loss cost multiplier;

(iii) the combined change in the loss costs and the loss cost multipliers;

(iv) a six-year rate change history; and

(v) the effect that changes in fee income have on the total average rate change for all coverages and forms combined.

(B) For all other filings, rate change information consists of:

(i) the average proposed rate change for each applicable coverage or form;

(ii) the total average rate change for all applicable coverages and forms combined;

(iii) a six-year rate change history; and

(iv) the effect that changes in fee income have on the total average rate change for all applicable coverages and forms combined.

(8) Historical premium and loss information. This information consists of an insurer's most recent five-year experience, for both Texas and countrywide, of direct premiums written, direct premiums earned, direct losses and defense and cost containment expenses paid, direct losses and defense and cost containment expenses incurred, and the ratio of the direct losses and defense and cost containment expenses incurred to direct earned premiums. The Texas experience is the amounts, or a subset of the amounts, pertinent to the line of business reported on the Exhibit of Premiums and Losses (Statutory Page 14 Data) in the insurer's Annual Statement. The countrywide experience is the amounts, or a subset of the amounts, pertinent to the line reported on the insurer's Insurance Expense Exhibit (IEE), Part III in the insurer's Annual Statement.

(9) Expense information. This information consists of Texas experience and, if applicable, countrywide experience. The loss adjustment expenses must be shown as a dollar amount and as a ratio to incurred losses. All other expenses must be shown as a dollar amount and as a ratio to premium. All expense items must be on a direct basis.

(A) Three years of historical Texas experience must be included for commissions and brokerage expenses incurred; taxes, licenses, and fees incurred; losses incurred; and defense and cost containment expenses incurred. These must be the amounts, or a subset of the amounts, reported on the Exhibit of Premiums and Losses (Statutory Page 14 Data) in the insurer's Annual Statement.

(B) Three years of historical countrywide experience must be included for commissions and brokerage expenses incurred, other acquisition expenses incurred, general expenses incurred, losses incurred, defense and cost containment expenses incurred, and adjusting and other loss adjustment expenses incurred. These must be the amounts, or a subset of the amounts, reported in the insurer's IEE, Part III in the insurer's Annual Statement.

(C) Three years of historical countrywide experience must be included for each category of disallowed expenses. These must be the amounts reported in the insurer's response to the annual TDI Disallowed Expense Call. Other acquisition and general expenses, each adjusted to remove disallowed expenses, must be listed separately. The total adjusted general expense percentage must reflect any necessary adjustment due to the capping of general expenses at 110% [~~110 percent~~] of the industry median for the line of insurance.

(D) To the extent that the expense provisions differ from the historical expenses, the filing must provide additional support for the expense provisions underlying the rates. Provisions for commis-

sions and brokerage expenses; other acquisition expenses; general expenses; taxes, licenses, and fees; and profit and contingencies must be displayed and a sum computed. For filings submitted under Insurance Code Chapter 2251, the expense provisions must exclude disallowed expenses.

(E) When additional expense provisions are included, such as the net cost of reinsurance or an expense offset from fee income, the filing must include expected or historical experience. Support for provisions for the net cost of reinsurance may include reinsurance premiums, expected reinsurance recoverables, and a description of reinsurance coverage including attachment points and limits.

(10) Loss cost information for reference filings. This information consists of the following:

(A) the TDI file number or SERFF tracking number of the loss costs being referenced;

(B) the derivation of the proposed loss cost multiplier including any loss cost modification factor and the following expense and profit provisions:

(i) commissions and brokerage expenses;

(ii) other acquisition expenses, adjusted to remove disallowed expenses;

(iii) general expenses, adjusted to remove disallowed expenses;

(iv) taxes, licenses, and fees; and

(v) underwriting profit and contingencies;

(C) supporting documentation for loss cost modification factors other than 1.00;

(D) the loss cost multiplier to be used as of the effective date of the filing;

(E) the loss cost multiplier used immediately before the effective date of the filing; and

(F) the effective rate-level change due to any change in the loss cost multiplier.

(11) Profit provision information. This information consists of a description of the methodology, assumptions, and support for the assumptions used to arrive at the profit provisions underlying the proposed rates.

(12) A side-by-side comparison. This comparison must show any differences between the previously filed and the proposed rates, rating manual, rules, or other supplementary rating information.

(13) A mark-up [~~mark up~~]. This is a copy of the previously filed rates, rating manuals, rules, or other supplementary rating information indicating the differences between it and the revised version, with any new language or factors underlined and the deleted language or factors in brackets with a strikethrough, or other clearly identified or highlighted editorial notations referencing the new and replaced language or factors.

(14) Sample premium impacts by selected ZIP codes. These are sample premiums and premium changes based on all changes included in a filing for certain specified policy types and ZIP codes.

(15) Rate filing templates. These are found in the Filings Made Easy Guide and provide insurers with an optional means of providing certain supporting information and supplementary rating information.

(16) Third-party data information. For each third-party data set, this information consists of the following:

(A) the name of the data vendor or source;

(B) a description of the data, such as a data dictionary, that includes the name for each data element and the corresponding definition;

(C) a description of how the data is used in ratemaking or otherwise used to determine rates or premiums; and

(D) a list of the rating variables that reflect use of the data.

(17) Third-party model information. For each third-party model, this information consists of the following:

(A) the name of the model vendor or source;

(B) the model name and version number;

(C) a description of the model;

(D) a description of the model input;

(E) a description of how the model output is used in ratemaking or otherwise used to determine rates or premiums; and

(F) a list of the rating variables that depend on the output of the model.

(18) [~~(16)~~] Other information. This includes any other information required by the Commissioner necessary to determine that the rates meet the rate standards.

§5.9334. Requirements for Rate and Rule Filing Submissions.

(a) Insurers must file any new rates or revisions to previously filed rates governed by Insurance Code Chapter 2053, concerning Rates for Workers' Compensation Insurance, at least 30 days before they become effective. The insurer must file any supplementary rating information not prescribed under Insurance Code Article 5.96, concerning Promulgated Lines.

(b) For rates governed by Insurance Code Chapter 2251, concerning Rates, insurers must file any new rates, rating manuals, rules, all other supplementary rating information, and fees, or revisions to these items and all other information required by this section. An insurer may use the information filed under this division on and after the date of the filing, unless the insurer is subject to prior approval under Insurance Code Chapter 2251, Subchapter D, concerning Prior Approval of Rates Under Certain Circumstances.

(c) Insurers must file any new rates and supplementary rating information or revisions to previously filed rates and supplementary rating information governed by Insurance Code Chapter 3502, concerning Mortgage Guaranty Insurance, at least 15 days before they become effective.

(d) All rate and rule filings must be submitted for only one line of insurance except for multi-peril and interline filings.

(e) Each filing must include the transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements).

(f) Insurers must inform TDI of a change in the effective date of a rate and rule filing on or before the effective date in the filing.

(g) Each filing must include a filing memorandum that explains the purpose of the filing and provides all material background details relating to the filing, including a statement on the overall impact of the filing. The filing memorandum must briefly describe each change to the rates, rating manuals, rules, any other supplementary rat-

ing information and fees used by the insurer, and briefly describe the supporting information provided for each change. A brief summary of any related policy form or endorsement filings, including the coverages, limitations, and exclusions, must be included.

(h) Except as provided in Division 9 of this subchapter (relating to Filings Made Easy - Reduced Filing Requirements for Certain Insurers), or subsection (j) [~~(i)~~] of this section, each filing must include supporting information. Sufficient supporting information is necessary for TDI to establish that a filing produces rates that are not excessive, inadequate, unreasonable, or unfairly discriminatory for the risks to which they apply. Insurers must provide sufficient documentation to justify specific rates or revisions they are proposing. To the extent the information originally submitted in a rate and rule filing is insufficient, TDI may request additional information as deemed necessary by TDI or the Commissioner. Each filing must contain the following items:

(1) a completed rate filing checklist;

(2) rate change information;

(3) SERFF rate data;

(4) loss cost information, if the filing references an advisory organization loss cost filing;

(5) an actuarial memorandum;

(6) actuarial support appropriate to the rating information being filed, as specified in subparagraphs (A) - (C) of this paragraph:

(A) All filings that propose changes to relativities, such as territory or class, and those implied by discounts, surcharges, or tiers, must include relativity analyses. This requirement applies when the proposed rate changes vary across a characteristic, regardless of presentation. The related territory codes and descriptions, classification systems and descriptions, or rules must also be included.

(B) All except the following filings must include rate indications:

(i) filings for new rates that will not replace, modify, or supersede any existing rates, unless the rates are derived from the experience of an affiliate, including an eligible surplus lines insurer;

(ii) fee filings; or

(iii) filings containing changes only to supplementary rating information with no overall rate impact. Examples include filings with no overall rate impact that contain only items such as relativity changes or rates for endorsements.

(C) Filings must include other actuarial support when neither the relativity analysis in subparagraph (A) of this paragraph nor the rate indications in subparagraph (B) of this paragraph apply;

(7) policyholder impact information for owner-occupied homeowner and personal automobile filings that include changes that will result in a difference between the minimum and maximum policyholder impact that is greater than 5% [~~5 percent~~];

(8) the average rate change by county for owner-occupied homeowners rate filings;

(9) historical premium and loss information, if the filing changes or replaces existing rates;

(10) expense information; [~~and~~]

(11) profit provision information;[~~.~~]

(12) third-party data information; and

(13) third-party model information.

(i) Filings submitted by advisory organizations do not need to include:

(1) the proposed effective date as specified in §5.9310(c)(9) of this title;

(2) the written premium and policyholder information in the SERFF rate data as specified in subsection (h)(3) of this section;

(3) policyholder impact information as specified in subsection (h)(7) of this section;

(4) historical premium and loss information as specified in subsection (h)(9) of this section;

(5) expense information as specified in subsection (h)(10) of this section; or

(6) profit provision information as specified in subsection (h)(11) of this section.

(j) [~~(i)~~] Instead of the items in subsection (h) of this section, short track filings must include:

(1) a completed rate filing checklist;

(2) rate change information;

(3) SERFF rate data; and

(4) a side-by-side comparison or a mark-up [~~mark up~~], if applicable.

(k) [~~(j)~~] Each filing submitted must be legible, accurate, internally consistent, complete, and contain all required documents. In each filing:

(1) each table must be clearly labeled, including titles and column and row headings to clearly identify the contents;

(2) row and column headings must be repeated on each page of tables displayed on multiple pages;

(3) all pages must print to at least 10-point type [~~font~~] in black ink, unless the pages are a mark-up [~~mark up~~];

(4) text shading, other than yellow highlighting, may not be used; and

(5) each page should include a page number or other unique identifier.

(l) [~~(k)~~] Paragraphs (1) - (3) of this subsection address public information.

(1) If an insurer believes a portion of the information required to be filed under Insurance Code Chapter 2053 or Chapter 2251 is confidential and excepted from disclosure under Government Code Chapter 552, concerning Public Information, the insurer must mark each page excepted.

(2) For filings submitted under Insurance Code Chapters 2053 or 2251 that include information that is marked confidential, TDI will request an attorney general decision under Government Code Chapter 552 before making the information open for public inspection. TDI does not consider the following excepted from disclosure under Government Code Chapter 552: loss cost multipliers, rates, rating factors and relativities, rating manuals, fees, or summary information about the filing, including date filed, rate impact, effective dates, or a summary of the changes. TDI does not consider the following categories of supporting information excepted from disclosure under Government Code Chapter 552: rate change information, SERFF rate data, average rate change by county, sample premium impacts

by selected ZIP codes, historical premium and loss information, or historical expense information.

(3) Each filing submitted under Insurance Code Chapter 3502, including any supporting information filed, will be open for public inspection as of the date of the filing.

(m) [~~(l)~~] The insurer is responsible for ensuring that its filing complies with Texas statutes and rules.

(n) [~~(m)~~] TDI maintains the Filings Made Easy Guide to help insurers comply with Texas statutes and rules. Insurers may refer to the Filings Made Easy Guide for rate filing templates or exhibits that insurers can use to display necessary supporting information required in subsection (h) of this section. Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

(o) [~~(n)~~] Filings under this division may not be combined with any other filing types submitted under this subchapter.

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

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Jessica Barta
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Texas Department of Insurance
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DIVISION 7. FILINGS MADE EASY - REQUIREMENTS FOR UNDERWRITING GUIDELINE FILINGS

28 TAC §5.9342

STATUTORY AUTHORITY. The amendments to §5.9342 are proposed under Insurance Code §§36.002(2)(E), 38.002, 38.003, 2053.034, and 36.001.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

Insurance Code §38.002 requires each insurer writing personal automobile insurance or residential property insurance to file its underwriting guidelines with TDI and to ensure that the underwriting guidelines are sound, actuarially justified, substantially commensurate with the contemplated risk, and not unfairly discriminatory.

Insurance Code §38.003 provides that TDI may obtain a copy of the underwriting guidelines of an insurer for lines other than personal automobile insurance or residential property insurance.

Insurance Code §2053.034 provides that each insurer writing workers' compensation insurance must file with TDI a copy of its underwriting guidelines.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9342 implement Insurance Code §§38.002, 38.003, and 2053.034.

§5.9342. Filing Requirements.

(a) Not later than 10 days after use, an [~~An~~] insurer writing personal automobile, residential property, or workers' compensation insurance must file with TDI a comprehensive set of underwriting guidelines used by the insurer or its agent.[~~:~~]

[~~(1) at least once every three calendar years on or before March 1, beginning March 1, 2004, a written, comprehensive set of each underwriting guideline used by the insurer or the insurer's agent; and~~]

[~~(2) not later than the 10th day after the underwriting guideline has changed, a written update to the underwriting guideline clearly identifying each section of the previously filed underwriting guideline that has changed.~~]

(b) A filing made under subsection (a) of this section must contain:

(1) a comprehensive set of underwriting guidelines;

(2) a mark-up or redline version of the underwriting guidelines, clearly indicating any changes in the underwriting guidelines;

(3) for each third-party data set used in underwriting, the following information:

(A) the name of the data vendor or source;

(B) a description of the data, such as a data dictionary, that includes the name for each data element and the corresponding definition;

(C) a description of how the data is used in underwriting; and

(D) a list of the underwriting guidelines that reflect use of the data; and

(4) for each third-party model used in underwriting, the following information:

(A) the name of the model vendor or source;

(B) the model name and version number;

(C) a description of the model;

(D) a description of the model input;

(E) a description of how the model output is used in underwriting; and

(F) a list of the underwriting guidelines that depend on the output of the model.

(c) Filings must clearly indicate any changes in the underwriting guidelines resulting from the change in third-party data and modeling information. No filing is necessary for a change in third-party data and modeling information that does not result in a change to underwriting guidelines.

(d) [~~(b)~~] For purposes of compliance with this section, an oral or electronic underwriting guideline must be converted to written form.

(e) [~~(c)~~] An insurer group or group of affiliated insurers may file one set of underwriting guidelines [~~or update to underwriting guidelines~~] on behalf of individual insurers in the group under the requirements of this section if the group clearly identifies which underwriting guidelines apply to each insurer within the group.

(f) [(d)] An insurer that files underwriting guidelines [or updates to underwriting guidelines] under this section must submit the filing transmittal information required in §5.9310 of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements) with each underwriting guideline filing.

(g) [(e)] All filings for underwriting guidelines must relate to only one line of insurance.

(h) [(f)] Underwriting guidelines contemplated by Insurance Code §38.003, concerning Underwriting Guidelines for Other Lines; Confidentiality, other than workers' compensation insurance, are required only if requested. Underwriting guidelines submitted in response to a request under Insurance Code §38.003 must be filed in compliance with subsections (d), (e), and (f) [(b), (c), and (d)] of this section.

(i) [(g)] Filings under this division may not be combined with any other filings submitted under this subchapter.

(j) [(h)] Information used to classify risks for the purpose of determining a rate must be filed under Division 6 of this title (relating to Filings Made Easy--Requirements for Rate and Rule Filings), even if the information is included in an underwriting guideline filing under this division.

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

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DIVISION 9. FILINGS MADE EASY - REDUCED FILING REQUIREMENTS FOR CERTAIN RESIDENTIAL PROPERTY INSURERS

28 TAC §5.9355, §5.9357

STATUTORY AUTHORITY. The amendments to §5.9355 and §5.9357 are proposed under Insurance Code §§36.002(1)(F), 36.002(2)(E), and 36.001.

Insurance Code §36.002(1)(F) authorizes the commissioner to adopt reasonable rules necessary to effect the purposes of a provision of Insurance Code Chapters 2251.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9355 and §5.9357 implement Insurance Code §2251.252.

§5.9355. Purpose.

The purpose of this division is to specify requirements for certain insurers who qualify for reduced rate filing requirements under the provisions of Insurance Code Chapter 2251, Subchapter F, concerning Exemptions for Certain Insurers from Rate Filing and Approval Requirements. [Subchapters C or F.]

§5.9357. Filing Requirements.

(a) Insurers writing residential property in underserved areas that may qualify under Insurance Code Chapter 2251, Subchapter F, concerning Exemptions for Certain Insurers from Rate Filing and Approval Requirements, must submit rate and rule filings in compliance with this subsection and with all provisions of §5.9334 (relating to Requirements for Rate and Rule Filing Submissions) not listed in paragraph (2) of this subsection. If TDI determines that an insurer is not exempted under Insurance Code §2251.252(a), concerning Exemption from Certain Other Law, the insurer must file in compliance with Division 6 of this subchapter (relating to Filings Made Easy - Requirements for Rate and Rule Filings).

(1) Insurers must include a form meeting the elements in subparagraphs (A) and (B) of this paragraph. The Certification of §2251.251 and §2251.252 Exemption Compliance (EC-1) Form, found in the Filings Made Easy Guide, may be used to satisfy these requirements.

(A) The form must include the following statement: "{Insurance company name} certifies to the Texas Department of Insurance that the insurance company meets the requirements of Insurance Code Sections 2251.251 and 2251.252 and qualifies for the reduced filing requirements of 28 Texas Administrative Code Section 5.9357."

(B) The form must be dated and include the name, signature, and title of the insurance company representative certifying the statement.

(2) Insurers exempted under Insurance Code §2251.252(a) are not required to file the supporting information described in §5.9334(h)(5), (6), (9), (10), (11), (12), and (13) of this title.

[(a) Insurers writing personal automobile insurance. Insurers required to file under the provisions of Insurance Code Chapter 2251 may make rate and rule filings for personal automobile insurance according to the requirements described in this subsection if they meet the criteria under Insurance Code §2251.1025(a). Insurers that qualify to file under this subsection must file in compliance with Division 6 of this subchapter (relating to Filings Made Easy - Requirements for Rate and Rule Filings) with the following modifications:]

[(1) Insurers must include a Certification of §2251.1025 Exemption Compliance (EC-2), found in the Filings Made Easy Guide, with each filing.]

[(2) Insurers are not required to file supporting information described in §5.9334(h)(5), (6), (9), (10), and (11) of this title (relating to Requirements for Rate and Rule Filing Submissions), unless requested.]

[(b) Insurers writing residential property in underserved areas. In compliance with Insurance Code §2251.252(c), insurers otherwise exempt from the rate and rule filing requirements of Chapter 2251 must submit rate and rule filings in compliance with this subsection. Insurers who qualify to file under this subsection must file in compliance with Division 6 of this subchapter:]

[(1) Insurers must include a Certification of §2251.251 and §2251.252 Exemption Compliance (EC-1), found in the Filings Made Easy Guide.]

[(2) Insurers are not required to file supporting information described in §5.9334(h)(5), (6), (9), (10), and (11) of this title, unless requested.]

[(c) Additional provisions. The following provisions apply to any rate and rule filing submitted under subsection (a) or (b) of this section:]

(b) [(1)] The reduced rate and rule filing requirements provided under this division do not affect the requirements under §5.9941 of this title (relating to Differences in Rates Charged Due Solely to Difference in Credit Scores) and §5.9960 of this title (relating to Exception to Rating Territory Requirements under §2253.001 of the Insurance Code).

[(2) Requests for additional information are as outlined in §5.9335 of this title (relating to Requests for Information).]

(c) [(d)] [Filings Made Easy Guide.] TDI maintains the Filings Made Easy Guide to help insurers comply with Texas statutes and rules. [Insurers may refer to the Filings Made Easy Guide for the Certification of §2251.251 and §2251.252 Exemption Compliance (EC-1) form referenced in subsection (b)(1) of this section and the Certification of §2251.1025 Exemption Compliance (EC-2) form referenced in subsection (a)(1) of this section.] Insurers may obtain this guide from TDI's website at www.tdi.texas.gov.

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

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DIVISION 10. FILINGS MADE EASY - ADDITIONAL FILING REQUIREMENTS FOR CERTAIN COUNTY MUTUAL INSURANCE COMPANIES

28 TAC §5.9361

STATUTORY AUTHORITY. The amendments to §5.9361 are proposed under Insurance Code §§36.002(1)(F), 36.002(2)(E), 912.056, 2251.101, and 36.001.

Insurance Code §36.002(1)(F) authorizes the commissioner to adopt reasonable rules necessary to effect the purposes of a provision of Insurance Code Chapters 2251.

Insurance Code §36.002(2)(E) authorizes the commissioner to adopt reasonable rules appropriate to accomplish the purposes of a provision of Subtitles B, C, D, E, F, H, or I of Title 10 of the Insurance Code.

Insurance Code §912.056 requires that certain county mutual insurance companies that have appointed managing general agents, created districts, or organized local chapters to manage a portion of their business must, for each managing general agent, district, or local chapter program, file the rating information that the commissioner requires by rule.

Insurance Code §2251.101 requires that each insurer must file its rates, rating manuals, supplementary rating information, and additional information with TDI as required by the commissioner. It also requires that the commissioner adopt rules on the information to be included in rate filings and prescribe the process by which TDI may request supplementary rating information and supporting information.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9361 implement Insurance Code §912.056 and §2251.101.

§5.9361. Additional Requirements.

(a) Filing transmittal. In addition to the information required by Division 4 of this subchapter (relating to Filings Made Easy--Transmittal Information and General Filing Requirements for Property and Casualty Form, Rate and Rule, Underwriting Guideline, and Credit Scoring Model Filings), the following information must be included:

(1) the name and license number of the managing general agent, district, or local chapter of a county mutual insurance company; and

(2) contact information for the county mutual insurance company, if the county mutual insurance company's contact information has not already been provided under §5.9310(c)(10) of this title (relating to Property and Casualty Transmittal Information and General Filing Requirements).

(b) Rate and rule filings.

(1) All rate and rule filings must be made directly by the county mutual insurance company on the county mutual insurance company's letterhead, unless the county mutual insurance company submits written notice with the filing authorizing the submission of rate filings by the managing general agent, district, or local chapter.

(2) Each rate and rule filing must include:

(A) all information required under §5.9334 of this title (relating to Requirements for Rate and Rule Filing Submissions), which must be specific to the managing general agent, district, or local chapter; and

(B) a list of policy forms and endorsements, including their name, number, and the TDI file number or SERFF tracking number, used by the managing general agent, district, or local chapter. The submission of a list of policy forms and endorsements under this subsection does not constitute a form filing under Insurance Code Chapter 2301, concerning Policy Forms.

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

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DIVISION 11. FILINGS MADE EASY - CERTIFICATES OF PROPERTY AND CASUALTY INSURANCE

28 TAC §5.9372, §5.9373

STATUTORY AUTHORITY. The amendments to §5.9372 and §5.9373 are proposed under Insurance Code §1811.003 and §36.001.

Insurance Code §1811.003 allows the commissioner to adopt rules necessary or proper to accomplish the purposes of Insurance Code Chapter 1811.

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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §5.9372 and §5.9373 implement Insurance Code §§1811.052, 1811.053, and 1811.101.

§5.9372. Preparation and Submission of Certificate of Insurance Form Filings.

(a) Approval required. A certificate of insurance issued on property or casualty operations or a risk located in Texas, regardless of where the certificate holder, policyholder, insurer, or agent is located, must be on a form that has been filed and approved before use.

(b) Filing content. All filings for new or amended certificate of insurance forms submitted under Insurance Code Chapter 1811, concerning Certificates of Property and Casualty Insurance, must comply with the filing requirements in this division, any other applicable rules the Commissioner has adopted, and any applicable Commissioner's orders.

(1) All filings must contain transmittal information as required by §5.9373 of this title (relating to Certificate of Insurance Form Filing Transmittal Information).

(2) All filings must contain a copy of the subject certificate of insurance form. For identification purposes, the certificate of insurance must contain a form number and edition date.

(c) Combined filings. Do not combine a certificate of insurance form filing with any other filing types.

(d) Filing submission.

(1) TDI will accept a filing required under this division:

(A) by mail;

(B) by hand delivery;

(C) by email; or

(D) through SERFF.

(2) Mailing addresses and other contact information are available on the Property and Casualty Certificates of Insurance web page on TDI's website.

[~~(1) TDI will accept a filing required under this division by mail. Send filings to the Texas Department of Insurance, Property and Casualty Filings Intake, Mail Code 104-3B, P.O. Box 149104, Austin, Texas 78714-9104.~~]

[~~(2) TDI will accept a filing required under this division if it is hand delivered. Bring filings to the Texas Department of Insurance, Customer Service Center, William P. Hobby Jr. State Office Building, 333 Guadalupe St., Tower 1, Room 103, Austin, Texas 78701.~~]

[~~(3) TDI will accept a filing required under this division that is submitted electronically, whether by email to PCFilingsIntake@tdi.texas.gov or through SERFF.~~]

(3) [~~(4)~~] TDI will not collect a filing fee for a certificate of insurance filing.

(e) Public inspection of filing.

(1) A certificate of insurance form and any supporting information filed with TDI under this division is open to public inspection as of the date of the filing.

(2) To the extent that a filing includes company contact information, the company affirmatively consents to the release and disclosure of its company contact information, including any email addresses.

§5.9373. Certificate of Insurance Form Filing Transmittal Information.

(a) Required information. The filing transmittal information must be typed and must contain, at a minimum, the following:

(1) company name;

(2) NAIC number if the filing is submitted by an insurer;

(3) FEIN if the filing is submitted by an entity other than an insurer or agent; and

(4) contact person, including name, telephone number, mailing address, fax number, and email address (if available).

(b) Transmittal information format.

(1) The Certificate of Insurance Form Filing Transmittal Form is available on TDI's website at www.tdi.texas.gov [~~or by request to the Texas Department of Insurance, Property and Casualty Filings Intake, Mail Code 104-3B, P.O. Box 149104, Austin, Texas 78714-9104~~].

(2) Filers may submit transmittal information in a format other than the form provided by TDI if the information included in the transmittal form, or in an addendum to the transmittal form, contains all the information required under subsection (a) of this section.

(c) SERFF filings. Persons filing through SERFF must follow existing procedures for SERFF filings.

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

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 7. TEXAS COMMISSION ON LAW ENFORCEMENT

CHAPTER 211. ADMINISTRATION

37 TAC §211.36

The Texas Commission on Law Enforcement (Commission) proposes new 37 Texas Administrative Code Chapter 211, §211.36, concerning Advisory Committee Operations and Procedures. This new rule conforms with Texas Occupations Code § 1701.165.

Mr. John P. Beauchamp, Interim Executive Director, has determined that for each year of the first five years the section as proposed will be in effect, there will be no effect on state or local governments as a result of administering this section.

Mr. Beauchamp has determined that for each year of the first five years the section as proposed will be in effect, there will be a positive benefit to the public by conforming with Texas Occupations Code § 1701.165.

Mr. Beauchamp has determined that for each year of the first five years the section as proposed will be in effect, there will be no anticipated cost to small businesses, microbusinesses, and/or individuals as a result of the proposed section.

Mr. Beauchamp has determined the following:

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

(2) implementation of the proposed rule requires the creation of new employee positions or the elimination of existing employee positions;

(3) implementation of the proposed rule requires an increase or decrease in future legislative appropriations to the agency;

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

(5) the proposed rule does not create a new regulation;

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

(7) the proposed rule does not increase or decrease the number of individuals subject to the rule's applicability;

(8) the proposed rule does not positively or adversely affect this state's economy.

The Commission will accept comments regarding the proposal. The comment period will last 30 days following the publication of this proposal in the *Texas Register.* Comments may be submitted electronically to public.comment@tcole.texas.gov or in writing to Mr. John P. Beauchamp, Interim Executive Director, Texas Commission on Law Enforcement, 6330 E. Highway 290, Suite 200, Austin, Texas 78723-1035.

The new rule is proposed under Texas Occupations Code §§ 1701.151, General Powers of the Commission; Rulemaking Authority; 1701.165, Advisory Committees and Texas Government Code § 2001.028, Notice of Proposed Law Enforcement Rules.

The new rule as proposed is in compliance with Texas Occupations Code §§ 1701.151, General Powers of the Commission; Rulemaking Authority; 1701.165, Advisory Committees and Texas Government Code, § 2001.028, Notice of Proposed Law Enforcement Rules.

No other code, article, or statute is affected by this proposal.

§211.36. Advisory Committee Operations and Procedures.

(a) Role of advisory committee. The role of an advisory committee is to provide advice and recommendations to the commission. Advisory committees shall meet and carry out their functions upon a request from the commission for advice and recommendations on an issue.

(b) Appointment of advisory committee. The commission shall appoint members to an advisory committee. Each advisory committee shall elect from its members a presiding officer, or may be appointed by the commission's presiding officer, who shall report the advisory committee's recommendations to the commission. The executive director may designate a staff member to participate with, or to provide subject-matter expertise, guidance, or administrative support to the advisory committee as necessary. Any commission staff assigned to an advisory committee shall be non-voting members.

(c) Member qualifications. Members shall have knowledge about and interests in, and represent a broad range of viewpoints about, the work of the committee or applicable divisions and meet the enrollment and appointment requirements and qualifications for licenses under Texas Occupations Code Chapter 1701 and 37 Texas Administrative Code Chapters 211-229. Currently appointed Commission members shall not serve as advisory committee members.

(d) Composition of advisory committees. In making appointments to the advisory committees, the commission shall, to the extent practical, ensure representation of members from the public, agencies, organizations, and geographical regions of the state who have an interest or expertise in the subject area of the particular advisory committee.

(e) Committee size and quorum requirements. An advisory committee shall be composed of a reasonable number of members not to exceed 12 as determined by the commission. A simple majority of advisory committee members will constitute a quorum. An advisory committee may only deliberate on issues within the jurisdiction of the committee or any public business when a quorum is present.

(f) Terms of service. Advisory committee members may serve terms of four years or as otherwise designated by the commission. A member will serve on the committee until the member resigns, is dismissed or replaced by the commission, or the member's term expires.

(g) Member training requirements. Each member of an advisory committee must receive training regarding the Open Meetings Act, Government Code, Chapter 551 and the Public Information Act, Government Code, Chapter 552.

(h) Compliance with Open Meetings Act. The advisory committee shall comply with the Open Meetings Act, Government Code, Chapter 551.

(i) Conflict of Interest. Advisory committee members are subject to the same laws and policies governing ethical standards of conduct as those for commission members and employees.

(j) Public input and participation. Advisory committees shall accept public comments made in-person at advisory committee meetings or submitted in writing in advance of the advisory committee meeting with sufficient copies for all members.

(k) Reporting recommendations. Recommendations of the advisory committee shall be reported to the commission at a commission meeting prior to commission action on issues related to the recommendations. The recommendations shall be in writing and include any necessary supporting materials. The presiding officer of the advisory committee or the presiding officer's designee may appear before the commission to present the committee's advice and recommendations. This subsection does not limit the ability of the advisory committee to provide advice and recommendations to the executive director as necessary.

(l) Commission use of advisory committee recommendations. In developing commission policies, the commission shall consider the written recommendations and reports submitted by advisory committees.

(m) Reimbursement. The department may, if authorized by law and the executive director, reimburse advisory committee members for reasonable and necessary travel expenses.

(n) Expiration dates for advisory committees. Unless a different expiration date is established by the commission for the advisory committee, each advisory committee is abolished on the fourth anniversary of its creation by the commission.

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

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