PROPOSED RULES

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

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to Texas Administrative Code Title 1, Chapter 355, Subchapter A, §355.102 and §355.105; Subchapter C, §355.318; Subchapter D, §355.456; Subchapter E, §§355.503, 355.505, 355.507, 355.509, and 355.513; Subchapter F, §355.723; Subchapter G, §355.5902 and §355.6907; Subchapter H, §355.7051; Subchapter M, §355.9090; new rules in Subchapter C, §355.305; and Subchapter H, §355.7052; and the repeals in Subchapter A, §355.112; Subchapter C, §§355.304; 355.306 - 355.308; and 355.320; Subchapter D, §355.457; and Subchapter F, §355.722.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement the 2026-27 General Appropriations Act (GAA), Senate Bill (S.B.) 1, 89th Legislature, Regular Session, 2025 (Article II, Health and Human Services Commission, Rider 23 and Rider 25, respectively) and Senate Bill 457 (S.B. 457), 89th Legislature, Regular Session, 2025. The proposal amends and repeals existing rules and creates new rules that address the following topics.

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

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

The proposal amends §355.105, General Reporting and Documentation Requirements, Methods, and Procedures, to update the language so that cost reports must be completed every state fiscal year and removes the mention of the Internal Revenue Service fiscal year in cost reporting. The proposal specifies how related party attendant staff costs will be limited in the rate methodology for programs with attendant services. The proposal repeals §355.457, Cost Finding Methodology, because the amendment of §355.105 makes this rule obsolete. The proposal repeals §355.722, Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers, because the amendment of §355.105 makes this rule obsolete.

The proposal repeals §355.112, Attendant Compensation Rate Enhancement, to implement a requirement of Rider 23. The proposal creates new rule §355.7052, Reimbursement Methodology for Determining Attendant Cost Component, to establish the rate methodology for the attendant cost rate component, which currently exists in §355.112.

The proposal amends §355.456, Reimbursement Methodology; §355.503, Reimbursement Methodology for Long-Term Services and Supports State Plan and Home and Community-Based Services Waiver Program Services Delivered through the STAR+PLUS Managed Care Program; §355.505, Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program; §355.507, Reimbursement Methodology for Long-Term Services and Supports State Plan and Medically Dependent Children Waiver Program Services Delivered through the STAR Kids and STAR Health Managed Care Programs; §355.509, Reimbursement Methodology for Residential Care; §355.513, Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program; §355.723, Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs; §355.5902, Reimbursement Methodology for Primary Home Care; and §355.6907, Reimbursement Methodology for Day Activity and Health Services; to replace references to §355.112, which is being repealed by this proposal, with proposed new rule §355.7052. The proposal amends §355.9090, Reimbursement Methodology for Community First Choice, to add a reference to proposed new §355.7052. The proposal amends §355.7051, concerning Base Wage for Personal Attendant, to update the rule title to reflect that this rule will expire on August 31, 2025.

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

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

The proposal repeals §355.304, Direct Care Staff Spending Requirement on or after September 1, 2023, to implement S.B. 457. The proposal adds new §355.305, Annual Patient Care Expense Ratio for Nursing Facilities, to implement the requirement of S.B.

457. The proposal repeals §355.306, Cost Finding Methodology before September 1, 2025, and §355.307, Reimbursement Setting Methodology before September 1, 2025, because the amendment of §355.318 makes these rules obsolete.

The proposal amends §355.318, Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025, to implement S.B. 457. The proposal repeals §355.308, concerning Direct Care Staff Rate Component before September 1, 2025, and §355.320, Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025, to implement S.B 457. This bill discontinues the Nursing Care Staff Rate Enhancement Program for Nursing Facilities.

3. The proposal revises cost report training requirements.

The proposal amends §355.102, General Principles of Allowable and Unallowable Costs, to update the language for the cost report training requirements.

SECTION-BY-SECTION SUMMARY

Editorial revisions are made throughout the rules to update formatting, organization, punctuation, and references.

The proposed amendment to §355.102(d) clarifies training requirements for cost report submission. Cost report preparers must complete a required state-sponsored training for each program in which a cost report is required. The training applies to any required reports for that program during the following cost report collection period. The proposed amendment also enables HHSC to require that a contracted provider's primary entity or financial contacts complete state-sponsored training to certify and submit a cost report. The training would apply to the submission of any other reports in the following calendar year. The proposed amendment also deletes references to accountability reports.

The proposed amendment to §355.105(b) requires that contracted providers' cost reporting period aligns with the state fiscal year. The proposed amendment also deletes references to the Attendant Compensation Rate Enhancement program and the Direct Care Staff Enhancement program. The proposed amendment to §355.105(i) limits related party attendant staff costs to calculate the methodological attendant cost rate component for programs with attendant services.

The proposal repeals §355.112 because the Attendant Compensation Rate Enhancement Program is being discontinued effective September 1, 2025. The proposal repeals §355.304, §355.306, §355.307, §355.308, and §355.320 because these requirements no longer apply to reimbursement of nursing facilities effective September 1, 2025.

The proposed new §355.305(a) introduces the new annual patient expense ratio for nursing facilities effective September 1, 2025. Subsection (b) defines terms used in the rule. Subsection (c) requires that nursing facilities must submit annual cost reports to HHSC. Subsections (d) and (e) establish how HHSC will calculate the annual expense ratio and determine recoupments for nursing facility providers who fail to meet spending requirements. Subsection (f) establishes criteria to exclude nursing facility providers from recoupment for failing to meet spending requirements under subsection (e). Subsection (g) establishes how HHSC will notify nursing facility providers regarding the annual patient expense ratio. Subsection (h) confirms that this section does not apply to state-owned facilities.

The proposed amendment to §355.318(d) clarifies how HHSC defines the nursing, Brief Interview for Mental Status (BIMS), and non-therapy ancillary rate components. The proposal also replaces the non-case-mix rate component with new rate components for dietary costs, operations costs, administration costs, and fixed capital assets costs. The amendment to subsection (e) establishes how HHSC calculates the new dietary, operations, administration, and fixed capital assets rate components. The amendment to subsection (g) replaces the reference to the non-case-mix component with the administration rate component. A reference to the new §355.321, which is also proposed in this issue, Reimbursement Methodology for Intellectual and Developmental Disabilities Nursing Facilities Special Reimbursement Class, is added to subsection (h). New subsection (k) establishes how the Medicaid Swing Bed Program for Rural Hospitals will be reimbursed under this section.

The proposed amendment to §355.456(d) replaces references to §355.112 with proposed new §355.7052 and deletes references to §355.320 and replaces it with §355.318. The proposed amendment deletes current subsection (d)(6) related to the High Medical Needs Add-on reimbursement rate before September 1, 2025.

The proposed repeal of §355.457 deletes the rule as it is no longer necessary because the rule is superseded by the amendment of §355.105.

The proposed amendment to §355.503(c) replaces references to §355.112 with proposed new §355.7052 and replaces references to §355.509(c)(2)(E)(iii) with reference to §355.509(c)(2).

The proposed amendment to §355.505(b) replaces references to the "Department of Aging and Disability Services (DADS)" with "the Texas Health and Human Services Commission (HHSC)" and replaces references to §355.112 with proposed new §355.7052 in subsection (c) and deletes information about the attendant compensation rate enhancement in §355.505(b)(2)(A).

The proposed amendment to §355.507(c) replaces references to §355.112 with new §355.7052.

The proposed amendment to §355.509(c) replaces references to §355.112 with proposed new §355.7052. The proposed amendment to subsection (d) replaces a reference to "DADS" with "HHSC."

The proposed amendment to §355.513(c) replaces references to §355.112 with proposed new §355.7052.

The title of Subchapter F, Reimbursement Methodology for Programs Serving Persons with Mental Illness or Intellectual or Developmental Disability, is changed to "Reimbursement Methodology for Programs Serving Persons with an Intellectual or Developmental Disability."

The proposed repeal of §355.722 deletes the rule as it is no longer necessary because the rule is superseded by the amendment of §355.105.

The proposed amendment to §355.723(c) replaces references to §355.112 with proposed new §355.7052 and deletes a reference to §355.722 and replaces it with §355.102.

The proposed amendment to §355.5902(c) replaces references to §355.112 with proposed new §355.7052.

The proposed amendment to §355.6907(a) and subsection (h) replaces a reference to "Department of Aging and Disability Services (DADS)" with "Texas Health and Human Services Commis-

sion (HHSC)." The amendment of subsection (f) replaces references to §355.112 with proposed new §355.7052.

The title of Subchapter H, "Base Wage Requirements for Personal Attendant" is changed to "Attendant Cost Determination."

The proposed amendment to §355.7051 retitles the rule to "Base Wage for a Personal Attendant before September 1, 2025" to establish that the rule applies before September 1, 2025.

Proposed new §355.7052(a) introduces the rate methodology for the attendant cost component. Subsection (b) defines terms used in the rule. Subsection (c) establishes the attendant cost center. Subsection (d) lists the programs and services that apply to this section. Subsection (e) establishes how HHSC will calculate the attendant cost component for the applicable programs and services. Subsection (f) establishes how HHSC will calculate the attendant cost component for services delivered through the Consumer Directed Services (CDS) option. Subsection (g) specifies that the attendant cost component is limited to available appropriations.

The proposed amendment to §355.9090(b) revises how the Community First Choice- State Plan Attendant and Habilitation rate is calculated by defining an attendant rate component and an administration and operations rate component.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the repeals, amendments, and new rules will be in effect, there will be an estimated additional cost to state government as a result of enforcing and administering the repeals, amendments, and new rules as proposed. Enforcing or administering the repeals, amendments, and new 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 repeals, amendments, and new rules are in effect is an estimated cost of $575,361,762 in General Revenue (GR) ($1,447,861,789 All Funds (AF)) in fiscal year (FY) 2026; $604,733,115 GR ($1,521,684,159 AF) in FY 2027; $618,177,712 GR ($1,555,428,422 AF) in FY 2028; $633,296,065 GR ($1,599,476,655 AF) in FY 2029; and $651,545,393 GR ($1,645,496,096 AF) in FY 2030. 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 repeals, amendments, and new rules will be in effect:

(1) the proposed repeals, amendments, and new rules will create or eliminate a government program;

(2) implementation of the proposed repeals, amendments, and new rules will not affect the number of HHSC employee positions;

(3) implementation of the proposed repeals, amendments, and new rules will not result in an assumed change in future legislative appropriations;

(4) the proposed repeals, amendments, and new rules will not affect fees paid to HHSC;

(5) the proposed repeals, amendments, and new rules will create a new regulation;

(6) the proposed repeals, amendments, and new rules will expand, limit and repeal existing regulations;

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

(8) HHSC has insufficient information to determine the proposal's effect on the state's economy.

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

Trey Wood has also determined that there could be adverse economic effects on small businesses, micro-businesses, or rural communities. The repeals, amendments, and new rules may impose additional costs on small businesses, micro-businesses, or rural communities. However, these costs may be offset by the rate increases provided. HHSC lacks sufficient information to provide an estimate of the economic impact.

LOCAL EMPLOYMENT IMPACT

The proposed repeals, amendments, and new 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 Provider Finance, has determined that for each year of the first five years the repeals, amendments, and new rules are in effect, the public benefit will be the reduced administrative burden on providers participating in the Attendant Compensation Rate Enhancement Program and a stabilized attendant and direct care workforce for community care providers and nursing facilities.

Trey Wood has also determined that for the first five years the repeals, amendments, and new rules are in effect, there may be anticipated economic costs to persons who are required to comply with the proposed repeals, amendments, and new rules. Rate increases are anticipated to offset any economic costs to comply with the repeals, amendments, and new 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 HEARING

A public hearing to receive comments on the proposal will be held via GoTo Webinar on July 25, 2025, from 9:00 a.m. to 12:00 p.m Central Daylight Time. The hearing will be conducted as an online event only. Details will be posted on the HHS Meetings and Events website at https://www.hhs.texas.gov/about/meetings-events.

Please contact the HHSC Provider Finance Department Long-Term Services and Supports at PFD-LTSS@hhs.texas.gov or (737) 867-7817, if you have questions.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin,

Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@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 25R039" in the subject line.

SUBCHAPTER A. COST DETERMINATION PROCESS

1 TAC §355.102, §355.105

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.102. General Principles of Allowable and Unallowable Costs.

(a) - (c) (No change.)

(d) Cost and accountability report training. It is the responsibility of the provider to ensure that each cost or accountability report preparer has completed the required state-sponsored training. Preparers may be employees of the provider or persons who have been contracted by the provider for the purpose of cost [~~or accountability~~] report preparation. Preparers must complete training for each program for which a cost [~~or accountability~~] report is submitted, as applicable. Contracted preparer's fees to complete training are considered allowable expenses for cost reporting purposes. Preparers that participate in training may be assessed a convenience fee, which will be determined by HHSC. Convenience fees assessed for training are allowable costs. Applicable federal and state accessibility standards apply to training. Reporting [~~Beginning with the 2018 cost reports and 2019 accountability reports, reporting~~] schedules per program are determined by HHSC and are published on the HHSC website.

(1) Training schedules.

[~~(A) For programs with odd-year and even-year cost reports. Preparers must complete state-sponsored cost report training every other year in order to be eligible to complete both that odd-year cost report and the following even-year cost report. If a new preparer wishes to complete an even-year cost report and has not completed the previous odd-year cost report training, the preparer must complete an even-year cost report training.~~]

[~~(B) For programs with odd-year and even-year accountability reports. Preparers must complete state-sponsored accountability report training every other year in order to be eligible to complete both that odd-year accountability report and the following even-year accountability report. If a new preparer wishes to complete an even-year accountability report and has not completed the previous odd-year accountability report training, the preparer must complete an even-year accountability report training.~~]

[~~(C)~~] For all [~~other~~] programs. Preparers must complete the state-sponsored training each year a cost report is requested by HHSC and for each program for which a cost [~~or accountability~~] report is submitted. Preparers who complete the required state-sponsored training during the year in which a cost report is submitted for a program will not have to complete the training for that program to prepare any other reports required by HHSC during the following calendar year. At HHSC's discretion, HHSC may require a provider's primary entity contact and financial contact of a contracted provider to complete a state-sponsored training to certify and submit a cost or other report required by HHSC. A provider's primary entity contract and financial contact who completes a state-sponsored training to certify and submit a cost report for a program will not have to complete the training for that program during the next calendar year to submit other reports for that program required by HHSC. [~~Beginning with the 2018 cost reports, new preparers must complete cost report training every other year for each program cost or accountability report being prepared in order to be eligible to complete both that year's cost report and the following year's accountability report, if applicable. If a new preparer wishes to complete an accountability report and has not completed the previous year's cost report training, the preparer must complete an accountability report training for that program for that year.~~]

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

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

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

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

(e) - (k) (No change.)

§355.105. General Reporting and Documentation Requirements, Methods, and Procedures.

(a) (No change.)

(b) Cost report requirements. Unless specifically stated in program rules or excused as described in paragraph (4)(D) of this subsection, each provider must submit financial and statistical information on cost report forms provided by HHSC, on facsimiles that are formatted according to HHSC specifications and are pre-approved by HHSC staff, or electronically in HHSC-prescribed format in programs where

these systems are operational. The cost reports must be submitted to HHSC in a manner prescribed by HHSC. The cost reports must be prepared to reflect the activities of the provider while delivering contracted services during the fiscal year specified by the cost report. Cost reports or other special surveys or reports may be required for other periods at the discretion of HHSC. Each provider is responsible for accurately completing any cost report or other special survey or report submitted to HHSC.

(1) Accounting methods. All financial and statistical information submitted on cost reports must be based upon the accrual method of accounting, except where otherwise specified in §355.102 and §355.103 of this subchapter (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs) and in the case of governmental entities operating on a cash or modified accrual basis. For cost-reporting purposes, accrued expenses must be incurred during the cost-reporting period and must be paid within 180 days after the end of that cost-reporting period. In situations where a contracted provider, any of its controlling entities, its parent company/sole member, or its related-party management company has filed for bankruptcy protection, the contracted provider may request an exception to the 180-day requirement for payment of accrued allowable expenses by submitting a written request to the HHSC Provider Finance Department. The written request must be submitted within 60 days of the date of the bankruptcy filing or at least 60 days prior to the due date of the cost report for which the exception is being requested, whichever is later. The contracted provider will then be requested by the HHSC Provider Finance Department to provide certain documentation, which must be provided by the specified due date. Such exceptions due to bankruptcy may be granted for reasonable, necessary, and documented accrued allowable expenses that were not paid within the 180-day requirement. Accrued revenues must be for services performed during the cost-reporting period and do not have to be received within 180 days after the end of that cost reporting period in order to be reported as revenues for cost-reporting purposes. Except as otherwise specified by the cost determination process rules of this chapter, cost report instructions, or policy clarifications, cost reports should be prepared consistent with generally accepted accounting principles (GAAP), which are those principles approved by the American Institute of Certified Public Accountants (AICPA). Internal Revenue Service (IRS) laws and regulations do not necessarily apply in the preparation of the cost report. In cases where cost-reporting rules differ from GAAP, IRS, or other authorities, HHSC rules take precedence for provider cost-reporting purposes.

(2) Recordkeeping and adequate documentation. There is a distinction between noncompliance in recordkeeping, which equates with unauditability of a cost report and constitutes an administrative contract violation or, for the Nursing Facility program, may result in vendor hold, and a provider's inability to provide adequate documentation, which results in disallowance of relevant costs. Each is discussed in the following paragraphs.

(A) Recordkeeping. Providers must ensure that records are accurate and sufficiently detailed to support the legal, financial, and other statistical information contained in the cost report. Providers must maintain all work papers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys, and schedules. HHSC may require supporting documentation other than that contained in the cost report to substantiate reported information.

(i) For contracted providers subject to 26 TAC Chapter 52 (relating to Contracting for Community Services) [40 ~~TAC Chapter~~ 49], each provider must maintain records according to the requirements stated in 26 TAC §52.113 [40 ~~TAC §49.307~~] (relating to Record Retention and Disposition) and according to the HHSC's prescribed chart of accounts, when available.

(ii) If a contractor is terminating business operations, the contractor must ensure that:

(I) records are stored and accessible; and

(II) someone is responsible for adequately maintaining the records.

(iii) For nursing facilities, failure to maintain all work papers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys, and schedules may result in vendor hold as specified in §355.403 of this chapter (relating to Vendor Hold).

(iv) For all other programs, failure to maintain all work papers and any other records that support the information submitted on the cost report relating to all allocations, cost centers, cost or statistical line items, surveys, and schedules constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this subchapter (relating to Administrative Contract Violations).

(B) Adequate documentation. The relationship between reported costs and contracted services must be clearly and adequately documented to be allowable. Adequate documentation consists of all materials necessary to demonstrate the relationship of personnel, supplies, and services to the provision of contracted client care or the relationship of the central office to the individual service delivery entity level. These materials may include but are not limited to, accounting records, invoices, organizational charts, functional job descriptions, other written statements, and direct interviews with staff, as deemed necessary by HHSC auditors to perform required tests of reasonableness, necessity, and allowability.

(i) The minimum allowable statistical duration for a time study upon which to base salary allocations is four weeks per year, with one week being randomly selected from each quarter so as to assure that the time study is representative of the various cycles of business operations. One week is defined as only those days the contracted provider is in operation for seven continuous days. The time study can be performed for one continuous week during a quarter, or it can be performed over five or seven individual days, whichever is applicable, throughout a quarter. The time study must be a 100% time study, accounting for 100% of the time paid to the employee, including vacation and sick leave.

(ii) To support the existence of a loan, the provider must have available a signed copy of the loan contract, which contains the pertinent terms of the loan, such as amount, rate of interest, method of payment, due date, and collateral. The documentation must include an explanation for the purpose of the loan, and an audit trail must be provided showing the use of the loan proceeds. Evidence of systematic interest and principal payments must be available and supported by the payback schedule in the note or amortization schedule supporting the note. Documentation must also include substantiation of any costs associated with the securing of the loan, such as broker's fees, due diligence fees, lender's fees, attorney's fees, etc. To document allowable interest costs associated with related party loans, the provider is required to maintain documentation verifying the prime interest rate in accordance with §355.103(b)(11)(C) of this subchapter for a similar type of loan as of the effective date of the related party loan.

(iii) For ground transportation equipment, a mileage log is not required if the equipment is used solely (100%) for the provision of contracted client services in accordance with program require-

ments in delivering one type of contracted care. However, the contracted provider must have a written policy that states that the ground transportation equipment is restricted to that use, and that policy must be followed. For ground transportation equipment that is used for several purposes (including for personal use) or multiple programs or across various business components, mileage logs must be maintained. Personal use includes, among other things, driving to and from a personal residence. At a minimum, mileage logs must include for each individual trip the date, the time of day (beginning and ending), driver, persons in the vehicle, trip mileage (beginning, ending, and total), purpose of the trip, and the allocation centers (the departments, programs, and/or business entities to which the trip costs should be allocated). Flight logs must include dates, mileage, passenger lists, and destinations, along with any other information demonstrating the purpose of the trips so that a relationship to contracted client care in Texas can be determined. For the purpose of comparison to the cost of commercial alternatives, documentation of the cost of operating and maintaining a private aircraft includes allowable expenses relating to the lease or depreciation of the aircraft; aircraft fuel and maintenance expenses; aircraft insurance, taxes, and interest; pilot expenses; hangar and other related expenses; mileage, vehicle rental or other ground transportation expense; and airport parking fees. Documentation demonstrating the allowable cost of commercial alternatives includes commercial airfare ticket costs at the lowest fare offered (including all discounts) and associated expenses, including mileage, vehicle rental or other ground transportation expenses; airport parking fees; and any hotel or per diem due to necessary layovers (no scheduled flights at the time of return trip).

(iv) To substantiate the allowable cost of leasing a luxury vehicle as defined in §355.103(b)(10)(C)(i) of this subchapter, the provider must obtain at the time of the lease a separate quotation establishing the monthly lease costs for the base amount allowable for cost-reporting purposes as specified in §355.103(b)(10)(C)(i) of this subchapter. Without adequate documentation to verify the allowable lease costs of the luxury vehicle, the reported costs shall be disallowed.

(v) For adequate documentation purposes, a written description of each cost allocation method must be maintained that includes, at a minimum, a clear and understandable explanation of the numerator and denominator of the allocation ratio described in words and in numbers, as well as a written explanation of how and to which specific business components the remaining percentage of costs were allocated.

(vi) To substantiate the allowable cost for staff training as defined in §355.103(b)(15)(A) of this subchapter, the provider must maintain a description of the training verifying that the training pertained to contracted client care-related services or quality assurance. At a minimum, a program brochure describing the seminar or a conference program with a description of the workshop must be maintained. The documentation must provide a description clearly demonstrating that the seminar or workshop provided training for contracted client care-related services or quality assurance.

(vii) Documentation regarding the allocation of costs related to noncontracted services, as specified in §355.102(j)(2) of this subchapter, must be maintained by the provider. At a minimum, the provider must maintain written records verifying the number of units of noncontracted services provided during the provider's fiscal year, along with adequate documentation supporting the direct and allocated costs associated with those noncontracted services.

(viii) Adequate documentation to substantiate legal, accounting, and auditing fees must include, at a minimum, the amount of time spent on the activity, a written description of the activity performed which clearly explains to which business component the cost should be allocated, the person performing the activity, and the hourly billing amount of the person performing the activity. Other legal, accounting, and auditing costs, such as photocopy costs, telephone costs, court costs, mailing costs, expert witness costs, travel costs, and court reporter costs, must be itemized and clearly denote to which business component the cost should be allocated.

(ix) Providers who self-insure for all or part of their employee-related insurance costs, such as health insurance and workers' compensation costs, must use one of the two following methods for determining and documenting the provider's allowable costs under the cost ceilings and any carry forward as described in §355.103(b)(13)(E) of this subchapter.

(I) Providers may obtain and maintain each fiscal year's documentation to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years.

(II) If providers choose not to obtain and maintain commercial bids as described in subclause (I) of this clause, providers may claim as an allowable cost the health insurance actual paid claims incurred on behalf of the employees that do not exceed 10% of the payroll for employees eligible for receipt of this benefit. In addition, providers may claim as an allowable cost the workers' compensation actual paid claims incurred on behalf of the employees, an amount in each cost report period that is not to exceed 10% of the payroll for employees eligible for receipt of this benefit.

(III) Providers who self-insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods.

(x) Providers who self-insure for all or part of their coverage for nonemployee-related insurance, such as malpractice insurance, comprehensive general liability, and property insurance, must maintain documentation for each cost-reporting period to establish what their premium costs would have been had they purchased commercial insurance for total coverage. The documentation should include, at a minimum, bids from two commercial carriers. Bids must be obtained no less frequently than every three years. Providers who self-insure must also maintain documentation that supports the amount of claims paid each year and any allowable costs to be carried forward to future cost-reporting periods. Governmental providers must document the existence of their claims management and risk management programs.

(xi) Regarding compensation of owners and related parties, providers must maintain the following documentation, at a minimum, for each owner or related party: a detailed written description of actual duties, functions, and responsibilities; documentation substantiating that the services performed are not duplicative of services performed by other employees; time sheets or other documentation verifying the hours and days worked; the amount of total compensation paid for these duties, with a breakdown detailing regular salary, overtime, bonuses, benefits, and other payments; documentation of regular, periodic payments and/or accruals of the compensation, documentation that the compensation is subject to payroll or self-employment taxes; and a detailed allocation worksheet indicating how the total compensation was allocated across business components receiving the benefit of these duties.

(I) Regarding bonuses paid to owners and related parties, the provider must maintain clearly defined bonus policies in its written agreements with employees or in its overall employment policy.

At a minimum, the bonus policy must include the basis for distributing the bonuses, including qualifications for receiving the bonus and how the amount of each bonus is calculated. Other documentation must specify who received bonuses, whether the persons receiving bonuses are owners, related parties, or arm's-length employees, and the bonus amount received by each individual.

(II) Regarding benefits provided to owners and related parties, the provider must maintain clearly defined benefit policies in its written agreements with employees or in its overall employment policy. At a minimum, the documentation must include the basis for eligibility for each type of benefit available, who is eligible to receive each type of benefit, who actually receives each type of benefit, whether the persons receiving each type of benefit are owners, related parties, or arm's-length employees, and the amount of each benefit received by each individual.

(xii) Regarding all forms of compensation, providers must maintain documentation for each employee which clearly identifies each compensation component, including regular pay, overtime pay, incentive pay, mileage reimbursements, bonuses, sick leave, vacation, other paid leave, deferred compensation, retirement contributions, provider-paid instructional courses, health insurance, disability insurance, life insurance, and any other form of compensation. Types of documentation would include insurance policies; provider benefit policies; records showing paid leave accrued and taken; documentation to support hours (regular and overtime) worked and wages paid; and mileage logs or other documentation to support mileage reimbursements and travel allowances. For accrued benefits, the documentation must clearly identify the period of the accrual. For example, if an employee accrues two weeks of vacation during 20x1 and receives the corresponding vacation pay during 20x3, that employee's compensation documentation for 20x3 should clearly indicate that the vacation pay received had been accrued during 20x1.

(I) For staff required to maintain continuous daily time sheets as per §355.102(j) of this subchapter and subclause (II) of this clause, the daily timesheet must document, for each day, the staff member's start time, stop time, total hours worked, and the actual time worked (in increments of 30 minutes or less) providing direct services for the provider, the actual time worked performing other functions, and paid time off. The employee must sign each timesheet. The employee's supervisor must sign the timesheets each payroll period or at least monthly. Work schedules are unacceptable documentation for staff whose duties include multiple direct service types, both direct and indirect service component types, and both direct hands-on support and first-level supervision of direct care workers.

(II) For the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID), Home and Community-based Services (HCS), and Texas Home Living (TxHmL) programs, staff required to maintain continuous daily timesheets include staff whose duties include multiple direct service types, both direct and indirect service component types and/or both direct hands-on support and first-level supervision of direct care workers.

(xiii) Management fees paid to related parties must be documented as to the actual costs of the related party for materials, supplies, and services provided to the individual provider and upon which the management fees were based. If the cost to the related party includes owner compensation or compensation to related parties, documentation guidelines for those costs are specified in clause (xi) of this subparagraph. Documentation must be maintained that indicates stated objectives, periodic assessment of those objectives, and evaluation of the progress toward those objectives.

(xiv) For central office and/or home office costs, documentation must be maintained that indicates the organization of the business entity, including position, titles, functions, and compensation. For multi-state organizations, documentation must be maintained that clearly defines the relationship of costs associated with any level of management above the individual Texas contracted entity allocated to the individual Texas contracted entity.

(xv) Documentation regarding depreciable assets includes, at a minimum, historical cost, date of purchase, depreciable basis, estimated useful life, accumulated depreciation, and the calculation of gains and losses upon disposal.

(xvi) Providers must maintain documentation clearly itemizing their employee relations expenditures. For employee entertainment expenses, documentation must show the names of all persons participating, along with a classification of the person attending, such as employee, nonemployee, owner, family of employee, client, or vendor.

(xvii) Adequate documentation substantiating the offsetting of grants and contracts from federal, state, or local governments prior to reporting either the net expenses or net revenue must be maintained by the provider. As specified in §355.103(b)(18) of this subchapter, such offsetting is required prior to reporting on the cost report. The provider must maintain written documentation as to the purpose for which the restricted revenue was received and the offsetting of the restricted revenue against the allowable and unallowable costs for which the restricted revenue was used.

(xviii) During the course of an audit or an audit desk review, the provider must furnish any reasonable documentation requested by HHSC auditors within ten working days of the request or a later date as specified by the auditors. If the provider does not present the requested material within the specified time, the audit or audit desk review is closed, and HHSC automatically disallows the costs in question.

(xix) Any expense that cannot be adequately documented or substantiated is disallowed. HHSC is not responsible for the contracted provider's failure to adequately document and substantiate reported costs.

(xx) Any cost report that is determined to be unauditable through a field audit or that cannot have its costs verified through a desk review will not be used in the reimbursement determination process.

(3) Cost report and methodology certification. Providers must certify the accuracy of cost reports submitted to HHSC in the format specified by HHSC. Providers may be liable for civil and/or criminal penalties if the cost report is not completed according to HHSC requirements or is determined to contain misrepresented or falsified information. Cost report preparers must certify that they read the cost determination process rules, the reimbursement methodology rules, the cost report cover letter, and cost report instructions, and that they understand that the cost report must be prepared in accordance with the cost determination process rules, the reimbursement methodology rules and cost report instructions. Not all persons who contributed to the completion of the cost report must sign the certification page. However, the certification page must be signed by a responsible party with direct knowledge of the preparation of the cost report. A person with supervisory authority over the preparation of the cost report who reviewed the completed cost report may sign a certification page in addition to the actual preparer.

(4) Requirements for cost report completion.

(A) A completed cost report must:

(i) be completed according to the cost determination rules of this chapter, program-specific allowable and unallowable rules, cost report instructions, and policy clarifications;

(ii) contain a signed, notarized, original certification page or an electronic equivalent where such equivalents are specifically allowed under HHSC policies and procedures;

(iii) be legible with entries in sufficiently dark print to be photocopied;

(iv) contain all pages and schedules;

(v) be submitted on the proper cost report form;

(vi) be completed using the correct cost reporting period; and

(vii) contain a copy of the state-issued cost report training certificate except for cost reports submitted through the State of Texas Automated Information and Reporting System (STAIRS).

(B) Providers are required to report amounts on the appropriate line items of the cost report pursuant to guidelines established in the methodology rules, cost report instructions, or policy clarifications. Refer to program-specific reimbursement methodology rules, cost report instructions, or policy clarifications for guidelines used to determine the placement of amounts on cost report line items.

(i) For nursing facilities, placement on the cost report of an amount, which was determined to be inaccurately placed, may result in vendor hold as specified in §355.403 of this chapter [~~(relating to Vendor Hold)~~].

(ii) For School Health and Related Services (SHARS), placement on the cost report of an amount, which was determined to be inaccurately placed, may result in an administrative contract violation as specified in §355.8443 of this chapter (relating to Reimbursement Methodology for School Health and Related Services (SHARS)).

(iii) For all other programs, placement on the cost report of an amount, which was determined to be inaccurately placed, constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this subchapter.

(C) A completed cost report must be filed by the cost report due date.

(i) For nursing facilities, failure to file a completed cost report by the cost report due date may result in vendor hold as specified in §355.403 of this chapter.

(ii) For SHARS, failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.8443 of this chapter.

(iii) For all other programs, failure to file a completed cost report by the cost report due date constitutes an administrative contract violation. In the case of an administrative contract violation, procedural guidelines and informal reconsideration and/or appeal processes are specified in §355.111 of this subchapter.

(D) HHSC may excuse providers from the requirement to submit a cost report[~~. A provider that is not enrolled in Attendant Compensation Rate Enhancement as described in §355.112 of this subchapter (relating to Attendant Compensation Rate Enhancement) for a specific program or the Nursing Facility Direct Care Staff Rate enhancement as described in §355.308 of this chapter (relating to Direct Care Staff Rate Component) during the reporting period for the cost report in question, is excused from the requirement to submit a cost report for such program~~] if the provider meets one or more of the following conditions.[~~:~~]

(i) For all programs, if the provider performed no billable services during the provider's cost-reporting period.

(ii) For all programs, if the cost-reporting period would be less than or equal to 30 calendar days or one entire calendar month.

(iii) For all programs, if circumstances beyond the provider's control, such as the loss of records due to natural disasters or removal of records from the provider's custody by a regulatory agency, make cost-report completion impossible.

(iv) For all programs, if all of the contracts that the provider is required to include in the cost report have been terminated before the cost-report due date.

(v) For the Nursing Facility, ICF/IID, STAR+PLUS Home and Community-Based Services Assisted Living Facilities, [~~Assisted Living/Residential Care (AL/RC),~~] and Residential Care (RC) programs, if the total number of days that the provider performed service for recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period.

(vi) For the Day Activity and Health Services (DAHS) program, if the provider's total units of service provided to recipients during the cost-reporting period is less than the total number of calendar days included in the cost-reporting period times 1.5.

(vii) For the Home-Delivered Meals program, if a provider agency served an average of fewer than 500 meals a month for the designated cost report period.

(viii) On or after September 1, 2023, for the Department of Family and Protective Services (DFPS) 24-Hour Residential Child-Care program, if:

(I) the provider has no current contract(s) within the state for 24-Hour Residential Child-Care program;

(II) the total number of DFPS-placed days and Single Source Continuum Contractor (SSCC)-placed days was 10 percent or less of the total days of service provided during the cost-reporting period;

(III) for facilities that provide Emergency Care Services only, the occupancy rate was less than 30 percent during the cost-reporting period; or

(IV) for all other facility types except child-placing agencies and those providing Emergency Care Services, the occupancy rate was less than 50 percent during the cost-reporting period.

(5) Cost report year. For cost reports collected after September 1, 2025, a [A] provider's cost report year must coincide with [~~the provider's fiscal year as used by the provider for reports to the Internal Revenue Service (IRS) or with~~] the state of Texas' fiscal year, which begins September 1 and ends August 31, unless the specific rate methodology or program rules specify a different reporting period. [~~except for SSCC providers in the DFPS 24-Hour Residential Child Care program whose cost report year must coincide with the state fiscal year.~~]

[~~(A) Providers whose cost report year coincides with their IRS fiscal year are responsible for reporting to HHSC Provider Finance Department any change in their IRS fiscal year and subse-~~

quent cost report year by submitting written notification of the change to HHSC Provider Finance Department along with supportive IRS documentation. HHSC Provider Finance Department must be notified of the provider's change in IRS fiscal year no later than 30 days following the provider's receipt of approval of the change from the IRS.]

[(B) Providers who chose to change their cost report year from their IRS fiscal year to the state fiscal year or from the state fiscal year to their IRS fiscal year must submit a written request to HHSC Provider Finance Department by August 1 of state fiscal year in question.]

(6) Failure to report allowable costs. HHSC is not responsible for the contracted provider's failure to report allowable costs; however, any omitted costs identified during the desk review or audit process will be included in the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

(c) - (h) (No change.)

(i) Limits on related-party compensation. HHSC may place upper limits or caps on related-party compensation as follows.[:]

(1) For related-party administrators and directors, the upper limit for compensation is equal to the 90th percentile in the array of all non-related-party annualized compensation as reported by all contracted providers within a program. In addition, the hourly compensation for related-party administrators and directors is limited to the annualized upper limit for related-party administrators and directors divided by 2,080.

(2) For related-party assistant administrators and assistant directors, the upper limit for compensation is equal to the 90th percentile in the array of all non-related party annualized compensation as reported by all contracted providers within a program. In addition, the hourly compensation for related-party assistant administrators and assistant directors is limited to the annualized upper limit for related-party assistant administrators and assistant directors divided by 2,080.

(3) For owners, partners, and stockholders (when the owner, partner, or stockholder is performing contract level administrative functions but is not the administrator, director, assistant administrator or assistant director), the upper limits for compensation are equal to the upper limits for related-party administrators and directors.

(4) For all other staff types.[:]

(A) For all related party attendant staff in programs specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component), the upper limit for compensation is equal to the 90th percentile in the array of all non-related-party attendant staff annualized compensation as reported by all contracted providers within a program. In addition, the hourly compensation for related-party attendant staff is limited to the annualized upper limit for related-party administrators and directors divided by 2,080. [For the Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions, Home and Community-based Services and Texas Home Living programs, related-party limitations are specified in §355.457 of this title (relating to Cost Finding Methodology), and §355.722 of this title (relating to Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers).]

(B) For all other programs, related-party compensation is limited to reasonable and necessary costs as described in §355.102 of this title.

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

1 TAC §355.112

STATUTORY AUTHORITY

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

The repeal affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.112. Attendant Compensation Rate Enhancement.

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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SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §§355.304, 355.306 - 355.308, 355.320

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §524.0005, which provides the executive commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §532.0051, which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas;

and Texas Government Code §532.0057(a), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for Medicaid payments under Texas Human Resources Code Chapter 32; and Senate Bill 457, 89th Legislature, Regular Session, 2025.

The repeals affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

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

§355.306. Cost Finding Methodology before September 1, 2025.

§355.307. Reimbursement Setting Methodology before September 1, 2025.

§355.308. Direct Care Staff Rate Component before September 1, 2025.

§355.320. Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025.

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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1 TAC §355.305, §355.318

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

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

(a) Introduction. The Texas Health and Human Services Commission (HHSC) establishes the annual patient care expense ratio for nursing facilities (NF) on or after September 1, 2025.

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

(1) Annual patient expense ratio--The ratio of patient care expenses as defined in paragraph (2) of this subsection to the NF's patient care revenue as defined in paragraph (3) of this subsection for a rate year as defined in paragraph (4) of this subsection.

(2) Patient care expenses--

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

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

(I) licensed registered nurse;

(II) licensed vocational nurse;

(III) medication aide;

(IV) restorative aide;

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

(VI) licensed social worker;

(VII) social services assistant;

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

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

(X) central supply staff and ancillary facility staff;

(XI) laundry staff;

(XII) housekeeping staff; and

(XIII) food service staff; and

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

(I) diagnostic laboratory and radiology costs;

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

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

(IV) prescription and nonprescription drug costs;

(V) therapy consultant costs; and

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

(B) exclude the following:

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

(ii) fixed capital assets costs.

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

(A) nursing rate component;

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

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

(D) dietary rate component; and

(E) operations rate component.

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

(c) Reporting requirements. An NF must submit an annual cost report in accordance with §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs) and §355.103 of this chapter (relating to Specifications for Allowable and Unallowable Costs). HHSC will examine the cost report in accordance with §355.106 of this chapter (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports).

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

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

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

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

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

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

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

(A) overall;

(B) health inspections;

(C) staffing; and

(D) long-stay quality measures.

(2) The NF:

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

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

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

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

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

§355.318. Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025.

(a) - (c) (No change.)

(d) PDPM LTC rate components. Total per diem PDPM LTC rates consist of the following four rate components. Costs used in HHSC's determination of the following rate components are subject to the cost-finding methodology as specified in subsection (g) of this section.

(1) Nursing rate component. This rate component includes compensation costs for employee and contract labor Registered Nurses (RNs), including Directors of Nursing (DONs) and Assistant Directors of Nursing (ADONs); Licensed Vocational Nurses (LVNs), including DONs and ADONs; medication aides; restorative aides; nurse aides performing nursing-related duties for Medicaid contracted beds; and certified social worker and social service assistant wages[~~; and other direct care non-professional staff wages, including medical records staff compensation and benefits~~].

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

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

(C) Nurse aides must meet the qualifications specified under 26 TAC §556.3 (relating to NATCEP [~~Nurse Aide Training and Competency Evaluation Program (NATCEP)~~] Requirements) to be included in this rate component. Nurse aides include certified nurse aides and nurse aides in training.

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

(E) For facilities providing care to children with tracheostomies requiring daily care, [~~as described in §355.307(b)(3)(G) of this chapter (relating to Reimbursement Setting Methodology before September 1, 2025),~~] staff required by 26 TAC §554.901(15)(C)(iii) (relating to Quality of Care) performing nursing-related duties for Medicaid contracted beds are included in the nursing rate component.

(F) For facilities providing care for qualifying ventilator-dependent residents, [~~as described in §355.307(b)(3)(F) of this chapter,~~] Registered Respiratory Therapists and Certified Respiratory Therapy Technicians are included in the nursing rate component.

(G) Nursing facility administrators and assistant administrators are not included in the nursing rate component.

(H) Staff members performing more than one function in a facility without a differential in pay between functions are cate-

gorized at the highest level of licensure or certification they possess. If this highest level of licensure or certification is not that of an RN, LVN, medication aide, restorative aide, or certified nurse aide, the staff member is not to be included in the nursing rate component but rather in the rate component where staff members with that licensure or certification status are typically reported.

(I) Paid feeding assistants are not included in the nursing rate component. Paid feeding assistants are intended to supplement certified nurse aides, not to be a substitute for certified or licensed nursing staff.

(2) NTA rate component. This rate component includes costs of providing care to residents with certain comorbidities or the use of certain extensive services. This rate component includes central supply costs, including central supply staff compensation and benefits, and other direct care non-professional staff wages, including medical records staff compensation and benefits; ancillary costs, including ancillary staff compensation and benefits; diagnostic laboratory and radiology costs; durable medical equipment purchase, rent, or lease costs; oxygen costs; drugs and pharmaceuticals; therapy consultant costs; and other ancillary supplies and services purchased by a nursing facility.

(3) BIMS rate component. This rate component includes additional staff costs associated with providing care to residents with severe cognitive impairment defined as residents with a BIMS score between 0 and 7 or a determination of severe or moderate impairment based on the calculation of the PDPM cognitive level for residents without a BIMS score on the MDS.

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

[~~(4) Non-Case-Mix rate component. The Non-Case-Mix rate component includes the following cost areas.~~]

[~~(A) Dietary costs, including food service and nutritionist staff expenses and supplies.~~]

[~~(B) The administration and operations cost includes compensation and benefits for the following staff: laundry and housekeeping staff, maintenance and transportation staff, administrator and assistant, other administrative personnel, activity director and assistant, and central office staff. Administration and operations also include operations supply costs; building repair and maintenance costs; laundry and housekeeping supply costs; transportation and vehicle depreciation costs; utilities, telecommunications, and technology costs; contracted management costs; insurance costs, excluding liability insurance reimbursed under §355.312 of this subchapter (relating to Reimbursement Setting Methodology--Liability Insurance Costs).~~]

[~~(C) The fixed capital asset costs, including the cost categories listed below:~~]

[~~*(i)* building and building equipment depreciation and lease expense;~~]

[~~*(ii)* mortgage interest;~~]

[~~*(iii)* land improvement depreciation; and~~]

[~~*(iv)* leasehold improvement amortization.~~]

(5) Operations rate component. The operations component includes the following expenses: compensation, payroll taxes, benefits, and worker's compensation claims for activity director, activity services assistants, laundry and housekeeping staff, and other facility and operations staff, including transportation and maintenance staff expenses. This rate component also includes the following non-staff costs; including, non-durable equipment and supplies, transportation costs, operations supplies, and other contracted services.

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

(7) Fixed capital asset rate component. This rate component includes building and building equipment depreciation and lease expense, mortgage interest, land improvement depreciation, and leasehold improvement amortization.

(e) Reimbursement determination. HHSC calculates methodological PDPM LTC rates for each rate component as defined below.

(1) Calculation of the nursing rate component. HHSC determines a per diem cost for the nursing component by calculating a median of the allowable nursing costs defined in subsection (d)(1) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter (relating to Determination of Inflation Indices) and multiplied by 1.07.

(2) Calculation of the NTA rate component. HHSC determines a per diem cost for the NTA component by calculating a median of allowable NTA costs as defined in subsection (d)(2) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

(3) Calculation of CMI-adjusted rate components. HHSC adjusts the nursing component and the NTA component by the most recent corresponding CMI established for PDPM Medicare available for the rate year, as determined by the Medicare Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The CMI-adjusted rate components are calculated as follows.

(A) Calculation of the total nursing rate component. HHSC will calculate CMI-adjusted nursing rate components for each nursing case-mix classifier by multiplying the result from paragraph (1) of this subsection by a CMI specific to each nursing case-mix classifier. There is one CMI per each nursing case-mix classifier.

(B) Calculation of the total NTA rate component. HHSC will calculate CMI-adjusted NTA rate components for each NTA case-mix classifier by multiplying the result from paragraph (2) of this subsection by a CMI specific to each NTA case-mix classifier. There is one CMI per each NTA case-mix classifier.

(4) Calculation of the BIMS rate component. This rate component is calculated at 5 percent of the nursing rate component es-

tablished for a nursing case-mix classifier associated with the highest CMI.

(5) Calculation of the dietary rate component. HHSC calculates a median of allowable dietary costs defined in subsection (d)(4) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.

[(5) Calculation of the non-case mix rate component. HHSC determines a per diem cost for the non-case mix rate component by the following.]

[(A) HHSC calculates a median of allowable dietary costs defined in subsection (d)(4)(A) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.]

[(B) HHSC calculates a median of the allowable administration and operations costs defined in subsection (d)(4)(B) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.]

[(C) HHSC calculates a median of allowable fixed capital costs defined in subsection (d)(4)(C) of this section from the most recently examined cost report database, weighted by the total nursing facility units of service from the same cost report database, adjusted for inflation from the cost reporting period to the prospective rate period as specified in §355.108 of this chapter and multiplied by 1.07.]

[(D) HHSC sums the results from subparagraphs (A) - (C) of this paragraph for the total non-case mix rate component.]

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

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

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

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

(A) Nursing rate component;

(B) NTA rate component;

(C) BIMS rate component; [and]

(D) Dietary rate component;

[(D) Non-Case Mix rate component.]

(E) Operations rate component;

(F) Administration rate component; and

(G) Fixed capital asset rate component.

(10) [(7)] HIV/AIDS Add-on. According to the Texas Health and Safety Code (THSC) §81.103, it is prohibited to input selected International Classification of Diseases, Tenth Revision (ICD-10) diagnosis codes for human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in the MDS assessment data. PDPM LTC methodology establishes a special per diem add-on intended to reimburse nursing facilities for enhanced nursing and NTA costs associated with providing care to a resident with an HIV/AIDS diagnosis. The total HIV/AIDS add-on is a sum of the amounts discussed as follows.

(A) The nursing rate component per PDPM LTC group assigned to a qualifying resident will receive an 18 percent add-on amount.

(B) The NTA rate component amount will receive an add-on amount, which is calculated as the difference between the resident's NTA rate component amount based on their assigned NTA case-mix classifier and the NTA rate component amount associated with the NTA case-mix classifier with the highest CMI.

(f) (No change.)

(g) Cost finding methodology.

(1) Cost reports. A nursing facility provider must file a cost report unless:

(A) the provider meets one or more of the conditions in §355.105(b)(4)(D) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures); or

(B) the cost report would represent costs accrued during a time period immediately preceding a period of decertification if the decertification period was greater than either 30 calendar days or one entire calendar month.

(2) Communication. When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for one of the reasons stated in paragraph (1) of this subsection.

(3) Exclusion of and adjustments to certain reported expenses. Providers are responsible for eliminating unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable costs from the cost report and to exclude entire cost reports from the reimbursement determination database if there is reason to doubt the accuracy or allowability of a significant part of the information reported.

(A) Cost reports included in the database used for reimbursement determination.

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

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

(II) an HHSC examiner determines that reported costs are not verifiable.

(ii) If all cost reports submitted for a specific facility are disqualified through the application of subparagraph (A)(i)(I) or (II) of this paragraph, the facility will not be represented in the reimbursement database for the cost report year in question.

(B) Occupancy adjustments. HHSC adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. HHSC adjusts the target occupancy rate to the lower of:

(i) 85 percent; or

(ii) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost reporting periods included in the base.

(4) Cost projections. HHSC projects certain expenses in the reimbursement base to normalize or standardize the reporting period and to account for cost inflation between reporting periods and the period to which the prospective reimbursement applies as specified in §355.108 of this chapter.

(5) In addition to the requirements of §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs) and §355.103 of this chapter (relating to Specifications for Allowable and Unallowable costs), the following apply to costs for nursing facilities.

(A) Medical costs. The costs for medical services and items delineated in 26 TAC §554.2601 (relating to Vendor Payment (Items and Services Included)) are allowable. These costs must also comply with the general definition of allowable costs as stated in §355.102 of this chapter.

(B) Chaplaincy or pastoral services. Expenses for chaplaincy or pastoral services are allowable costs.

(C) Voucherable costs. Any expenses directly reimbursable to the provider through a voucher payment and any expenses in excess of the limit for a voucher payment system are unallowable costs.

(D) Preferred items. Costs for preferred items that are billed to the recipient, responsible party, or the recipient's family are not allowable costs.

(E) Preadmission Screening and Annual Resident Review (PASARR) expenses. Any expenses related to the direct delivery of specialized services and treatment required by PASARR for residents are unallowable costs.

(F) Advanced Clinical Practitioner (ACP) or Licensed Professional Counselor (LPC) services. Expenses for services provided by an ACP or LPC are unallowable costs.

(G) Limits on contracted management fees. To ensure that the results of HHSC's cost analyses accurately reflect the costs that an economical and efficient provider must incur, HHSC may place upper limits on contracted management fees and expenses included in the administration [~~non-case mix~~] rate component. HHSC sets upper limits at the 90th percentile of all costs per unit of service as reported by all contracted facilities using the cost report database immediately preceding the database used to establish reimbursements in subsection (e) of this section.

(h) Special Reimbursement Class. HHSC may define special reimbursement classes, including experimental reimbursement classes of service to be used in research and demonstration projects on new reimbursement methods and reimbursement classes of service, to address the cost differences of a select group of recipients. Special classes may be implemented on a statewide basis, may be limited to a specific region of the state, or may be limited to a selected group of providers. Reimbursement for the Pediatric Care Facility Class is calculated as specified in §355.316 of this chapter (relating to Reimbursement Methodology for Pediatric Care Facilities) and §355.321 of this chapter (relating to Reimbursement Methodology for Intellectual and Developmental Disabilities Nursing Facilities Special Reimbursement Class).

(i) - (j) (No change.)

(k) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes nursing care to a Medicaid recipient under 26 TAC §554.2326 (relating to Medicaid Swing Bed Program for Rural Hospitals), HHSC or its designee pays the hospital using the same procedures, the same case-mix methodology, and the same PDPM LTC rates that HHSC authorizes for reimbursing nursing facilities under this section.

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

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Karen Ray
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1 TAC §355.321

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

BACKGROUND AND PURPOSE

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

SECTION-BY-SECTION SUMMARY

Proposed new §355.321(a) introduces the new special reimbursement class for nursing facilities serving individuals with intellectual and developmental disabilities. Subsection (b) defines terms used in the rule. Subsection (c) establishes how HHSC will calculate payment rates for facilities under this section. Subsection (d) establishes the criteria under which facilities qualify for membership in the special reimbursement class. Subsection (e) establishes the criteria under which facilities could be disqualified from membership in the special reimbursement class.

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 $779,805 in General Revenue (GR) ($1,949,513 All Funds (AF])) in fiscal year (FY) 2026, $810,997 GR ($2,027,493 AF) in FY 2027, $862,075 GR ($2,146,067 AF) in FY 2028, $900,905 GR ($2,252,263 AF) in FY 2029, and $943,858 GR ($2,359,645 AF) in FY 2030.

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 create a new regulation;

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

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

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

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

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

The proposed rule does 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 the rule because the rule does not impose a cost on regulated persons and the rule is necessary 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 the implementation of Rider 31 which creates an NF serving residents with IDD.

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 rate increases are anticipated to offset any economic costs to comply with the rule.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

A public hearing to receive comments on the proposal will be held via GoTo Webinar on July 25, 2025, from 9:00 a.m. to 12:00 p.m Central Daylight Time. The hearing will be conducted as an online event only. Details will be posted on the HHS Meetings and Events website at https://www.hhs.texas.gov/about/meetings-events.

Please contact the HHSC Provider Finance Department Long-Term Services and Supports at PFD-LTSS@hhs.texas.gov or (737) 867-7817 if you have questions.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@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 25R040" in the subject line.

STATUTORY AUTHORITY

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

The new rule affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.321. Reimbursement Methodology for Intellectual and Developmental Disabilities Nursing Facility Special Reimbursement Class.

(a) Intellectual and Developmental Disabilities (IDD) Facility Class. The purpose of this special class is to recognize, through the adoption of a special payment rate, the cost differences that exist in a nursing facility (NF) that predominately serves individuals with an IDD diagnosis.

(b) Definitions. The following terms, when used in this section, have the following meanings unless otherwise stated.

(1) Intellectual and Developmental Disabilities (IDD)--A range of conditions that can affect a person's ability to learn, communicate, and function independently. These disabilities typically originate before the age of 18 and can continue throughout a person's life.

(2) IDD NF--An IDD NF is an entire facility that has maintained an average daily census in which 90 percent of residents have a Preadmission Screening and Resident Review (PASRR) positive screen for IDD for the six-month period prior to its entry into the IDD care facility class based on the entire licensed facility. To remain an IDD NF, the IDD NF in its entirety must maintain an average daily census in which 90 percent of residents have a PASRR positive screen for IDD.

(c) Payment rate determination. Payment rates will be determined in the following manner.

(1) Cost reports for IDD nursing facilities are governed by the requirements specified in Subchapter A of this chapter (relating to Cost Determination Process).

(2) The payment rate methodology for this class of service equals the nursing and non-therapy ancillary components contained in the federal per diem rate for rural Medicare skilled NFs for the most recent federal fiscal year as published in the *Federal Register*, adjusted by applying the highest case-mix index (CMI). Payment rates are based on available funds and are limited to legislative appropriations.

(3) The payment rate described in paragraph (2) of this subsection will be paid for all Medicaid residents of a qualifying IDD NF.

(d) Qualification for membership. A NF that wishes to be a member of the special reimbursement class must submit a letter to HHSC Provider Finance Department via an email to PFD-LTSS@hhs.texas.gov with a request to be considered for membership. HHSC will verify the NF meets the definition of IDD NF as defined in subsection (b)(2). HHSC will respond in writing to the facility within 30 days of receiving its request for membership. HHSC will review the status of any members within the special reimbursement class on an annual basis to verify that all members meet requirements defined in subsection (b)(2) of this section.

(e) Disqualification for membership. If HHSC determines that an NF no longer qualifies as a member of such class according to subsection (b) of this section, HHSC will notify the facility in writing. A facility that is disqualified as a member of the special reimbursement class, can request to reenter the class by sending a letter to HHSC as specified in subsection (d) of this section after no less than 365 days from its notification of disqualification in the class.

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

1 TAC §355.456

STATUTORY AUTHORITY

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

The amendment affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.456. Reimbursement Methodology.

(a) - (c) (No change.)

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

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

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

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

(4) Direct service workers cost area. This cost area includes direct service workers' salaries and wages, benefits, and mileage reimbursement expenses. The reimbursement rate for this cost area is calculated as specified in §355.7052 [~~§355.112~~] of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component) [~~title (relating to Attendant Compensation Rate Enhancement)~~].

(5) Direct care trainers and job coaches cost area. This cost area includes direct care trainers' and job coaches' salaries and wages, benefits, and mileage reimbursement expenses. The reimbursement rate for this cost area is calculated as specified in §355.7052 [~~§355.112~~] of this chapter [~~title~~].

[~~(6) High Medical Needs Add-on reimbursement rate before September 1, 2025. There is an available add-on reimbursement~~

rate, in addition to the daily reimbursement rate, for certain individuals.]

[(A) The add-on is based on the Resource Utilization Group (RUG-III) 34 group classification system as described in §355.307 of this title (relating to Reimbursement Setting Methodology before September 1, 2025).]

[(B) There are three add-on groupings based on certain RUG-III 34 classification groups and the assessed Activities of Daily Living (ADL) score.]

[*(i)* Group 1 includes Extensive Services 3 (SE3), Extensive Services 2 (SE2), and Rehabilitation with ADL score of 17-18 (RAD).]

[*(ii)* Group 2 includes Rehabilitation with ADL score of 14-16 (RAC), Rehabilitation with ADL score of 10-13 (RAB), Extensive Services 1 (SE1), Special Care with ADL score of 17-18 (SSC), Special Care with ADL score of 15-16 (SSB), and Special Care with ADL score of 4-14 (SSA).]

[*(iii)* Group 3 includes Rehabilitation with ADL score of 4-9 (RAA), Clinically Complex with Depression and ADL score of 17-18 (CC2), Clinically Complex with ADL score of 17-18 (CC1), Clinically Complex with Depression and ADL score of 12-16 (CB2), Clinically Complex and ADL score of 12-16 (CB1), Clinically Complex with Depression and ADL score of 4-11 (CA2), and Clinically Complex and ADL score of 4-11 (CA1).]

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

[*(i)* be assigned a RUG-III 34 classification in Group 1, Group 2, or Group 3;]

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

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

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

[*(i)* For each Group, compute the median direct care staff per diem base rate component for all facilities as specified in §355.308 of this title (relating to Direct Care Staff Rate Component before September 1, 2025); and]

[*(ii)* Subtract the average nursing portion of the current recommended modeled rates as specified in subsection (d)(3) of this section.]

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) For each Group, compute the median per diem amount of the nursing care base case-mix adjusted rate component for all facilities as specified in §355.318 of this chapter (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025) [§355.320 of this chapter (relating to Nursing Care Staff Rate Enhancement Program for Nursing Facilities on or after September 1, 2025)]; and

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

(e) - (i) (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.

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Karen Ray

Chief Counsel

Texas Health and Human Services Commission

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

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1 TAC §355.457

STATUTORY AUTHORITY

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

The repeal affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.457. Cost Finding Methodology.

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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SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

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

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

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

(a) - (b) (No change.)

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

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

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

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

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

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

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

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

(i) The attendant cost area includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.7052 [~~§355.112~~] of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~title (relating to Attendant Compensation Rate Enhancement).~~]

(ii) The administration and facility cost area includes field supervisors' salaries and wages, benefits, and mileage reimbursement expenses; building, building equipment, and operation and maintenance costs; administration costs; and other service costs. An allowable cost per unit of service is determined for each contracted provider cost report for the administration and facility cost area. The allowable cost per unit of service for each contracted provider cost report are arrayed. The units of service for each contracted provider

cost report in the array are summed until the median unit of service is reached. The corresponding expense to the median unit of service is determined and multiplied by 1.044.

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

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

(2) Per day reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) - (g) (No change.)

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

(a) (No change.)

(b) Reporting of cost.

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

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

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

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

[~~*(ii)* At different levels of enhancement. If all the contracts under the legal entity participate in the enhancement but they~~

~~participate at more than one enhancement level, the contracted provider must submit one cost report for each level of enhancement.~~]

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

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

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

[~~*(I)* one cost report for the contracts that do not participate; and~~]

[~~*(II)* one cost report for the contracts that do participate.~~]

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

[~~*(I)* one cost report for the contracts that do not participate; and~~]

[~~*(II)* one cost report for each level of enhancement.~~]

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

(c) Waiver reimbursement determination methodology.

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

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

(3) Reporting and verification of allowable cost.

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

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

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

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

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

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

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

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

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

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

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

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

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

to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

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

(I) The attendant cost area includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.7052 [§355.112]of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [(relating to Attendant Compensation Rate Enhancement).]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) - (j) (No change.)

§355.507. Reimbursement Methodology for Long-Term Services and Supports State Plan and Medically Dependent Children Waiver Program Services Delivered through the STAR Kids and STAR Health Managed Care Programs.

(a) - (b) (No change.)

(c) MDCP reimbursement determination. Recommended payment rates 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). Recommended payment rates for MDCP services are determined as follows.

(1) Reimbursement for nursing services. The rates for in-home respite and flexible family supports nursing services provided by a registered nurse (RN) or licensed vocational nurse (LVN) are determined in accordance with §355.502 of this subchapter (relating to Reimbursement Methodology for Common Services in Home and Community-Based Services Waivers).

(2) Reimbursement for in-home respite and flexible family supports attendant services. The rates for in-home respite and flexible family supports provided by an attendant without delegation of the service by an RN are based on the STAR+PLUS Home and Community-Based Services (HCBS) waiver rate methodology for PAS in accordance with §355.503 of this subchapter (relating to Reimbursement Methodology for Long-Term Services and Supports State Plan and Home and Community-Based Services Waiver Program Services Delivered through the STAR+PLUS Managed Care Program) and §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component) [§355.112(m) of this title (relating to Attendant Compensation Rate Enhancement)]. The rates for in-home respite and flexible family supports provided by an attendant with delegation of the service by an RN are based on the STAR+PLUS HCBS waiver rate methodology for PAS in accordance with §355.503 of this subchapter and are modeled to account for additional requirements of this service. [and the add-on payment for the highest level of attendant compensation rate enhancement in accordance with §355.112(o) of this title.]

(3) The rate ceiling for respite care. Camp setting services is equivalent to the Community Living Assistance and Support Services direct service agency (CLASS DSA) out-of-home respite rate.

Actual payments for this service are the lesser of the rate ceiling or the actual cost of the camp.

(4) Reimbursement for facility-based respite care. Facility-based respite care rates are determined on a 24-hour basis. The rates for facility-based respite care are calculated at 77 percent of the daily nursing facility rate methodology in accordance with §355.307 of this title (relating to Reimbursement Setting Methodology before September 1, 2025). After September 1, 2025, the rates for facility-based respite care are calculated at 77 percent of the daily nursing facility rate methodology in accordance with §355.318 of this title (relating to Reimbursement Setting Methodology for Nursing Facilities on or after September 1, 2025). The base rates used in this calculation do not include nursing facility rate add-ons.

(5) Reimbursement for supported employment and employment assistance. The rates for supported employment and employment assistance are based on the rate methodology for supported employment and employment assistance in accordance with §355.503 of this subchapter.

(6) Reimbursement for transition assistance services. Transition assistance services rates are determined in accordance with §355.502 of this subchapter.

(d) - (g) (No change.)

§355.509. Reimbursement Methodology for Residential Care.

(a) - (b) (No change.)

(c) Reimbursement determination.

(1) Reporting and verification of allowable costs.

(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 or its designee excludes from reimbursement determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information that are necessary for the provision of services and that are consistent with federal and state regulations.

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

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

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

(2) Residential care reimbursement. Recommended per diem reimbursement for residential care is determined as follows.

(A) Reported allowable expenses are combined into four cost areas:

(i) attendant;

(ii) other direct care;

(iii) facility; and

(iv) administration and transportation.

(B) Facility, transportation (vehicle), and administration expenses are lowered to reflect expenses for a provider at the lower of:

(i) 85% occupancy rate; or

(ii) the overall average occupancy rate for licensed beds in facilities included in the database during the cost-reporting periods included in the base. The occupancy adjustment is applied if the provider's occupancy rate is below 85% or the overall average, whichever is lower. The occupancy adjustment is determined by the individual provider occupancy rate being divided by .85 or the average occupancy rate of all providers in the database.

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

(D) The attendant cost area from subparagraph (A)(i) of this paragraph will be calculated as specified in §355.7052 [~~§355.112~~] of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~title (relating to Attendant Compensation Rate Enhancement).~~]

(E) The following applies to the cost areas from subparagraph (A)(ii) - (iv) of this paragraph.[~~:~~]

(i) 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.

(ii) Cost area per diem expenses are calculated by dividing total reported allowable costs for each cost area by the total days of service. Cost area per diem expenses are rank ordered from low to high to produce projected per diem expense arrays.

(iii) Reimbursement is determined by selecting from each cost area the median day of service and the corresponding per diem expense times 1.07. The resulting cost area amounts are totaled to determine the per diem reimbursement.

(iv) The client is required to pay for their room and board portion of the per diem reimbursement. HHSC [~~DADS~~] will pay the services portion of the per diem reimbursement. The room and board payments will be paid to providers by the client from the client's Supplemental Security Income (SSI). When SSI is increased or decreased by the Federal Social Security Administration, the per diem reimbursement will be adjusted in amounts equal to the increase or decrease in SSI received by clients.

(3) Exceptions to the reimbursement determination methodology. Reimbursement may be adjusted in accordance with §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs) when new legislation, regulations, or economic factors affect costs.

(d) - (g) (No change.)

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

(a) - (b) (No change.)

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

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

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

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

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

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

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

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

(A) The attendant cost area, which includes salaries, wages, benefits, and mileage reimbursement calculated as specified in §355.7052 [~~§355.112~~] of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~(relating to Attendant Compensation Rate Enhancement).~~]

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

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

(8) For Interveners I, II, and III, payment rates are developed based on rates determined for other programs that provide similar services. If payment rates are not available from other programs that provide similar services, payment rates are determined using a pro forma approach in accordance with §355.105(h) of this chapter (relating to General Reporting and Documentation Requirements, Methods, and Procedures). [~~Interveners I, II, and III are not considered attendants for purposes of the Attendant Compensation Rate Enhancement described in §355.112 of this chapter, 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 chapter. The rates are adjusted periodically for inflation. The room and board payments for waiver clients receiving assisted living services are covered in the reimbursement for these services and will be paid to providers from the client's Supplemental Security Income, less a personal needs allowance.

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

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

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

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

(d) - (h) (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.

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

1 TAC §355.722

STATUTORY AUTHORITY

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

The repeal affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.722. Reporting Costs by Home and Community-based Services (HCS) and Texas Home Living (TxHmL) Providers.

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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1 TAC §355.723

STATUTORY AUTHORITY

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

The amendment affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

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

(a) - (b) (No change.)

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

(1) Attendant compensation cost area. The determination of the attendant compensation cost area is calculated as specified in §355.7052 [~~§355.112~~] of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~(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) employment readiness;

(ii) individualized skills and socialization;

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

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

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

(vi) RSS; and

(vii) SL.

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

(A) administration and operation costs; and

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

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

(ii) service-specific transportation costs.

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

(A) Step 1. Determine total projected administration and operation costs and projected units of service by service type using cost reports submitted by HCS and TxHmL providers in accordance with §355.102 of this chapter (relating to General Principles of Allowable and Unallowable Costs). [~~§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 and employment readiness in HCS and TxHmL. Projected weighted units of service for individualized skills and socialization and employment readiness equal projected individualized skills and socialization and employment readiness units of service times a weight of 0.25.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) CFC PAS/HAB;

(II) CSS;

(III) EA;

(IV) in-home individualized skills and socialization;

(V) in-home respite;

(VI) OHR in a camp;

(VII) OHR in a respite facility;

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

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

(X) SE; and

(XI) SHL.

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

(I) employment readiness;

(II) individualized skills and socialization;

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

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

(V) RSS; and

(VI) SL.

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

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

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

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

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

(i) HH/CC;

(ii) OHR in a camp;

(iii) OHR in a respite facility; and

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

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

(i) employment readiness;

(ii) individualized skills and socialization;

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

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

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

(vi) RSS; and

(vii) SL.

(d) - (f) (No change.)

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

1 TAC §355.5902, §355.6907

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.5902. Reimbursement Methodology for Primary Home Care.

(a) - (b) (No change.)

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

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

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

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

Attendant Cost Component). [~~calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).~~]

(C) Priority attendants cost area. This includes priority attendants' salaries and wages, benefits, and mileage reimbursement expenses. This cost area is specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~calculated as specified in §355.112 of this title.~~]

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

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

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

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

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

(3) Total recommended reimbursement.

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

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

(d) - (g) (No change.)

§355.6907. Reimbursement Methodology for Day Activity and Health Services.

(a) Day Activity and Health Care Services. Day activity and health care facilities provide noninstitutional care to clients residing in the community through rehabilitative nursing and social services. The Texas Health and Human Services Commission (HHSC) [~~Department of Aging and Disability Services (DADS)~~] reimburses Day Activity and Health Services (DAHS) provider agencies for the services they provide to clients.

(b) - (e) (No change.)

(f) Reimbursement determination. HHSC determines reimbursement in the following manner.

(1) 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.

(2) HHSC staff allocate payroll taxes and employee benefits 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. The employee benefits for administrative staff are allocated directly to the corresponding salaries for those positions. The allocated payroll taxes are Federal Insurance Contributions Act (FICA) or Social Security, Workers' Compensation Insurance (WCI), Federal Unemployment Tax Act (FUTA), and the Texas Unemployment Compensation Act (TUCA).

(3) HHSC staff project all allowable expenses, excluding depreciation and mortgage interest, for the period from each provider's reporting period to the next ensuing reimbursement period. HHSC staff determine reasonable and appropriate economic adjusters as described in §355.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. HHSC staff also adjust reimbursement if new legislation, regulations, or economic factors affect costs as specified in §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(4) HHSC staff combine allowable reported costs into the following four cost areas.[~~:~~]

(A) Attendant cost area. This cost area is specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component). [~~calculated as specified in §355.112 of this title (relating to Attendant Compensation Rate Enhancement).~~]

(B) Other direct care costs. This cost area includes other direct care staff; food and food service costs; activity costs; and other direct service costs.

(C) Facility cost area. This cost area includes building, maintenance staff, and utility costs.

(D) Administration and transportation cost area. This cost area includes transportation, administrative staff, and other administrative costs.

(5) For the cost areas described in paragraph (4)(B) - (D) of this subsection, allowable costs are totaled by cost area and then divided by the total units of service for the reporting period to determine the cost per unit of service. HHSC staff rank from low to high all provider agencies' projected costs per unit of service in each cost area. The median projected unit of service cost from each cost area is then determined. Those median projected unit of service costs from each cost area are totaled. That resulting total is multiplied by 1.07 and becomes the recommended reimbursement.

(6) The reimbursement determination authority is specified in §355.101 of this title (relating to Introduction).

(g) (No change.)

(h) DAHS-specific allowable costs. Allowable costs specific to the DAHS program are:

(1) certain medical equipment and supplies, if they are related to the services for which HHSC [~~DADS~~] has contracted. This may include, but is not limited to, supplies and equipment considered necessary to perform client assessments, medication administration, and nursing treatment.

(2) transportation costs if they are related to the services for which HHSC [DADS] has contracted. This includes the costs of garaging a vehicle that is primarily used to transport clients to and from the DAHS center. The vehicle may be garaged off-site of the center for security reasons or for route efficiency management. In these cases of off-site vehicle garaging, a mileage log is not required if the vehicle is not used for personal use and is used solely (100 percent [%]) for the delivery of DAHS services.

(i) - (j) (No change.)

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SUBCHAPTER H. ATTENDANT COST DETERMINATION

1 TAC §355.7051, §355.7052

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.7051. Base Wage for a Personal Attendant before September 1, 2025.

(a) - (f) (No change.)

§355.7052. Reimbursement Methodology for Determining Attendant Cost Component.

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

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

(1) An attendant includes the following:

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

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

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

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

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

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

(1) Attendant compensation is the allowable compensation for attendants defined in §355.103(b)(1) of this chapter (relating to Specifications for Allowable and Unallowable Costs) and required to be reported as either salaries and/or wages, including payroll taxes and workers' compensation, or employee benefits. Benefits required by §355.103(b)(1)(A)(iii) of this chapter to be reported as costs applicable to specific cost report line items, except as noted in paragraph (3) of this subsection, are not to be included in this cost center.

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

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

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

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

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

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

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

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

(A) services in the Community Attendant Services program;

(B) services in the Family Care program;

(C) services in the Primary Home Care program;

(D) DAHS;

(E) RC;

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

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

(ii) employment assistance;

(iii) habilitation (transportation) and prevocational services;

(iv) in-home respite;

(v) service planning team meeting; or

(vi) supported employment;

(G) in the DBMD Program:

(i) CFC PAS/HAB;

(ii) chore services;

(iii) employment assistance;

(iv) individualized skills and socialization services;

(v) in-home respite;

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

(vii) licensed assisted living;

(viii) licensed home health assisted living;

(ix) residential habilitation (transportation); or

(x) service planning team meeting;

(H) in the HCS Program:

(i) CFC PAS/HAB;

(ii) employment assistance;

(iii) employment readiness;

(iv) individualized skills and socialization services;

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

(vi) supported employment;

(vii) supported home living (transportation); or

(viii) SL/RSS; and

(I) in the Texas Home Living Program:

(i) CFC PAS/HAB;

(ii) community support services (transportation);

(iii) employment assistance;

(iv) employment readiness;

(iv) individualized skills and socialization services;

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

(vi) supported employment.

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

(A) assisted living services;

(B) employment assistance;

(C) in-home respite;

(D) supported employment;

(E) supported home living services; or

(F) supervised living services.

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

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

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

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

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

(i) assisted living;

(ii) CFC PAS;

(iii) CFC HAB;

(iv) employment assistance;

(v) DAHS;

(vi) in-home respite care;

(vii) personal assistance services;

(viii) protective supervision; or

(ix) supported employment;

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

(i) CFC PAS;

(ii) CFC HAB;

(iii) employment assistance;

(iv) DAHS;

(v) flexible family support;

(vi) in-home respite;

(vii) personal care services; or

(viii) supported employment; and

(C) in the STAR Kids program and MDCP:

(i) CFC PAS;

(ii) CFC HAB;

(iii) employment assistance;

(iv) DAHS;

(v) flexible family support;

(vi) in-home respite;

(vii) personal care services; or

(viii) supported employment.

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

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

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

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

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

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

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

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

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

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

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

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

(i) CFC PAS/HAB

(ii) employment assistance;

(iii) in-home respite;

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

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

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

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

(viii) supported employment; and

(ix) supported home living (transportation).

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

(i) individualized skills and socialization services;

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

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

(iv) SL/RSS.

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

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

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

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

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

The agency certifies that legal counsel has reviewed the 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) 867-7817

SUBCHAPTER M. MISCELLANEOUS PROGRAMS
DIVISION 7. COMMUNITY FIRST CHOICE

1 TAC §355.9090

STATUTORY AUTHORITY

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

The amendment affects Texas Government Code Chapter 532 and Texas Human Resources Code Chapter 32.

§355.9090. Reimbursement Methodology for Community First Choice.

(a) (No change.)

(b) Reimbursement Methodology. Community First Choice (CFC) rates are established using pre-existing rates as follows.

(1) CFC State Plan Rate--Attendant and Habilitation: The recommended payment rate is calculated by summing the following cost components. [Rates will be equal to a weighted average of rates established for Community Living Assistance and Support Services (CLASS) habilitation services according to the reimbursement methodology for the CLASS program under §355.505 of this title (relating to Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program) and proxy rates for attendant services used in the calculation of the STAR+PLUS managed care capitation rates for the Home and Community-based Services (HCBS) risk group. The weighted average will include applicable attendant compensation rate enhancements.]

(A) Attendant cost area. This cost area is specified in §355.7052 of this chapter (relating to Reimbursement Methodology for Determining Attendant Cost Component).

[(A) Proxy rates are equal to rates established for attendant services under the Community Based Alternatives (CBA) waiver prior to its termination, updated for changes in allowable reported expenses and units of service.]

(B) Administration and operations cost area. An allowable cost per unit of service is calculated for the other habilitation cost area. The allowable costs per unit of service for each contracted provider cost report are arrayed and weighted by the number of units of service, and the median cost per unit of service is calculated. The median cost per unit of service is multiplied by 1.044.

[(B) Weighting factors assume that 30 percent of personal attendant services historically provided to existing recipients in the STAR+PLUS HCBS risk group and 100 percent of personal attendant services provided to newly eligible recipients under CFC will be for habilitation.)]

(2) CLASS--Attendant and Habilitation CFC: Rates will be equal to rates established for CLASS habilitation services, including applicable attendant compensation rate enhancements, under §355.505 of this title.

(3) Deaf-Blind with Multiple Disabilities (DBMD)--Attendant and Habilitation CFC: Rates will be equal to rates established for DBMD Residential Habilitation, including applicable attendant compensation rate enhancements, under §355.513 of this title (relating to Reimbursement Methodology for the Deaf-Blind with Multiple Disabilities Waiver Program).

(4) Home and Community-Based Services (HCS)--Supported Home Living (SHL) CFC: Rates will be equal to rates established for HCS SHL, including applicable attendant compensation rate enhancements, under §355.723 of this title (relating to Reimbursement Methodology for Home and Community-Based Services and Texas Home Living Programs).

(5) Texas Home Living (TxHmL)--Community Support Services (CSS) CFC: Rates will be equal to rates established for TxHmL CSS, including applicable attendant compensation rate enhancements, under §355.723 of this title.

(6) Personal Care Services (PCS)--Habilitation CFC: Rates will be equal to rates established for PCS attendant services for recipients with a behavioral health condition under §355.8441 of this title (relating to Reimbursement Methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services).

(7) Personal Care Services (PCS)--Attendant CFC: Rates will be equal to the rates established for PCS attendant services for recipients without a behavioral health condition under §355.8441 of this title.

(8) Consumer Directed Services (CDS)--CFC: Rates will be equal to rates established for CDS for the equivalent non-CFC service under §355.114 of this title (relating to Consumer Directed Services Payment Option).

(9) Support Consultation Services--CFC: Rates will be equal to rates established for Support Consultation Services under §355.114 of this title.

(10) CFC State Plan rate for Financial Management Services Agencies (FMSA) (only authorized for individuals receiving all of their CDS services under CFC): Rates will be equal to rates established for FMSAs for an equivalent non-CFC service under §355.114 of this title.

(11) Emergency Response Services (ERS)--CFC: Rates will be equal to rates established for ERS under §355.510 of this title (relating to Reimbursement Methodology for Emergency Response Services (ERS)).

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
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TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 53. REGIONAL EDUCATION SERVICE CENTERS

SUBCHAPTER AA. COMMISSIONER'S RULES

19 TAC §53.1002, §53.1021

The Texas Education Agency (TEA) proposes amendments to §53.1002 and §53.1021, concerning regional education service centers (RESCs). The proposed amendments would clarify existing rules, reflect current RESC practices, allow electronic application submissions, and replace the Performance Standards and Indicators Manual with a reference to online metrics.

BACKGROUND INFORMATION AND JUSTIFICATION: Section 53.1002 allows the commissioner of education to appoint a nonvoting charter school representative to the board of an RESC if at least one open-enrollment charter school operates in the region and outlines the eligibility, application, and appointment process for that role.

The proposed amendment to §53.1002 would clarify the term limits for charter members serving on RESC boards to ensure consistent understanding and implementation of the rule. Additionally, the amendment would permit applicants to submit their applications electronically to the commissioner, which would reduce the administrative burden and result in time and cost savings for both applicants and RESCs. A cross reference would also be updated to reflect a reorganization of charter school rules in 19 TAC Chapter 100.

Section 53.1021 authorizes the commissioner to establish and communicate performance standards and indicators for evaluating RESCs and their executive directors, as outlined in the manual adopted as Figure: 19 TAC §53.1021(b).

The proposed amendment would remove the current figure containing the outdated Performance Standards and Indicators Manual. This manual would be replaced by a new version, which would reflect more relevant and accurate metrics. The new manual would be published on the TEA website rather than included as a figure in the rule, allowing for easier updates and improved accessibility. Section 53.1021(c), which references the outdated manual, would also be removed.

FISCAL IMPACT: Alejandro Delgado, deputy commissioner for operations, has determined that for the first five-year period the proposal is in effect, there are no additional costs to state or local government, including school districts and open-enrollment charter schools, required to comply with the proposal. RESCs may have a decrease in postage costs if they choose to submit applications electronically.

LOCAL EMPLOYMENT IMPACT: The proposal has no effect on local economy; therefore, no local employment impact statement is required under Texas Government Code, §2001.022.

SMALL BUSINESS, MICROBUSINESS, AND RURAL COMMUNITY IMPACT: The proposal has no direct adverse economic impact for small businesses, microbusinesses, or rural communities; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

COST INCREASE TO REGULATED PERSONS: The proposal does not impose a cost on regulated persons, another state agency, a special district, or a local government and, therefore, is not subject to Texas Government Code, §2001.0045.

TAKINGS IMPACT ASSESSMENT: The proposal does not impose a burden on private real property and, therefore, does not constitute a taking under Texas Government Code, §2007.043.

GOVERNMENT GROWTH IMPACT: TEA staff prepared a Government Growth Impact Statement assessment for this proposed rulemaking. During the first five years the proposed rulemaking would be in effect, it would limit an existing regulation by removing a manual from the current rule.

The proposed rulemaking would not create or eliminate a government program; would not require the creation of new employee positions or elimination of existing employee positions; would not require an increase or decrease in future legislative appropriations to the agency; would not require an increase or decrease in fees paid to the agency; would not create a new regulation; would not expand or repeal an existing regulation; would not increase or decrease the number of individuals subject to its applicability; and would not positively or adversely affect the state's economy.

PUBLIC BENEFIT AND COST TO PERSONS: Mr. Delgado has determined that for each year of the first five years the proposal is in effect, the public benefit anticipated as a result of enforcing the proposal would be a reduction of administrative burden and costs for RESCs by introducing the electronic application process. In addition, replacing obsolete standards with current, relevant metrics published online would enhance transparency and ensure evaluations reflect present-day practices. There is no anticipated economic cost to persons who are required to comply with the proposal.

DATA AND REPORTING IMPACT: The proposal would have no data and reporting impact.

PRINCIPAL AND CLASSROOM TEACHER PAPERWORK REQUIREMENTS: TEA has determined that the proposal would not require a written report or other paperwork to be completed by a principal or classroom teacher.

PUBLIC COMMENTS: The public comment period on the proposal begins July 11, 2025, and ends August 11, 2025. A request for a public hearing on the proposal submitted under the Administrative Procedure Act must be received by the commissioner of education not more than 14 calendar days after notice of the proposal has been published in the *Texas Register* on July 11, 2025. A form for submitting public comments is available on the TEA website at https://tea.texas.gov/About_TEA/Laws_and_Rules/Commissioner_Rules_(TAC)/Proposed_Commissioner_of_Education_Rules/.

STATUTORY AUTHORITY. The amendments are proposed under Texas Education Code (TEC), §8.001, which provides the

commissioner of education with authority to decide any matter concerning the operation or administration of regional education service centers (RESCs); TEC, §8.003, which provides the commissioner of education with rulemaking authority regarding the local selection, appointment, and continuity of membership of RESC boards of directors; TEC, §8.101, which provides that the commissioner of education shall establish performance standards and indicators for evaluating RESCs; and TEC, §12.104, which provides that the commissioner of education with rulemaking authority to provide for the representation of open-enrollment charter schools in RESCs.

CROSS REFERENCE TO STATUTE. The amendments implement Texas Education Code, §§8.001, 8.003, 8.101, and 12.104.

§53.1002. Charter School Representation on Board of Directors.

(a) Charter school member. Notwithstanding the provisions of §53.1001 of this title (relating to Board of Directors), where a regional education service center (RESC) has at least one open-enrollment charter school, as defined by §100.1001(6) [§100.1011(3)] of this title (relating to Definitions), approved to operate within its boundaries on or after June 1, and to which the RESC provides services, the commissioner of education shall appoint a representative of the open-enrollment charter schools in the region to serve as a non-voting member of the board of directors of that RESC as provided by this section.

(b) Term of office.

(1) A charter school member of an RESC board of directors shall be appointed for a one-year term. The term of office shall begin June 1[,] and may be extended for an additional [up to] three years, for a total of four years, by the commissioner.

(2) If a vacancy occurs due to death or resignation of a charter school member of an RESC board of directors, a 30-day period shall elapse, after notice has been given to the board chair, before the vacancy is filled.

(3) At the beginning of the 30-day period, notice of any vacancy shall be given to the president of the governing body and the chief executive officer of each open-enrollment charter school in the education service center region and shall be posted in appropriate locations.

(4) A vacancy for the unexpired term of a charter school member of an RESC board of directors shall be filled by appointment by the commissioner [of education].

(c) Appointment process.

(1) A charter school member of an RESC board of directors must be a United States citizen, [and] a resident of the State of Texas, and [must be] at least 18 years of age. A person may be appointed to serve as a charter school member of more than one RESC board of directors.

(2) Any eligible person wishing to seek appointment as a charter school member of an RESC board of directors shall file an application between February 1 and February 20. The application shall be in the form of a letter seeking appointment to a specific RESC board of directors. The letter must:

(A) include a description of the applicant's qualifications to serve as a charter member of the RESC board of directors;

(B) enclose letters of support signed by representatives from at least one open-enrollment charter school in the education service center region; and

(C) supply contact information for the persons signing the letters of support.

(3) The application for appointment as a charter school member of an RESC board of directors may be filed electronically by sending the application materials to the commissioner or by mail to the Commissioner of Education [if sent by certified United States mail, return receipt requested, or by an overnight courier service. The envelope must be addressed to the Charter School Division], Texas Education Agency, 1701 N. Congress Avenue, Austin, Texas 78701-1494.

(4) Not later than May 31, the commissioner [of education] shall notify the board of directors of each qualifying RESC of the commissioner's appointee to serve as the charter school member of that RESC board of directors effective June 1.

(d) No applicant appointed. If the commissioner does not select a representative from among the applicants under subsection (c) of this section, or if no applicant applies for such appointment, then there shall be a vacancy which shall be filled by appointment by the commissioner [of education].

§53.1021. Regional Education Service Center Performance Standards and Indicators.

(a) In accordance with the Texas Education Code, §8.101, the commissioner of education shall establish performance standards and indicators for regional education service centers (RESCs) to be used in the annual evaluation of each RESC [regional education service center] and executive director.

(b) The [specific] performance standards and indicators for evaluating [by which the commissioner shall evaluate] each RESC [regional education service center] and executive director will be published on the Texas Education Agency's website annually prior to the evaluation cycle [are described in the Regional Education Service Center Performance Standards and Indicators Manual provided in this subsection].

[Figure: 19 TAC §53.1021(b)]

[(c) The specific criteria used in the Regional Education Service Center Performance Standards and Indicators Manual are established by the commissioner and communicated to all regional education service centers and executive directors.]

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 30, 2025.

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Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
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For further information, please call: (512) 475-1497

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TITLE 22. EXAMINING BOARDS

PART 17. TEXAS STATE BOARD OF PLUMBING EXAMINERS

CHAPTER 363. EXAMINATION AND REGISTRATION

22 TAC §363.4

The Texas State Board of Plumbing Examiners (Board) proposes an amendment to the existing rule at 22 Texas Administrative Code (TAC), Chapter 363, §363.4. The proposed change is referred to as the "proposed rule."

EXPLANATION OF AND JUSTIFICATION FOR THE RULE

The Texas Occupations Code, Chapter 1301 (Plumbing License Law or PLL) was amended by House Bill 3214 (HB 3214), 89th Texas Legislature, Regular Session, 2025. The proposed rule implements the statutory change made by HB 3214.

HB 3214 amends the Plumbing License Law to reduce the minimum required work experience as a journeyman plumber from four years to two years in order to qualify for a master plumber license. Under this bill, a journeyman plumber may qualify to take the examination for a master plumber's license after holding a journeyman's license for two years. The bill aims to address a shortage of skilled plumbers in Texas by streamlining the path to becoming a master plumber, allowing capable professionals to advance more quickly and meet growing demand in the plumbing industry.

SECTION BY SECTION SUMMARY

Section 363.4 - The proposed rule amends the existing regulation by reducing the required number of years a journeyman plumber must be licensed--from four years to two--in order to qualify for the master plumber's licensing exam.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Lisa G. Hill, Executive Director for the board (Executive Director), has determined that for the first five-year period the proposed rule is in effect, there are no foreseeable increases or reductions in costs to the state or local governments as a result of enforcing or administering the rule. The executive director has further determined that for the first five-year period the proposed rule is in effect, there will be no foreseeable losses or increases in revenue for the state or local governments as a result of enforcing or administering the rule.

PUBLIC BENEFITS

The executive director has determined that for each of the first five years the proposed rule is in effect, the public benefit anticipated as a result of enforcing or administering the proposed rule will be to have fewer regulatory barriers to licensure and greater opportunity to expand the population of licensed plumbers.

PROBABLE ECONOMIC COSTS TO PERSONS REQUIRED TO COMPLY WITH THE RULE

The executive director has determined that for the first five years the proposed rule is in effect, there is no substantial economic costs anticipated to persons required to comply with the proposed rule.

ONE-FOR-ONE REQUIREMENT FOR RULE WITH A FISCAL IMPACT

Given that the proposed rule does not have a fiscal note which imposes a cost on regulated persons, including another state agency, a special district, or local government, proposal and adoption of the rule is not subject to the requirements of Government Code §2001.0045.

GOVERNMENT GROWTH IMPACT STATEMENT

For each of the first five years the proposed rule is in effect, the Board has determined the following: (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 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; and (8) the proposed rule does not positively or adversely affect this state's economy.

LOCAL EMPLOYMENT IMPACT STATEMENT

No local economies are substantially affected by the proposed rule. As a result, preparation of a local employment impact statement pursuant to Government Code §2001.022 is not required.

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

The proposed rule will not have an adverse effect on small or micro-businesses, or rural communities because there are no substantial economic costs anticipated to persons required to comply with the proposed rule. As a result, preparation of an economic impact statement and a regulatory flexibility analysis, as provided by Government Code §2006.002, are not required.

TAKINGS IMPACT ASSESSMENT

There are no private real property interests affected by the proposed rule. As a result, preparation of a takings impact assessment, as provided by Government Code §2007.043, is not required.

PUBLIC COMMENTS

Written comments regarding the proposed rule may be submitted by mail to Patricia Latombe at 929 East 41st Street, Austin, Texas 78751, or by email to rule.comment@tsbpe.texas.gov with the subject line "Rule Amendment." All comments must be received within 30 days of publication of this proposal.

STATUTORY AUTHORITY

This proposal is made under the authority of Texas Occupations Code Chapter 1301 as proposed by HB 3214 during the 89th Legislative Session. Section 1301.251(2) of the Texas Occupations Code authorizes the Texas State Board of Plumbing Examiners to adopt rule as necessary to implement the Chapter.

No other statutes, articles, or codes are affected by the proposed rule.

§363.4. Master Plumber License.

To be eligible for a Master Plumber License an applicant must have held a Journeyman Plumber License issued in Texas or another state:

(1) for at least two [~~four~~] years; or

(2) for at least one year if the applicant has successfully completed a training program approved by the United States Department of Labor, Office of Apprenticeship or another nationally-recognized apprentice training program accepted by the Board.

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 30, 2025.

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Patricia Latombe
General Counsel
Texas State Board of Plumbing Examiners
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For further information, please call: (512) 936-5216

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 259. COMMUNITY LIVING ASSISTANCE AND SUPPORT SERVICES (CLASS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC) SERVICES

SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

DIVISION 1. ELIGIBILITY AND MAINTENANCE OF THE CLASS INTEREST LIST

26 TAC §259.51

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §259.51, concerning Eligibility Criteria for CLASS Program Services and CFC Services.

BACKGROUND AND PURPOSE

The 2026-2027 General Appropriations Act, Senate Bill 1, 89th Texas Legislature, Regular Session, 2025 (Article II, HHSC Rider 23) includes appropriations to increase the base wage for personal attendant services. This wage increase will impact Medicaid personal attendant reimbursement rates.

As a result of this direction and prior reimbursement rate increases, HHSC proposes to amend the waiver cost limit, where applicable, for the Community Living Assistance and Support Services (CLASS) waiver program to ensure the cost limits align with the rate increases. The purpose for increasing the waiver cost limit for an individual's plan of care (IPC) is to off-set the cost of higher personal attendant reimbursement rates while allowing the individual to continue to qualify for services in the CLASS Program by not exceeding the cost limit for the IPC.

HHSC will also propose an amendment in the waiver cost limit for an individual's IPC in the Deaf Blind with Multiple Disabilities and Texas Home Living Programs, and the waiver cost limits in the Home and Community-based Services Program, in this same issue of the *Texas Register*.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §259.51(a)(4) amends the cost for the individual's IPC CLASS Program services to be 210 percent of the annualized cost of care in an ICF/IID using the unweighted average of the current non-state-operated small facility daily rates for levels of need 1, 5, and 8, rounded to the nearest dollar. This change provides more funding to pay for the services an individual needs, including the higher cost for personal attendant-like services, while maintaining eligibility for the program.

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, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rule is in effect, the public will benefit from this project because the individual cost limits allow individuals in the CLASS waiver program to adjust budgets to coincide with the individual plan of care for personal attendant and attendant-like services in alignment with the attendant rate increases. Similarly, providers will be reimbursed for the services provided to individuals according to their individual plans of care and waiver budgets.

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@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 25R038" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; and Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration.

The amendment affects Texas Government Code §524.0151 and Texas Human Resources Code §32.021.

§259.51. Eligibility Criteria for CLASS Program Services and CFC Services.

(a) An individual is eligible for CLASS Program services if:

(1) the individual meets the financial eligibility criteria described in Appendix B of the CLASS Program waiver application approved by CMS and available on the HHSC website;

(2) the individual is determined by HHSC to meet the LOC VIII criteria described in §261.239 of this title (relating to ICF/MR Level of Care VIII Criteria);

(3) the individual demonstrates a need for CFC PAS/HAB;

(4) the individual's IPC has an IPC cost for CLASS Program services at or below 210 percent of the annualized cost of care in an ICF/IID using the unweighted average of the current non-state operated small facility daily rates for level of need, as defined by the ICF/IID program rules in §261.203 of this title (relating to Definitions), 1, 5, and 8 rounded to the nearest dollar [~~$114,736.07~~];

(5) the individual is not enrolled in another waiver program or receiving a service that may not be received if the individual is enrolled in the CLASS Program, as identified in the Mutually Exclusive Services table in Appendix III of the Community Living Assistance and Support Services Provider Manual available on the HHSC website;

(6) the individual resides in the individual's own home or family home; and

(7) the individual requires the provision of:

(A) at least one CLASS Program service per month or a monthly monitoring by a case manager; and

(B) at least one CLASS Program service during an IPC period.

(b) Except as provided in subsection (c) of this section, an individual is eligible for a CFC service under this chapter if the individual:

(1) meets the criteria described in subsection (a) of this section;

(2) requires the provision of the CFC service; and

(3) is not receiving SFS or CFS.

(c) To be eligible for a CFC service under this chapter, an individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (b) of this section, receive a CLASS Program service at least monthly, as required by 42 CFR §441.510(d).

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
Health and Human Services Commission
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For further information, please call: (512) 438-2910

CHAPTER 260. DEAF BLIND WITH MULTIPLE DISABILITIES (DBMD) PROGRAM AND COMMUNITY FIRST CHOICE (CFC) SERVICES

SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

DIVISION 1. ELIGIBILITY AND MAINTENANCE OF THE DBMD INTEREST LIST

26 TAC §260.51

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §260.51, concerning Eligibility Criteria for DBMD Program Services and CFC Services.

BACKGROUND AND PURPOSE

The 2026-2027 General Appropriations Act, Senate Bill 1, 89th Texas Legislature, Regular Session, 2025 (Article II, HHSC Rider 23) includes appropriations to increase the base wage for personal attendant services. This wage increase will impact Medicaid personal attendant reimbursement rates.

As a result of this direction and prior reimbursement rate increases, HHSC proposes to amend the waiver cost limit, where applicable, for the Deaf Blind with Multiple Disabilities (DBMD) waiver program to ensure the cost limits align with the rate increases. The purpose for increasing the waiver cost limit for an individual's plan of care (IPC) is to off-set the cost of higher personal attendant reimbursement rates while allowing the individual to continue to qualify for services in the DBMD Program by not exceeding the cost limit for the IPC.

HHSC will also propose an amendment in the waiver cost limit for an individual's IPC in the Community Living Assistance and Support Services, and Texas Home Living Programs, and waiver cost limits in the Home and Community-based Services in this same issue of the *Texas Register*.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §260.51(a)(4) amends the cost for the individual's IPC DBMD Program services to be 210 percent of the annualized cost of care in an ICF/IID using the unweighted average of the current non-state-operated small facility daily rates for levels of need 1, 5, and 8, rounded to the nearest dollar. This change provides more funding to pay for the services an individual needs, including the higher cost for personal attendant-like services, while maintaining eligibility for the program.

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, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rule is in effect, the public will benefit from this project because the individual cost limits allow individuals in the DBMD waiver program to adjust budgets to coincide with the individual plan of care for personal attendant and attendant-like services in alignment with the attendant rate increases. Similarly, providers will be reimbursed for the services provided to individuals according to their individual plans of care and waiver budgets.

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@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 25R038" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; and Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration.

The amendment affects Texas Government Code §524.0151 and Texas Human Resources Code §32.021.

§260.51. Eligibility Criteria for DBMD Program Services and CFC Services.

(a) An individual is eligible for DBMD Program services if:

(1) the individual meets the financial eligibility criteria as described in Appendix B of the DBMD Program waiver application approved by CMS and available on the HHSC website;

(2) the individual is determined by HHSC to meet the LOC VIII criteria described in §261.239 of this title (relating to ICF/MR Level of Care VIII Criteria);

(3) the individual, as documented on the ID/RC Assessment:

(A) has one or more diagnosed related conditions and, as a result:

(i) has deafblindness;

(ii) has been determined to have a progressive medical condition that will result in deafblindness; or

(iii) functions as a person with deafblindness; and

(B) has one or more additional disabilities that result in impairment to independent functioning;

(4) the individual has an IPC with a cost for DBMD Program services at or below 210 percent of the annualized cost of care in an ICF/IID using the unweighted average of the current non-state operated small facility daily rates for level of need, as defined by the ICF/IID program rules in §261.203 of this title (relating to Definitions), 1, 5, and 8 rounded to the nearest dollar [~~$114,736.07~~];

(5) the individual is not enrolled in another waiver program or receiving a service that may not be received if the individual is enrolled in the DBMD Program, as identified in the Mutually Exclusive Services table in Appendix V of the Deaf Blind with Multiple Disabilities Program Manual;

(6) the individual does not reside in:

(A) an ICF/IID;

(B) a nursing facility;

(C) an ALF, unless it provides licensed assisted living in the DBMD Program;

(D) a residential child-care facility unless it is an agency foster home;

(E) a hospital;

(F) a mental health facility;

(G) an inpatient chemical dependency treatment facility;

(H) a residential facility operated by the Texas Workforce Commission;

(I) a residential facility operated by the Texas Juvenile Justice Department;

(J) a jail; or

(K) a prison;

(7) at least one program provider is willing to provide DBMD Program services to the individual;

(8) the individual resides or moves to reside in a county served by a program provider; and

(9) the individual requires the provision of:

(A) at least one DBMD Program Service per month or a monthly monitoring by a case manager; and

(B) at least one DBMD Program Service during an IPC period.

(b) Except as provided in subsection (c) of this section, an individual is eligible for a CFC service under this chapter if the individual:

(1) meets the criteria described in subsection (a) of this section;

(2) requires the provision of the CFC service; and

(3) is not receiving licensed assisted living or licensed home health assisted living.

(c) To be eligible for a CFC service under this chapter, an individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (b) of this section, receive a DBMD Program service at least monthly, as required by 42 CFR §441.510(d).

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 30, 2025.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

CHAPTER 262. TEXAS HOME LIVING (TxHmL) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

26 TAC §262.101

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §262.101, concerning Eligibility Criteria for TxHmL Program Services and CFC Services.

BACKGROUND AND PURPOSE

The 2026-2027 General Appropriations Act, Senate Bill 1, 89th Texas Legislature, Regular Session, 2025 (Article II, HHSC Rider 23) includes appropriations to increase the base wage for personal attendant services. This wage increase will impact Medicaid personal attendant reimbursement rates.

As a result of this direction and prior reimbursement rate increases, HHSC proposes to amend the waiver cost limit, where applicable, for the Texas Home Living (TxHmL) waiver program to ensure the cost align with the rate increases. The purpose for increasing the waiver cost limit for an individual's plan of care (IPC) is to off-set the cost of higher personal attendant reimbursement rates while allowing the individual to continue to qualify for services in the TxHmL Program by not exceeding the cost limit for the IPC.

HHSC will also propose an amendment in the waiver cost limit for an individual's IPC in the Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, and the waiver cost limits in the Home and Community-based Services Programs in this same issue of the *Texas Register*.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §262.101(a)(4) amends the cost for the individual's IPC TxHmL Program services to not exceed 50 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for level of need 1, rounded to the nearest dollar. This change provides more money to pay for the services an individual needs, including the higher cost to pay for personal attendant-like services, while maintaining eligibility for the program.

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, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rule is in effect, the public will benefit from this project because the individual cost limits allow individuals in the TxHmL waiver program to adjust budgets to coincide with the individual plan of care for personal attendant and attendant-like services in alignment with the attendant rate increases. Similarly, providers will be reimbursed for the services provided to individuals according to their individual plans of care and waiver budgets.

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@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 25R038" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; and Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration.

The amendment affects Texas Government Code §524.0151 and Texas Human Resources Code §32.021.

§262.101. Eligibility Criteria for TxHmL Program Services and CFC Services.

(a) An applicant or individual is eligible for TxHmL Program services if:

(1) the applicant or individual meets the financial eligibility criteria as described in Appendix B of the TxHmL waiver application approved by CMS and available on the HHSC website;

(2) the applicant or individual meets one of the following criteria:

(A) based on a DID and as determined by HHSC in accordance with §262.104 of this subchapter (relating to LOC Determination), the applicant or individual qualifies for an ICF/IID LOC I as defined in §261.238 of this title (relating to ICF/MR Level of Care I Criteria); or

(B) meets the following criteria:

(i) based on a DID and as determined by HHSC in accordance with §262.105 of this subchapter (relating to LON Assignment), qualifies for one of the following levels of care:

(I) an ICF/IID LOC I as defined in §261.238 of this title; or

(II) an ICF/IID LOC VIII as defined in §261.239 of this title (relating to ICF/MR Level of Care VIII Criteria);

(ii) meets one of the following:

(I) resides in a nursing facility immediately before enrolling in the TxHmL Program; or

(II) is at imminent risk of entering a nursing facility as determined by HHSC; and

(iii) is offered TxHmL Program services designated for a member of the reserved capacity group "Individuals with a level

of care I or VIII residing in a nursing facility" included in Appendix B of the TxHmL Program waiver application approved by CMS and available on the HHSC website;

(3) the applicant or individual has been assigned an LON in accordance with §262.105 of this subchapter;

(4) the applicant or individual has an IPC cost that does not exceed 50 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 1, rounded to the nearest dollar [$~~17,000~~];

(5) the applicant or individual is not enrolled in another waiver program and is not receiving a service that may not be received if the individual is enrolled in the TxHmL Program, as identified in the Mutually Exclusive Services table in Appendix I of the TxHmL Handbook available on the HHSC website;

(6) the applicant or individual has chosen, or the applicant's or individual's LAR has chosen, participation in the TxHmL Program over participation in the ICF/IID Program;

(7) the applicant's or individual's service planning team concurs that the TxHmL Program services and, if applicable, non-TxHmL Program services for which the applicant or individual may be eligible are sufficient to ensure the applicant's or individual's health and welfare in the community;

(8) the applicant or individual does not reside in:

(A) a hospital;

(B) an ICF/IID;

(C) a nursing facility;

(D) an assisted living facility licensed or subject to being licensed in accordance with THSC Chapter 247;

(E) a residential child care facility licensed by HHSC unless it is an agency foster home;

(F) an inpatient chemical dependency treatment facility;

(G) a mental health facility;

(H) a residential facility operated by the Texas Workforce Commission; or

(I) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; and

(9) the applicant or individual requires the provision of:

(A) at least one TxHmL Program service per month or a monthly monitoring visit by a service coordinator as described in §262.701(o) of this chapter (relating to LIDDA Requirements for Providing Service Coordination in the TxHmL Program); and

(B) at least one TxHmL Program service per IPC year.

(b) Except as provided in subsection (c) of this section, an applicant or individual is eligible for a CFC service under this subchapter if the applicant or individual:

(1) meets the criteria described in subsection (a) of this section; and

(2) requires the provision of the CFC service.

(c) To be eligible for a CFC service under this chapter, an applicant or individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (b) of this section, receive a TxHmL Program service at least monthly, as required by 42 CFR §441.510(d), which may not be met by a monthly monitoring visit by a service coordinator as described in §262.701(o)(1) and (2) of this chapter.

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

Filed with the Office of the Secretary of State on June 30, 2025.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-2910

CHAPTER 263. HOME AND COMMUNITY-BASED SERVICES (HCS) PROGRAM AND COMMUNITY FIRST CHOICE (CFC)

SUBCHAPTER B. ELIGIBILITY, ENROLLMENT, AND REVIEW

26 TAC §263.101

The executive commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §263.101, concerning Eligibility Criteria for HCS Program Services and CFC Services.

BACKGROUND AND PURPOSE

The 2026-2027 General Appropriations Act, Senate Bill 1, 89th Texas Legislature, Regular Session, 2025 (Article II, HHSC Rider 23) includes appropriations to increase the base wage for personal attendant services. This wage increase will impact Medicaid personal attendant reimbursement rates.

As a result of this direction and prior reimbursement rate increases, HHSC proposes to amend the waiver cost limit, where applicable, for the Home and Community-based Services waiver program to ensure the cost limits align with the rate increases. The purpose for increasing the waiver cost limit for an individual's plan of care (IPC) is to off-set the cost of higher personal attendant reimbursement rates while allowing the individual to continue to qualify for services in the HCS Program by not exceeding the cost limit for the IPC.

HHSC will also propose an amendment in the waiver cost limit for an individual's IPC in the Community Living Assistance and Support Services, Deaf Blind with Multiple Disabilities, and Texas Home Living Programs in this same issue of the *Texas Register*.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §263.101(a)(3)(A) amends the cost for the individual's IPC HCS Program services to be 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for level of need (LON) 8, rounded to the nearest dollar for an applicant or individual with an LON 1, LON 5, or LON 8. This change provides more money to pay for the services an individual needs, including the higher cost to pay for personal attendant-like services, while maintaining eligibility for the program.

The proposed amendment to §263.101(a)(3)(B) amends the cost for the individual's IPC HCS Program services to be 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 6, rounded to the nearest dollar for an applicant or individual with an LON 6. This change provides more money to pay for the services an individual needs, including the higher cost to pay for personal attendant-like services, while maintaining eligibility for the program.

The proposed amendment to §263.101(a)(3)(C) amends the cost for the individual's IPC HCS Program services to be 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 9, rounded to the nearest dollar for an applicant or individual with an LON 9. This change provides more money to pay for the services an individual needs, including the higher cost to pay for personal attendant-like services, while maintaining eligibility for the program.

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, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local government.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rule is in effect, the public will benefit from this project because the individual cost limits allow individuals in the HCS waiver program to adjust budgets to coincide with the individual plan of care for personal attendant and attendant-like services in alignment with the attendant rate increases. Similarly, providers will be reimbursed for the services provided to individuals according to their individual plans of care and waiver budgets.

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@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 25R038" in the subject line.

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §524.0151, which provides that the executive commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system; and Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance program in Texas and to adopt rules and standards for program administration.

The amendment affects Texas Government Code §524.0151 and Texas Human Resources Code §32.021.

§263.101. Eligibility Criteria for HCS Program Services and CFC Services.

(a) An applicant or individual is eligible for HCS Program services if the applicant or individual:

(1) meets the financial eligibility criteria as described in Appendix B of the HCS Program waiver application approved by CMS and available on the HHSC website;

(2) meets one of the following criteria:

(A) based on a DID and as determined by HHSC in accordance with §263.105 of this subchapter (relating to LOC Determination), qualifies for an ICF/IID LOC I, as defined in §261.238 of this title (relating to ICF/MR Level of Care I Criteria);

(B) as determined by HHSC in accordance with §263.105 of this subchapter, qualifies for an ICF/IID LOC I as defined in §261.238 of this title or ICF/IID LOC VIII, as defined in §261.239 of this title (relating to ICF/MR Level of Care VIII Criteria), and has been determined by HHSC:

(i) to have an intellectual disability or a related condition;

(ii) to need specialized services; and

(iii) to be inappropriately placed in a Medicaid certified nursing facility based on an annual resident review conducted in accordance with the requirements of Chapter 303 of this title (relating to Preadmission Screening and Resident Review (PASRR); or

(C) meets the following criteria:

(i) based on a DID and as determined by HHSC in accordance with §261.237 of this title (relating to Level of Care) qualifies for one of the following levels of care:

(I) an ICF/IID LOC I as defined in §261.238 of this title; or

(II) an ICF/IID LOC VIII as defined in §261.239 of this title;

(ii) meets one of the following:

(I) resides in a nursing facility immediately before enrolling in the HCS Program; or

(II) is at imminent risk of entering a nursing facility as determined by HHSC; and

(iii) is offered HCS Program services designated for a member of the reserved capacity group "Individuals with a level of care I or VIII residing in a nursing facility" included in Appendix B of the HCS Program waiver application approved by CMS and available on the HHSC website;

(3) has an IPC cost that does not exceed:

(A) 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 8, rounded to the nearest dollar [~~$167,468~~] for an applicant or individual with an LON 1, LON 5, or LON 8;

(B) 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 6, rounded to the nearest dollar [~~$168,615~~] for an applicant or individual with an LON 6; or

(C) 210 percent of the annualized cost of care in an ICF/IID using the current non-state-operated small facility daily rate for LON 9, rounded to the nearest dollar [~~$305,877~~] for an applicant or individual with an LON 9;

(4) is not enrolled in another waiver program and is not receiving a service that may not be received if the individual is enrolled in the HCS Program as identified in the Mutually Exclusive Services table in Appendix II of the HCS Handbook available on the HHSC website;

(5) does not reside in:

(A) a hospital;

(B) an ICF/IID;

(C) a nursing facility;

(D) an ALF;

(E) a residential child care facility licensed by HHSC unless it is an agency foster home;

(F) an inpatient chemical dependency treatment facility;

(G) a mental health facility;

(H) a residential facility operated by the Texas Workforce Commission; or

(I) a residential facility operated by the Texas Juvenile Justice Department, a jail, or a prison; and

(6) requires the provision of:

(A) at least one HCS Program service per month or a monthly monitoring visit by a service coordinator as described in §263.901(e)(40) of this chapter (relating to LIDDA Requirements for Providing Service Coordination in the HCS Program); and

(B) at least one HCS Program service per IPC year.

(b) For applicants or individuals with spouses who live in the community, the income and resource eligibility requirements are determined according to the spousal impoverishment provisions in §1924 of the Social Security Act and as specified in the Medicaid State Plan.

(c) Except as provided in subsection (d) of this section, an applicant or individual is eligible for a CFC service under this chapter if the applicant or individual:

(1) meets the criteria described in subsection (a) of this section;

(2) requires the provision of the CFC service; and

(3) is not receiving host home/companion care, supervised living, or residential support.

(d) To be eligible for a CFC service under this chapter, an applicant or individual receiving MAO Medicaid must, in addition to meeting the eligibility criteria described in subsection (c) of this section, receive an HCS Program service at least monthly, as required by 42 CFR §441.510(d), which may not be met by a monthly monitoring visit by a service coordinator as described in §263.901(e)(40) of this chapter.

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

Filed with the Office of the Secretary of State on June 30, 2025.

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Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: August 10, 2025
For further information, please call: (512) 438-2910

CHAPTER 745. LICENSING
SUBCHAPTER J. WAIVERS AND VARIANCES FOR MINIMUM STANDARDS

26 TAC §745.8301

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §745.8301, concerning What words must I know to understand

this subchapter, in Title 26, Texas Administrative Code, Chapter 745, Licensing.

BACKGROUND AND PURPOSE

The purpose of this proposal is to implement House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023, which requires Child Care Regulation (CCR) to collaborate with the Department of Family and Protective Services (DFPS) to develop and adopt a set of licensing and approval standards for kinship foster homes pursuant to the adoption of federal rules. The Administration for Children and Families amended 45 Code of Federal Regulations (CFR) Parts 1355 and 1356, with the amendments effective on November 27, 2023. The amendments allow CCR to adopt a set of licensing or approval standards for all kinship foster homes that (1) are different from the standards used for non-kinship foster homes, and (2) will allow a child-placing agency (CPA) to issue a foster home verification to a kinship foster home that meets the new standards.

CCR is proposing an amendment to §745.8301(3) to amend the definition of "kinship foster home" to be consistent with how the term is defined across CCR and DFPS rules.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §745.8301 (1) expands the definition of kinship foster home to include foster parents who have a longstanding and significant relationship with the foster child's family; (2) removes language from the rule for consistency with language in DFPS rules and (3) replaces "Licensing" with "Child Care Regulation (CCR)"; and (4) renames the section to "Definitions for Subchapter J."

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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; does not impose a cost on regulated persons; is necessary to receive a source of federal funds or comply with federal law; and is necessary to implement legislation that does not specifically state that §2001.0045 applies to the rule.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Associate Commissioner for Child Care Regulation, has determined that for each year of the first five years the rule is in effect, the public benefit will be improved regulatory consistency by aligning definitions across agencies.

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 fees and a CPA is not required to verify kinship foster homes.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@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 24R047" in the subject line.

STATUTORY AUTHORITY

The amended section is authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The amended section affects Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§745.8301. Definitions for Subchapter J. [~~What words must I know to understand this subchapter?~~]

These words have the following meanings in this subchapter:

(1) Foster family home--A home that is the primary residence of the foster parent or parents and provides care to six or fewer children or young adults, under the regulation of a child-placing agency. Also referred to as "foster home."

(2) Foster parent--A person verified to provide child care services in the foster home.

(3) Kinship foster home--A foster family home with a foster parent or parents who:

(A) Is related to a foster child by consanguinity or affinity; or

(B) Has a longstanding and significant relationship with the foster child or [~~before the child is placed with~~] the foster child's family [~~parent~~].

(4) Variance--A decision by Child Care Regulation (CCR) that there is good and just cause for an operation to meet the purpose of a minimum standard in a different way.

(5) [~~(4)~~] Waiver--A decision by CCR [~~Licensing~~] that waives an operation's compliance with a minimum standard if the economic impact of compliance with that standard is great enough to make compliance impractical.

[~~(5) Variance--A decision by Licensing that there is good and just cause for an operation to meet the purpose of a minimum standard in a different way.~~]

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, 2025.

TRD-202502131
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: August 10, 2025
For further information, please call: (512) 438-3269

CHAPTER 749. MINIMUM STANDARDS FOR CHILD-PLACING AGENCIES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes the repeal of §749.2472 and new §§749.4401, 749.4403, 749.4421, 749.4423, 749.4425, 749.4427, 749.4429, 749.4441, 749.4443, 749.4445, 479.4447, 479.4449, 749.4451, 749.4461, 749.4463, 749.4465, 749.4471, 749.4473, 749.4475, 749.4477, 749.4479, 749.4481, 749.4483, 749.4485, 749.4487, 749.4489, 749.4491, 749.4493, 749.4501, 749.4503, 749.4505, 749.4507, 749.4509, 749.4511, 749.4513, 749.4515, 749.4517, 749.4519, 749.4521, 749.4523, 749.4551, 749.4553, 749.4555, 749.4557, 749.4559, 749.4561, 749.4563, 749.4565, 749.4567, 749.4569, 749.4571, 749.4573, 749.4575, 749.4577, 749.4579, and 749.4581 in Texas Administrative Code, Title 26, Chapter 749, Minimum Standards for Child-Placing Agencies.

BACKGROUND AND PURPOSE

The purpose of this proposal is to implement House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023, which requires Child Care Regulation (CCR) to collaborate with the Department of Family and Protective Services (DFPS) to develop and adopt a set of licensing and approval standards for kinship foster homes pursuant to the adoption of federal rules. The Administration for Children and Families amended 45 Code of Federal Regulations (CFR) Parts 1355 and 1356, with the amendments effective on November 27, 2023. The amendments allow CCR to adopt a set of licensing or approval standards for all kinship foster homes that (1) are different from the standards used for non-kinship foster homes, and (2) will allow a child-placing agency (CPA) to issue a foster home verification to a kinship foster home that meets the new standards.

CCR is proposing the repeal of §749.2472 and new rules, in new Subchapter W of Chapter 749, to establish a CPA's ability to issue a non-expiring foster home verification to a kinship foster home.

SECTION-BY-SECTION SUMMARY

The proposed repeal of §749.2472 deletes the rule as it is no longer necessary because the content of the rule has been modified and moved to new §749.4503(a)(2).

Proposed new Subchapter W, Kinship Foster Homes, adds a new subchapter in Chapter 749 for rules related to kinship foster homes as listed below.

Proposed new Division 1, Definitions and Scope, in Subchapter W, (1) contains definitions for words and terms used in Subchapter W; and (2) establishes who is required to comply with the rules.

Proposed new §749.4401, Definitions for Subchapter W, provides terms and definitions that are used throughout the subchapter. The rule (1) includes definitions for the terms "affinity" and "consanguinity," which are identical to the definitions found in Chapter 745, Licensing, Subchapter A, §745.21; and (2) adds definitions for "kinship caregiver," "kinship foster child," "kinship foster home," "kinship foster home verification," and "kinship foster parent."

Proposed new §749.4403, Scope, establishes that a CPA must comply with the rules in new Subchapter W (1) before issuing a kinship foster home verification and (2) while the kinship foster home verification is in effect. It also identifies the other subchapters in Chapter 749 that apply to kinship foster homes. The rule clarifies that if a home is both a foster family home and a kinship foster home, the home may follow the rules in Subchapter W relating to the direct care of a kinship foster child, but the home must: (1) be verified as a kinship foster home; and (2) follow all other applicable rules in Chapter 749 for non-kinship foster children.

Proposed new Division 2, Pre-Verification and Ongoing Training Requirements, in Subchapter W, contains rules relating to training requirements for kinship caregivers.

Proposed new §749.4421, Documentation of Required Trainings, establishes documentation requirements for required trainings. The rule requires a CPA to document the completion of all required trainings and signed agreements. It also requires that certificates for pediatric first aid and pediatric cardiopulmonary resuscitation have an expiration date and be renewed prior to the expiration date. The rule clarifies that if a CPA requires a home to complete additional training, the documentation must include (1) the topics covered; (2) the curriculum used; and (3) how the CPA determined which training topics to use.

Proposed new §749.4423, Pre-Verification Training Requirements, establishes pre-verification training requirements. The rule requires each kinship caregiver to have pre-verification training that includes: (1) an overview of the minimum standards in Chapter 749 the kinship caregiver must follow; (2) the CPA's philosophy, structure, policies, and services; (3) a review of the prudent parent standard; (4) a review of the agreements between the CPA and kinship foster parents; and (5) a review of the CCR Statement of Foster Parents and Child-Placing Agency Rights and Responsibilities.

Proposed new §749.4425, Pediatric Fist Aid and Pediatric Cardiopulmonary Resuscitation (CPR) Requirements, requires one kinship foster parent to be certified in pediatric first aid and pediatric CPR prior to the home's verification. The rule allows subsequent caregivers to be certified within 90 days after the CPA issues the home's verification. The rule clarifies that the training must (1) include rescue breathing and choking, and (2) adhere to guidelines for CPR established by the American Heart Association.

Proposed new §749.4427, General Training Requirements, establishes the general training requirements and timeframes for completion for kinship caregivers. The rule requires all kinship caregivers to complete four hours of general training and at least six hours of emergency behavior intervention training within 60 days after the CPA issues the home's verification. If the home will care for children younger than two years of age, it also requires one kinship foster parent to complete safe sleep training prior to the CPA verifying the home; the rule additionally requires all other caregivers in the home to complete safe sleep training within 90 days after the verification. For all caregivers that administer psychotropic medication, the rule requires them to complete training on administering psychotropic medication prior to administering the medication. The rule specifies that general caregiver training must include specific curriculum requirements; however, for the other trainings, the CPA must determine the appropriate curriculum.

Proposed new §749.4429, Additional Training Requirements, establishes the additional training requirements for kinship caregivers. The rule requires the CPA to annually evaluate the kinship foster home for any areas of non-compliance with minimum standards. If the CPA identifies areas of non-compliance with minimum standards, the rule requires the CPA to provide all kinship caregivers in the home with additional training appropriate to the areas of non-compliance. The rule also requires the CPA to provide at least one hour of annual training to each kinship foster parent that provides care to a kinship foster child receiving treatment services for emotional disorders, intellectual disabilities, or autism spectrum disorder.

Proposed new Division 3, Admission and Placement, in Subchapter W, contains rules related to the admission and placement of kinship foster children.

Proposed new §749.4441, Admission Criteria, establishes criteria for admitting a kinship foster child. The rule (1) allows for regular or emergency admissions; (2) requires the CPA to ensure the placement meets the kinship foster child's needs; and (3) establishes situations when an individual over the age of 18 years old can remain in care or be admitted into the care of a kinship foster home.

Proposed new §749.4443, Documentation of Admission Information, specifies the admission information that a CPA must document into a kinship foster child's record.

Proposed new §749.4445, Initial Requirements at the Time of Admission or Verification, establishes the initial admission requirements for a kinship foster child. The rule requires the CPA to obtain specific information about the child, including (1) the circumstances that brought the child into care; (2) the child's current health status and medical conditions; (3) high-risk behaviors, including a suicide risk screening when applicable; (4) known contraindications to the use of restraint; and (5) any safety plans the kinship caregiver will implement related to the behaviors or risk factors.

Proposed new §749.4447, Placement Agreement, describes the general purpose of a placement agreement and specifies what the agreement must include.

Proposed new §749.4449, Admission Assessment, establishes requirements for the admission assessment. The rule describes functions for which the CPA must use information obtained during the assessment; timeframes for when the assessment must be completed; and what the assessment must include. For a child who is over three years of age, the rule also allows the CPA to use a written assessment of the child's needs provided by DFPS in lieu of the admission assessment; this documentation is presently entitled the Child Assessment of Needs and Strengths (CANS).

Proposed new §749.4451, Post-Placement Contacts, establishes requirements for post-placement contacts with the kinship foster child. The rule requires the CPA to have monthly face-to-face contact with a kinship foster child. The rule establishes requirements for the length and content of the visits.

Proposed new Division 4, Medical and Dental Requirements, in Subchapter W, contains rules related to medical and dental requirements for kinship foster children.

Proposed new §749.4461, Documentation Requirements for Medical and Dental Care, establishes documentation requirements related to medical and dental care. The rule specifies information the CPA must verify is documented in the kinship foster child's health passport or record; information a kinship foster home must maintain in a daily medication log for the child on a form provided by the CPA; and documentation requirements when a kinship caregiver fails to administer any medication to the child according to the medication label or subsequent signed orders.

Proposed new §749.4463 General Medical, Dental, and Medication Requirements, establishes the general medical, dental, and medication requirements. The rule describes requirements for medical and dental care that a kinship foster child must receive and requires (1) a kinship foster child to receive timely routine and emergency medical and dental care; (2) the CPA to verify that a kinship foster child at least three years of age has had (A) a medical examination in the last year and (B) a dental examination in the last year; (3) all medications to be administered according to the label or to a prescriber's subsequent signed orders; and (4) all medications to be stored securely and in a way that makes them inaccessible to kinship foster children.

Proposed new §749.4465, Immunization and Tuberculosis Testing, establishes requirements for immunizations and tuberculosis testing for kinship foster children.

Proposed new Division 5, Daily Care, Education, and Discipline, in Subchapter W contains rules relating to the daily care, education, and discipline of kinship foster children.

Proposed new §749.4471, Normalcy, requires a kinship foster parent to ensure a kinship foster child can participate in childhood activities, including unsupervised activities, that are appropriate in relation to the child's age and developmental needs.

Proposed new §749.4473, Infants: Basic Care and Supervision, establishes basic care and supervision requirements for infants in a kinship foster home. The rule establishes (1) that infants receive individual and prompt attention; (2) environmental requirements, including (A) keeping the area free of harmful objects, including diaper changing items, and (B) ensuring electrical outlets are inaccessible; and (3) that an infant may never be left unsupervised. The rule defines what is considered supervision for a sleeping infant, an awake infant, and further establishes supervision requirements.

Proposed new §749.4475, Infants: Cribs, establishes crib requirements for infants. The rule (1) requires a kinship foster home to have an individual crib that meets certain requirements for an infant; (2) clarifies when the home may use a full-sized, portable, or mesh-side crib; (3) prohibits (A) using a stackable crib for an infant and (B) leaving an infant in a crib portable crib, or mesh-side crib with a side folded down; (4) clarifies that special items may be used to assist with safe sleep in a crib used by an infant with primary medical needs with the written recommendation from a health care professional; and (5) requires the CPA to notify the parent of each child in care of each foster home verified by the CPA if specific rules in this section are cited as deficient.

Proposed new §749.4477, Infants: Safe Sleep Requirements, establishes safe sleep requirements for infants. The rule requires kinship caregivers to (1) place an infant who is unable to turn over unassisted in a face up sleeping position unless they have signed orders from a health care professional; (2) ensure the infant's head, face, and crib are not covered by any item; (3) ensure the infant does not (A) co-sleep with an adult or (B) sleep in a restrictive device, such as a car seat, swing, or highchair; and (4) ensure infants who can roll over are not swaddled. The rule requires the CPA to notify the parent of each child in care of each foster home verified by the CPA if specific rules in this section are cited as deficient.

Proposed new §749.4479, Infants: Equipment Safety, establishes equipment safety requirements for infants.

Proposed new §749.4481, Infants: Feeding Requirements, establishes feeding requirements for infants. The rule requires kinship caregivers to (1) feed an infant based on the recommendations of the infant's health-care professional; (2) hold infants birth through six months old or unable to sit unassisted while feeding; (3) never prop a bottle with anything other than the infant's or adult's hands; and (4) sterilize shared bottles and clean highchair trays before each use when caring for more than one infant.

Proposed new §749.4483, Toddlers: Basic Care Requirements, establishes basic care requirements for toddlers. The rule includes (1) environmental requirements, including (A) keeping the area free of harmful objects, and (B) ensuring electrical outlets are inaccessible; and (2) supervision requirements, including (A) never leaving a toddler unsupervised, and (B) ensuring the toddler is within eyesight or hearing range. The rule allows for the use of video camera or audio monitoring if the kinship caregiver is close enough to intervene as needed.

Proposed new §749.4485, Additional Requirements for Pregnant Kinship Foster Children, establishes additional requirements for pregnant kinship foster children. The rule requires the CPA to ensure information, training, and counseling is available to the kinship foster child.

Proposed new §749.4487, Additional Requirements for Kinship Foster Children Receiving Treatment Services for Primary Medical Needs or Intellectual Disabilities, establishes additional requirements for kinship foster children receiving treatment services for primary medical needs or intellectual disabilities. The rule requires kinship caregivers to (1) follow recommendations from the kinship foster child's medical providers; and (2) ensure that a kinship foster child receiving treatment services for primary medical needs or an intellectual disability has opportunities for sensory stimulation.

Proposed new §749.4489, Educational Services: General, establishes general educational requirements for kinship foster children. The rule requires the CPA to arrange appropriate education that includes an approved or accredited educational facility or program, and to advocate for a kinship foster child to receive educational and related services to which they are entitled under federal and state law. The rule establishes specific requirements for kinship foster children with autism spectrum disorder. The rule also requires the CPA to designate a liaison between the agency and the school for a kinship foster child who receives treatment services.

Proposed new §749.4491, Education Services: Caregiver Responsibilities, establishes kinship caregiver responsibilities related to education. The rule requires kinship caregivers to (1) request educational meetings with the school if concerns are identified; (2) attend scheduled educational meetings and staffings; and (3) know what is in the kinship foster child's Individual Education Plan.

Proposed new §749.4493, Discipline and Punishment, establishes discipline and punishment requirements in a kinship foster home. The rule requires (1) only a kinship caregiver known to a kinship foster child can discipline the child; and (2) all disciplinary measures be consistent with child's rights related to discipline and punishment.

Proposed new Division 6, Screenings and Verifications, in Subchapter W contains rules relating to the requirements for kinship home screenings and the verification of kinship foster homes.

Proposed new §749.4501, General Requirements, establishes the general requirements for a kinship foster home verification. The rule (1) requires kinship parents to be at least 18 years old; (2) establishes circumstances when a CPA can verify an individual spouse as a kinship foster parent; and (3) prohibits a kinship foster home from being verified by more than one CPA at a time for kinship foster care services.

Proposed new §749.4503, Kinship Foster Home Screenings, establishes the steps that a CPA takes to complete a home screening for a kinship foster home. The rule clarifies that the CPA (1) may (A) complete the home screening as detailed in the rule, or (B) use a completed home assessment obtained from the Department of Family and Protective Services (DFPS) or Single Source Continuum Contractor (SSCC) that meets the requirements of the Subchapter W, Division 5; and (2) must update a kinship foster home screening any time there is a major life change. The rule describes the specific categories of information that the CPA must discuss, document, and assess through interviews with each prospective kinship foster parent and joint interviews. The rule also requires a CPA to report to CCR any information obtained about domestic violence.

Proposed new §749.4505, Verifying a Kinship Foster Home, establishes steps the CPA takes to complete a kinship foster home verification. The rule requires the CPA to (1) complete and document requirements of Subchapter W, Division 5; (2) obtain a sketch or photo of the inside and outside of the home; (3) inspect the home and ensure and document compliance with applicable rules relating to Daily Care, Education, and Discipline, and Health and Safety Requirements, Environment, Space, and Equipment; (4) evaluate and make recommendations about the home's ability to keep children safe; (5) document (A) any indicators of substantial safety risk to children based on the evaluation of the home and (B) how the CPA addressed them prior to approving and verifying the home; (6) obtain from the child placement management staff (CPMS) (A) review and approval of the home screening and (B) recommendation for verification of the home; and (7) issue a verification certificate that includes (A) the name of the kinship foster family, (B) capacity details, and (C) services the kinship foster home provides.

Proposed new §749.4507, Previously Verified Kinship Foster Homes, establishes requirements for working with kinship foster homes that were previously verified by or transferring from another CPA.

Proposed new §749.4509, Releasing Information About a Previously Verified Kinship Foster Home, establishes requirements for releasing information about a previously verified kinship foster home. The rule requires a CPA to release background information about current and previous kinship foster homes to other CPAs and independent contractors who are hired or required by the court.

Proposed new §749.4511, Changes to the Verification Status of a Kinship Foster Home, establishes requirements for changing the verification status of a kinship foster home. The rule (1) describes changes a CPA must inform CCR about within two business days; (2) requires that child placement management staff ensure that any additional services offered by a kinship foster home do not create a conflict of care with children currently in the home; and (3) includes requirements for when a kinship foster home adds a new, unrelated household member.

Proposed new §749.4513, Transferring or Closing a Kinship Foster Home, establishes the criteria for a transfer or closing summary for a kinship foster home, including what the summary must include and timeframes for their completion.

Proposed new §749.4515, Temporary Kinship Foster Home Verifications, establishes criteria for issuing a temporary kinship foster home verification, including inspection requirements, that the temporary verification can be valid for a maximum of six months, and that the CPA must ensure compliance with requirements in subchapter W before issuing a non-expiring kinship foster home verification to the home at the new location.

Proposed new §749.4517, Capacity and Child/Caregiver Ratio, establishes capacity and child/caregiver ratio for a kinship foster home.

Proposed new §749.4519, Supervision, establishes supervision requirements at a kinship foster home. The rule addresses what the CPA must ensure that the supervision of a kinship foster child accounts for; describes the responsibilities of a kinship caregiver; and information that a kinship caregiver must have when a kinship foster child participates in an unsupervised childhood activity.

Proposed new §749.4521, Kinship Foster Children as Babysitters, establishes requirements for when a kinship foster child may act as a babysitter.

Proposed new §749.4523, Respite Child-Care Services, establishes that a kinship foster home may only provide respite care services for kinship foster children. The rule requires the CPMS to (1) approve of any respite placement to ensure the respite care will not cause a conflict of care; and (2) ensure information is shared about kinship foster children for continuity of care.

Proposed new Division 7, Health and Safety Requirements, Environment, Space, and Equipment, in Subchapter W, contains rules relating to health and safety, environment, space, and equipment in kinship foster homes.

Proposed new §749.4551, Documentation of Health and Safety Requirements, establishes what a CPA must document in a kinship foster home's record related to health and safety requirements.

Proposed new §749.4553, Health and Fire Inspections, establishes requirements for health and fire inspections or evaluations at a kinship foster home. The rule describes who must conduct each type of inspection or evaluation and requires a home to correct deficiencies and comply with any conditions or restrictions.

Proposed new §749.4555, Emergency Plans, establishes requirements for a written plan that a kinship foster home must have for handling potential disasters and emergencies, including fire and severe weather. The rule requires the CPA that verified the home to annually review and evaluate the plan with all kinship caregivers and kinship foster children in the home. The rule allows the CPA to develop the plan or to obtain a copy of the plan the kinship foster family developed with DFPS or the relevant Single Source Continuum Contractor.

Proposed new §749.4557, Fire Safety, establishes fire safety requirements. The rule includes the places in a kinship foster home where there must be a working smoke detector; a requirement for the home to have at least one non-expired and operational fire extinguisher that is accessible in an emergency; and that the home must ensure that exits to the home are not blocked.

Proposed new §749.4559, Animals, requires that any animals in a kinship foster home do not pose a health or safety threat to kinship foster children.

Proposed new §749.4561, Weapons, Firearms, Explosive Materials, and Projectiles at a Kinship Foster Home, establishes requirements related to weapons, firearms, explosive materials, and projectiles at a kinship foster home. The rule requires a CPA to have a policy identifying specific precautions to ensure that a kinship foster child does not have unsupervised access to these items; requires the CPA to determine whether it is appropriate for a specific kinship foster child to use a weapon, firearm, explosive material, or projectile or to use a toy that explodes or shoots; and exempts a firearm that is inoperable and solely ornamental from storage requirements.

Proposed new §749.4563, Storage of Weapons, Firearms, Explosive Materials, or Projectiles in a Kinship Foster Home, establishes what factors the CPA must consider when determining if a weapon, firearm, explosive material, or projectile is stored adequately in a kinship foster home. The rule specifies that a CPA may not require a kinship foster home to disclose the specific types of firearms that are stored or otherwise present in the kinship foster home, nor may a CPA require a kinship foster home

to notify the CPA if there is any change in the types of firearms present in the home.

Proposed new §749.4565, Determining Weapons, Firearms, Explosive Materials, or Projectiles are Present in a Kinship Foster Home, establishes how a CPA determines if weapons, firearms, explosive materials, and projectiles are present at a kinship foster home. The rule requires the CPA to assess this information during the home screening and document (1) whether weapons, firearms, explosive materials, or projectiles are present in the home; and (2) specific precautions the kinship caregiver must take to ensure that the kinship foster children do not have unsupervised access. The rule specifies that a CPA may not require a kinship foster home to disclose the specific types of firearms that are present in the kinship foster home or to notify the CPA if there is any change in the types of firearms present in the home. The rule further requires the CPA to discuss these items with the kinship foster home during the two-year evaluation.

Proposed new §749.4567, Transporting a Kinship Foster Child in a Vehicle Where Firearms, Explosive Materials, or Projectiles are Present, establishes requirements for transporting a kinship foster child in a vehicle where firearms, explosive materials, or projectiles are present. Due to the statutory requirements in Texas Human Resources Code §42.042(e-2), the rule addresses requirements related to transporting a child in a vehicle where a handgun is present separately from requirements related to transporting a child in a vehicle where another type of firearm or an explosive material or projectile is present.

Proposed new §749.4569, Physical Environment of a Kinship Foster Home, establishes requirements related to the safety of indoor and outdoor space and equipment. The rule requires the home to ensure that indoor and outdoor space and equipment do not pose a safety risk to kinship foster children. The rule also includes supervision requirements to prevent a kinship foster child from having access to space or equipment, if necessary, based on the child's age, maturity, and service plan restrictions.

Proposed new §749.4571, Indoor Space: Sleeping Spaces and Sleeping Surfaces, establishes requirements related to sleeping spaces and surfaces used by a kinship foster child, as well as what CPMS must determine and document before approving a kinship foster child to share a sleeping space or surface with another individual.

Proposed new §749.4573, Indoor Space: Bathrooms, describes bathroom requirements for a kinship foster home.

Proposed new §749.4575, Nutrition and Food Safety, establishes requirements for food and food safety at a kinship foster home, including that (1) kinship caregivers provide kinship foster children with drinking water and food that is served in a safe and sanitary manner; and (2) all food items are stored in a manner that protects them from contamination, spoiling, and insects and rodents.

Proposed new §749.4577, Transportation, establishes requirements for transporting a kinship foster child. The rule requires (1) kinship caregivers to secure safe and reliable transportation; (2) special provisions to be made for transporting non-ambulatory and non-mobile children; and (3) each kinship foster child to be secured in a safety seat or safety belt appropriate to their age, height, and weight.

Proposed new §749.4579, Water Safety: Pools, Hot Tubs, and Bodies of Water, establishes general water safety rules. The rule includes requirements related to a door alarm or lock; the bottom of a pool having to be visible; and swimming pool chemicals and machinery being inaccessible to kinship foster children.

Proposed new §749.4581, Swimming Supervision, establishes supervision requirements for swimming activities. The rule requires kinship caregivers to (1) inform each kinship foster child about house rules related to water activities; (2) adequately supervise and monitor kinship foster children while participating in water activities; (3) ensure that a kinship foster child has access to a lifesaving device when participating in water activities; and (4) be able to clearly see all parts of the swimming pool or hot tub while supervising. The rule defines "personal floatation device" (PFD) and requires a kinship foster child who is unable to swim to wear a PFD of the correct size for the child while participating in water activities.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new regulations;

(6) the proposed rules will repeal existing regulations;

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas; do not impose a cost on regulated persons; are necessary to receive a source of federal funds or comply with federal law; and are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Associate Commissioner for Child Care Regulation, has determined that for each year of the first

five years the rules are in effect the public benefit will be (1) increased safety and well-being of foster children placed with kinship caregivers who meet basic health and safety requirements; (2) kinship providers who can accept foster children more quickly with rules that are unique to kinship providers; and (3) rules that comply with state law.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because the rules do not impose fees and a CPA is not required to verify kinship foster homes.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's 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 Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4601 West Guadalupe Street, Austin, Texas 78751; or emailed to HHSRulesCoordinationOffice@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 24R047" in the subject line.

SUBCHAPTER M. FOSTER HOMES: SCREENINGS AND VERIFICATIONS

DIVISION 3. VERIFICATION OF FOSTER HOME

26 TAC §749.2472

STATUTORY AUTHORITY

The repealed sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.2472. Are there any additional requirements to verify a foster home that is currently acting as a kinship home with the Child Protective Services (CPS) Division of the Department?

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, 2025.

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Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: August 10, 2025
For further information, please call: (512) 438-3269

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SUBCHAPTER W. KINSHIP FOSTER HOMES

DIVISION 1. DEFINITIONS AND SCOPE

26 TAC §749.4401, §749.4403

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4401. Definitions for Subchapter W.

These terms have the following meanings in this subchapter.

(1) Affinity--Related by marriage, as set forth in Texas Government Code §573.024.

(2) Consanguinity--Two individuals are related to each other by consanguinity if one is a descendant of the other, or they share a common ancestor. An adopted child is related by consanguinity for this purpose. Consanguinity is defined in Texas Government Code §573.022.

(3) Kinship caregiver--A kinship caregiver:

(A) Is a person counted in the child/caregiver ratio for kinship foster care services, including employees, kinship foster parents, contract service providers, and volunteers whose duties include direct care, supervision, guidance, and protection of a kinship foster child, including any person who is solely responsible for a kinship foster child; a child placement staff taking a kinship foster child on an appointment or doctor's visit is an example of a kinship caregiver; and

(B) Does not include a babysitter, an overnight care provider, or a respite child-care provider unless the person is:

(i) A verified kinship foster parent;

(ii) An agency employee;

(iii) A contract service provider; or

(iv) A volunteer.

(4) Kinship foster child--A child in the care of a kinship foster home who:

(A) Is related to the kinship foster parents by consanguinity or affinity; or

(B) Has, or whose family has a longstanding and significant relationship with the kinship foster parent.

(5) Kinship foster home--A foster family home that has a kinship foster parent or parents.

(6) Kinship foster home verification--A verification for a kinship foster home. A kinship foster home must meet certain requirements for a non-expiring foster home verification, as provided in this subchapter, and may only care for kinship foster children.

(7) Kinship foster parent--A foster parent who:

(A) Is related to a foster child by consanguinity or affinity;

(B) Has a longstanding and significant relationship with a foster child or the child's family before the child is placed; or

(C) Is the spouse of a foster parent who has a longstanding and significant relationship with the foster child or the foster child's family.

§749.4403. Scope.

(a) A child-placing agency (CPA) must comply with the rules in the following subchapters of this chapter, as applicable, before issuing a kinship foster home verification and while the kinship foster home verification is in effect:

(1) Subchapter A (relating to Purpose and Scope);

(2) Subchapter B (relating to Definitions and Services);

(3) Subchapter C (relating to Organization and Administration);

(4) Subchapter D (relating to Reports and Record Keeping);

(5) Subchapter E (relating to Agency Staff and Caregivers);

(6) Subchapter G (relating to Children's Rights);

(7) Subchapter I (relating to Foster Care Services: Service Planning, Discharge);

(8) Subchapter L (relating to Foster Care Services: Emergency Behavior Intervention);

(9) Subchapter N (relating to Foster Homes: Management and Evaluation); and

(10) Subchapter P (relating to Foster-Adoptive Homes and Legal Risk Placements).

(b) For the regulation and ongoing monitoring of a kinship foster home, the CPA must comply with the divisions of this subchapter as noted in the following chart.
Figure: 26 TAC §749.4403(b)

(c) A foster family home that also provides care to a kinship foster child may follow the rules in this subchapter relating to the direct care of kinship foster children. However, the home must:

(1) Be verified as a foster family home; and

(2) Follow all other applicable rules in this chapter for the direct care of non-kinship foster children.

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 2. PRE-VERIFICATION AND ONGOING TRAINING REQUIREMENTS

26 TAC §§749.4421, 749.4423, 749.4425, 749.4427, 749.4429

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4421. Documentation of Required Trainings.

(a) A child-placing agency (CPA) must document completion of all required training, including any training certificates and signed agreements reviewed during pre-verification training, in the appropriate kinship foster home record.

(b) Certificates for pediatric first aid and pediatric cardiopulmonary resuscitation must have an expiration date, and the training documented on the certificate must be renewed prior to the expiration date.

(c) If the CPA determines that a kinship foster home requires additional training to address areas of non-compliance identified during the CPA's annual evaluation of the kinship foster home, the CPA must document:

(1) The additional training topics covered;

(2) The curriculum used for each of the kinship caregiver's additional training; and

(3) How the CPA determined which additional training topics were appropriate.

§749.4423. Pre-Verification Training Requirements.

Prior to a child-placing agency (CPA) verifying a kinship foster home, each kinship caregiver must have pre-verification training that includes:

(1) An overview of the relevant and applicable rules of this chapter;

(2) The CPA's philosophy, organizational structure, and policies, as well as a description of services and programs the CPA offers;

(3) A review of the reasonable and prudent parent standard, including how the kinship caregivers will use the standard to ensure safety in the kinship foster home;

(4) A review of the agreements between the CPA and kinship foster parents while the verification is in effect; and

(5) A review of the CCR Statement of Foster Parent and Child-Placing Agency Rights and Responsibilities, Form 2907, or a form created by the CPA with the same information.

§749.4425. Pediatric First Aid and Pediatric Cardiopulmonary Resuscitation (CPR) Requirements.

(a) One kinship foster parent must be certified in pediatric first aid and pediatric CPR before a child-placing agency (CPA) issues the kinship foster home's verification. Other kinship caregivers, including a second kinship foster parent, must be certified in pediatric first aid and CPR within 90 days after the CPA verifies the home.

(b) Pediatric first aid must include training related to rescue breathing and choking.

(c) Pediatric CPR training must adhere to guidelines for CPR established by the American Heart Association.

§749.4427. General Training Requirements.

A kinship caregiver must complete the following applicable types of general training within the noted timeframes.
Figure: 26 TAC §749.4427

§749.4429. Additional Training Requirements.

(a) From the date a child-placing agency (CPA) verifies a kinship foster home, the CPA must annually evaluate the kinship foster home to identify any areas of non-compliance with minimum standards.

(b) If the CPA identifies areas of non-compliance in the kinship foster home, the CPA must provide all kinship caregivers in that kinship foster home with additional training appropriate to address the areas of non-compliance.

(c) For each kinship foster home that provides care to a kinship foster child receiving treatment services for emotional disorders, intellectual disabilities, or autism spectrum disorder, the CPA must provide at least one hour of annual training to each kinship caregiver relating to the treatment services that the kinship foster child receives, regardless of whether the CPA identifies concerns in the home.

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 3. ADMISSION AND PLACEMENT

26 TAC §§749.4441, 749.4443, 749.4445, 749.4447, 749.4449, 749.4451

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4441. Admission Criteria.

(a) A kinship foster home may only provide foster care to kinship foster children. A kinship foster child may be admitted as a regular admission or emergency admission.

(b) Each kinship placement must meet the kinship foster child's physical, medical, recreational, educational, and emotional needs as identified in the kinship foster child's admission assessment or the written assessment of the child's needs and strengths by the Texas Department of Family and Protective Services.

(c) After a kinship foster child turns 18 years old, the person may remain in care until the person's 23rd birthday to:

(1) Transition to independence, including attending college or vocational or technical training;

(2) Attend high school, a program leading to a high school diploma, or GED classes;

(3) Complete the child-placing agency's program; or

(4) Stay with a minor sibling.

(d) A young adult who turns 18 years old in the care of a kinship foster home may remain in care indefinitely if the person:

(1) Continues to need the same level of care; and

(2) Is unlikely to physically or intellectually progress over time.

(e) The CPA may admit a young adult into the care of a kinship foster home if the person:

(1) Comes immediately from another residential child-care operation;

(2) Meets the conditions of subsection (d) of this section; and

(3) Is in the care of the Texas Department of Family and Protective Services.

§749.4443. Documentation of Admission Information.

A child-placing agency (CPA) must document the following in the kinship child's record:

(1) Initial admission information;

(2) The admission assessment;

(3) The signed placement agreement; and

(4) Post-placement contacts.

§749.4445. Initial Requirements at the Time of Admission or Verification.

For each kinship foster child living in the kinship foster home at the time of verification or who is subsequently placed in the home, a child-placing agency (CPA) must obtain the following information prior to verifying the home or admitting the kinship foster child:

(1) A brief description of the circumstance that led to the kinship foster child's placement in the kinship foster home;

(2) Current health status, chronic or acute health conditions, such as asthma, diabetes, or allergies, and medication the kinship foster child is taking;

(3) Identification of the kinship foster child's high-risk behaviors, if applicable; suicide risk screening, if required; and supervision needs;

(4) Known contraindication to the use of restraint; and

(5) Any safety plans kinship caregivers will implement related to the behaviors or risk factors.

§749.4447. Placement Agreement.

A placement agreement is a child-placing agency's (CPA's) agreement with the kinship foster child's parent or the kinship foster child that defines the CPA's roles and responsibilities and authorizes the CPA to obtain or provide services for the kinship foster child. The placement agreement must include:

(1) Authorization permitting the CPA to care for the kinship foster child;

(2) A medical consent form signed by a person authorized by the Texas Family Code to provide consent; and

(3) The reason for placement and anticipated length of time in care.

§749.4449. Admission Assessment.

(a) A child-placing agency (CPA) must use the information obtained during the admission assessment to facilitate service planning and evaluate whether the placement is appropriate for the kinship foster child.

(b) The admission assessment must be complete within the following timeframe.

Figure: 26 TAC §749.4449(b)

(c) The admission assessment must include:

(1) A description of the circumstances that led to the kinship foster child's referral for substitute care;

(2) A description of the kinship foster child's behavior, including appropriate and maladaptive behavior and any high-risk behavior;

(3) Any history of physical, sexual, or emotional abuse or neglect;

(4) Current medical status, including the available results of any medical and dental examinations;

(5) Current mental health and substance abuse status, including available results of any psychiatric evaluation, psychological evaluation, or psychosocial assessment;

(6) The child's current developmental, educational, and behavioral level of functioning;

(7) The kinship foster child's social history, including information about the past and existing relationship with the kinship foster child's birth parents, siblings, and extended family members and the quality of those relationships with the child;

(8) The kinship foster child's criminal history, if applicable;

(9) A determination how the CPA can meet the needs of the kinship foster child and the services the CPA plans to provide; and

(10) If the child is at least three years of age, the most recent copy of the written assessment of the child's needs and strengths by the Texas Department of Family and Protective Services (DFPS).

(d) The written assessment of the child's needs and strengths by DFPS may be used in place of completing the admission assessment. If the DFPS assessment is used in place of the admission assessment, it must be requested and reviewed within the timeframe established in subsection (b) of this section.

(e) The competed admission assessment or written assessment of the child's needs and strengths by DFPS must be shared with the kinship foster parents.

§749.4451. Post-Placement Contacts.

(a) Child placement staff must have monthly face-to-face contact with a kinship foster child.

(b) Monthly visits must meet the following requirements:

(1) At least half of the contacts must occur in the foster home;

(2) The child placement staff must ensure that the kinship foster child is safe and their basic needs are being met;

(3) The visits must:

(A) Be for a length of time to address the needs of a kinship foster child who is verbal, or observe the kinship foster child if they are non-verbal;

(B) Provide an opportunity to meet privately; and

(C) Provide an opportunity for the kinship foster child to express their feelings about how the placement is working out.

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

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DIVISION 4. MEDICAL AND DENTAL REQUIREMENTS

26 TAC §§749.4461, 749.4463, 749.4465

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4461. Documentation Requirements for Medical and Dental Care.

(a) A child-placing agency (CPA) must verify that the following is documented either in the kinship foster child's health passport or in the kinship foster child's record:

(1) Each emergency medical and dental visit or hospitalization, including a discharge summary;

(2) Applicable immunization requirements; and

(3) Results of the kinship foster child's tuberculosis screening.

(b) A kinship foster home must maintain a daily medication log for each controlled substance and psychotropic prescription medi-

cation administered to a kinship foster child on a form provided by the CPA. The daily medication log must include:

(1) The name of the kinship foster child;

(2) The name of the controlled substance or psychotropic medication administered; and

(3) The date and time the medication was administered.

(c) If a kinship caregiver fails to administer any medication to a kinship foster child according to the medication label or subsequent signed orders, the kinship caregiver must document the following on a form provided by the CPA:

(1) The kinship foster child's name;

(2) The medication name;

(3) A description of the medication error; and

(4) How the kinship caregiver ensured the kinship foster child's safety.

§749.4463. General Medical, Dental, and Medication Requirements.

(a) A kinship foster child must receive timely routine and emergency medical and dental care.

(b) At the time of verification, a child-placing agency (CPA) must verify whether a kinship foster child who is at least three years old has had a medical examination within the past year and a dental examination within the past year. If the CPA determines that the child has not had one of these examinations during that time frame, the CPA must develop a plan for the child to receive the examination.

(c) All medications must be administered according to the instructions on the label or according to a prescribing health-care professional's subsequent signed order.

(d) All medications must be stored securely and in a way that makes them inaccessible to kinship foster children.

§749.4465. Immunizations and Tuberculosis Testing.

(a) Each kinship foster child that a child-placing agency admits must meet and continue to meet applicable immunization requirements as specified by the Texas Department of State Health Services.

(b) Each kinship foster child over the age of one year must have a documented tuberculosis screening that was conducted as recommended in the testing and diagnosis guidelines by the Centers for Disease Control and Prevention (CDC) within 30 days before or after beginning to live at a kinship foster home unless the child:

(1) Has lived at a regulated residential child-care operation within the previous 12 months; and

(2) Provides documentation of tuberculosis screening.

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

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DIVISION 5. DAILY CARE, EDUCATION, AND DISCIPLINE

26 TAC §§749.4471, 749.4473, 749.4475, 749.4477, 749.4479, 749.4481, 749.4483, 749.4485, 749.4487, 749.4489, 749.4491, 749.4493

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4471. Normalcy.

A kinship foster parent must ensure a kinship foster child has the opportunity to participate in childhood activities, including unsupervised activities, as much as possible. Childhood activities, including unsupervised activities, must be appropriate in relation to the kinship foster child's age and developmental needs.

§749.4473. Infants: Basic Care and Supervision.

(a) Each infant in a kinship foster home must receive individual attention, including play, talking, cuddling, and holding.

(b) A kinship caregiver must provide prompt attention to an infant's physical needs, such as feeding and diapering.

(c) A kinship caregiver must ensure that the environment is safe for each infant, including:

(1) Keeping the area free of objects that may choke or harm the infant; and

(2) Ensuring accessible electrical outlets have childproof covers or safety outlets.

(d) Items necessary for diaper changing must be kept out of the reach of kinship foster children.

(e) A kinship caregiver must never leave an infant unsupervised.

(1) A sleeping infant is considered supervised if the kinship caregiver:

(A) Is within eyesight or hearing range of the infant and can intervene as needed; or

(B) Uses a video camera or audio monitoring device to monitor the infant and is close enough to the infant to intervene as needed.

(2) An awake infant is considered supervised if the kinship caregiver is within eyesight of the infant and is close enough to the infant to intervene as needed. For short periods of time during routine household activities, the infant may be out of the kinship caregiver's eyesight, as long as:

(A) The infant is within hearing range of the kinship caregiver;

(B) The infant's environment is free of any safety hazards; and

(C) The kinship caregiver can intervene immediately, as needed.

§749.4475. Infants: Cribs.

(a) A kinship foster home that provides care to a kinship foster child who is an infant must have an individual crib for the infant. All cribs must:

(1) Have a firm, flat mattress that snugly fits the sides of the crib, and the mattress must not be supplemented with additional foam material or pads and must be waterproof or washable;

(2) Have sheets that fit snugly and do not present an entanglement hazard;

(3) Be bare, except for a tight-fitting sheet, for an infant who is younger than twelve months of age; and

(4) Be assembled per the manufacturer's instructions with no loose hardware, damaged parts, or entrapment hazards.

(b) A kinship foster home may use a full-sized, portable, or mesh-side crib if:

(1) The kinship caregivers follow the manufacturer's instructions; and

(2) The crib has mesh that is securely attached to the top of the rails and floor plate, and the folded sides are securely latched in place when raised.

(c) The kinship foster home may not use a stackable crib for an infant.

(d) A kinship caregiver must never leave an infant in a crib, portable crib, or mesh-side crib with a side folded down.

(e) An infant receiving treatment services for primary medical needs may have special items that assist with safe sleep at the written recommendation of a health-care professional. The child-placing agency (CPA) must keep the recommendation in the kinship foster child's record.

(f) The CPA must notify the parent of each child in care of each kinship foster home verified by the CPA of any deficiencies relating to subsections (a)(1), (a)(3), or (b)(2) of this section.

§749.4477. Infants: Safe Sleep Requirements.

(a) A kinship caregiver must place an infant who is unable to turn over without assistance in a face-up sleeping position unless a healthcare professional orders otherwise. A child-placing agency (CPA) must keep any orders from a healthcare professional in the kinship foster child's record.

(b) An infant's head, face, or crib must not be covered at any time by any item, including a blanket, linen, or clothing.

(c) An infant must not co-sleep with an adult at any time, including in the adult's bed or on a couch.

(d) An infant must not sleep in a restrictive device, such as a car seat, swing, bouncy seat, or highchair. If an infant falls asleep in one of these devices, the kinship caregiver must move the infant to a crib as soon as possible.

(e) An infant who can roll over without assistance must not be swaddled.

(f) The CPA must notify the parent of each child in care of each kinship foster home verified by the CPA of any deficiencies cited in this section.

§749.4479. Infants: Equipment Safety.

A highchair, swing, stroller, infant carrier, rocker, bouncer seat, or similar type of equipment that a kinship foster home uses for an infant must have safety straps fastened when the equipment is in use with the infant.

§749.4481. Infants: Feeding Requirements.

(a) Kinship caregivers must feed an infant based on the recommendations of the infant's health-care professional.

(b) Unless recommendations from the service planning team are contrary, kinship caregivers must hold the infant while feeding the infant if the infant is:

(1) Birth through six months old; or

(2) Unable to sit unassisted in a highchair or other seating equipment during feeding.

(c) Kinship caregivers must never prop a bottle by supporting it with anything other than the infant's or adult's hands.

(d) A kinship caregiver who cares for more than one infant must:

(1) Sterilize shared bottles or training cups between uses by different infants; and

(2) Clean highchair trays before each use.

§749.4483. Toddlers: Basic Care Requirements.

(a) Each toddler must receive individual attention, including play, talking, and cuddling.

(b) A kinship caregiver must ensure that the environment is safe for each toddler, including:

(1) Keeping the area free of objects that may choke or harm the toddler; and

(2) Ensuring each accessible electrical outlet has a child-proof cover or safety outlet.

(c) A kinship caregiver must never leave a toddler unsupervised. A toddler is considered supervised if the kinship caregiver:

(1) Is within eyesight or hearing range of the child and can intervene as needed; or

(2) Uses a video camera or an audio monitoring device to monitor the kinship foster child and is close enough to the child to intervene as needed.

§749.4485. Additional Requirements for Pregnant Kinship Foster Children.

A child-placing agency must ensure information, training, and counseling is available regarding prenatal care, childbirth, and recovery from childbirth.

§749.4487. Additional Requirements for Kinship Foster Children Receiving Treatment Services for Primary Medical Needs or Intellectual Disabilities.

(a) A kinship caregiver who cares for a kinship foster child receiving treatment services for primary medical needs or an intellectual disability must follow recommendations from the kinship foster child's medical providers, including recommendations relating to physical stimulation.

(b) A kinship caregiver must ensure that a kinship foster child receiving treatment services for primary medical needs or an intellectual disability has opportunities for sensory stimulation.

§749.4489. Educational Services: General.

(a) A child-placing agency (CPA) must arrange appropriate education for each kinship foster child, including:

(1) Ensuring the kinship foster child attends an educational facility or program that is approved or accredited;

(2) Advocating for the kinship foster child to receive educational and related services to which the child is entitled under provisions of federal and state law and regulations, including the implementation of an individual education plan (IEP) for students receiving special education services; and

(3) Ensuring that an education program for a kinship foster child with autism spectrum disorder:

(A) Encourages normalization through appropriate stimulation and by encouraging self-help skills; and

(B) Is appropriate to the kinship foster child's intellectual and social functioning.

(b) For a kinship foster child receiving treatment services, the CPA must designate a liaison between the agency and the kinship foster child's school.

§749.4491. Educational Services: Caregiver Responsibilities.

Kinship caregivers must:

(1) Request Admission, Review, and Dismissal (ARD), Individual Education Plan (IEP), and Individual Transitional Planning (ITP) meetings, if concerned with a kinship foster child's education program or if the kinship foster child does not appear to be making progress;

(2) Attend ARD, IEP, ITP meetings, or other school staffings and conferences to represent the kinship foster child's educational best interests; and

(3) Know what is in the kinship foster child's IEP and support the school's efforts to implement the IEP, if applicable.

§749.4493. Discipline and Punishment.

(a) Only a kinship caregiver known to and knowledgeable of a kinship foster child may discipline the child.

(b) All disciplinary measures used with a kinship foster child must be consistent with the child's rights related to discipline and punishment.

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

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DIVISION 6. SCREENINGS AND VERIFICATIONS

26 TAC §§749.4501, 749.4503, 749.4505, 749.4507, 749.4509, 749.4511, 749.4513, 749.4515, 749.4517, 749.4519, 749.4521, 749.4523

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4501. General Requirements.

(a) Each kinship foster parent must be at least 18 years old.

(b) A child-placing agency (CPA) may verify only one spouse as a kinship foster parent if:

(1) The spouse whom the CPA verifies will be the only one responsible for the day-to-day care of kinship foster children in the home; and

(2) The CPA determines that the spouses maintain separate residences.

(c) A kinship foster home may not be verified to provide kinship foster services by more than one CPA at a time; however, a home may be verified by one agency to provide kinship foster care services only and approved by another CPA for adoption only.

§749.4503. Kinship Foster Home Screenings.

(a) A child-placing agency (CPA) must complete a home screening before verifying a kinship foster home. The CPA may:

(1) Complete the home screening as detailed in this section; or

(2) Use a completed home assessment obtained from the Texas Department of Family and Protective Services (DFPS) or Single Source Continuum Contractor (SSCC). If the CPA uses the home assessment obtained from DFPS or SSCC, the CPA is responsible for ensuring it meets the requirements of this division.

(b) The CPA must update a kinship foster home screening with an addendum any time there is a major life change in the kinship foster family.

(c) Through interviewing each prospective kinship foster parent or completing a joint interview, a CPA must obtain, discuss, document, and assess the following information about a prospective kinship foster home.
Figure: 26 TAC §749.4503(c)

(d) Regarding (c)(7) in subsection (c) of this section the CPA must report to Child Care Regulation the information obtained about the prospective kinship foster family's domestic violence history, as applicable. The CPA must report this information regardless of whether the CPA verifies the home.

§749.4505. Verifying a Kinship Foster Home.

A child-placing agency (CPA) must take the following steps to verify a kinship foster home.

(1) Complete and document the requirements in this division.

(2) Obtain the following:

(A) A sketch, photo, or other documentation of the home that shows the purposes of all rooms in the home and identifies the indoor areas for the kinship foster children's use; and

(B) A sketch or photo of the outside areas that shows the buildings, driveways, fences, storage areas, gardens, recreation areas, and bodies of water.

(3) Evaluate all areas required in this subchapter by:

(A) Completing an inspection of the kinship foster home to ensure that the home meets applicable rules relating to Daily Care, Education, and Discipline, and Health and Safety Requirements, Environment, Space and Equipment of this subchapter; and

(B) Making recommendations about the home's overall ability to keep kinship foster children safe, paying specific attention to areas of substantial safety risk to kinship foster children and how the CPA addressed areas of identified safety risks with the prospective kinship foster parent before approving and verifying the kinship foster home; and

(C) Documenting in the kinship foster home file the details of the inspection of the kinship foster home and any identified safety risks.

(4) Obtain from the child placement management staff the review and approval of the home screening, and the recommended verification of the home.

(5) Issue a verification certificate that must be posted at the kinship foster home or immediately available for review upon request that includes:

(A) The name and address of the kinship foster family;

(B) The kinship foster home's total capacity and kinship foster care capacity, including ages and sex of the kinship foster children being served; and

(C) The types of services the home provides.

§749.4507. Previously Verified Kinship Foster Homes.

(a) For a kinship foster home that was previously verified by another child-placing agency (CPA), the receiving CPA must conduct and complete a new home screening as required in this subchapter.

(b) If the kinship foster home is transferring from another CPA, the receiving CPA must request information about the home by submitting a written request to the agency that transferred the kinship foster home.

(c) If the kinship foster home is transferring from another CPA with a child in care, the receiving CPA may verify the kinship foster home prior to completion of the background check.

§749.4509. Releasing Information About a Previously Verified Kinship Foster Home.

(a) A child-placing agency (CPA) must release background information regarding a current or previous kinship foster home to:

(1) Another CPA conducting a foster home screening, preadoptive home screening, or post-placement adoptive report; or

(2) An independent contractor who is hired or required by the court to conduct a social study under Chapter 107 of the Texas Family Code.

(b) Background information includes:

(1) The kinship foster home screening and any related documentation or addendums;

(2) Documentation of supervisory visits and evaluations for the past year;

(3) Any record of deficiencies and their resolutions for the past year, including information regarding pending investigations and unresolved deficiencies;

(4) The most current fire and health inspections or checklists;

(5) The transfer or closing summary for the kinship foster home;

(6) Copies of any current or previous plans to achieve compliance or other type of development plan for the past two years, if applicable; and

(7) Copies of any current or previous corrective action or adverse action plans for the past two years, if applicable.

(c) A CPA must release the background information to the requesting agency by the 10th day after receiving the written request, including informing the requesting agency of any pending investigations and unresolved deficiencies. By the 10th day after the completion of any pending investigations and the resolution of any deficiencies, the CPA must release to the requesting agency the:

(1) Outcome of any investigations and any resulting deficiencies cited; and

(2) Resolution of any deficiencies.

§749.4511. Changes to the Verification Status of a Kinship Foster Home.

(a) A child-placing agency (CPA) must submit information to Child Care Regulation within two business days of:

(1) Verifying a new kinship foster home or issuing a temporary kinship foster home verification;

(2) Placing a kinship foster home on or taking it off inactive status;

(3) Changing conditions of the verification for an existing kinship foster home; and

(4) Closing a kinship foster home, including the reason the CPA closed the home.

(b) If a CPA changes the conditions of a kinship foster home's verification to allow the home to provide additional services, the child placement management staff must ensure there is no conflict of care with children currently in the home.

(c) If the kinship foster home adds a new, unrelated household member, the CPA must:

(1) Ensure the individual has the necessary background checks; and

(2) Evaluate the impact the individual will have on the kinship foster family and kinship foster children prior to the individual moving into the home.

§749.4513. Transferring or Closing a Kinship Foster Home.

(a) A child-placing agency (CPA) must complete a transfer summary or closing summary when a kinship foster home transfers to another CPA or closes.

(b) A transfer summary and a closing summary must include:

(1) A copy of the verification certificate;

(2) The kinship foster home's addresses for the past two years and, as needed, directions for rural addresses;

(3) The length of time the kinship foster parents have been verified by the CPA;

(4) For the kinship foster children that were in care for the last two years, the:

(A) Number of kinship children fostered;

(B) Type of treatment services provided to each kinship foster child; and

(C) Reason for each kinship foster child's discharge from care;

(5) A description of any limitations on the verification that were in place for the kinship foster home in caring for and working with kinship foster children;

(6) A description of any indicators of risk to children at the time of the transfer or closing;

(7) Any plan to achieve compliance or other type of development plan that was in place within the previous 12 months of the date of transfer or closing;

(8) Any corrective action or adverse action plan that was in place at the time of transfer or closing; and

(9) A statement concerning whether the CPA would recommend the kinship foster home for verification in the future, including whether the CPA would recommend any limitations or restrictions on the verification, and the basis of the CPA's recommendation.

(c) A transfer summary must also:

(1) Include pending investigations or unresolved deficiencies; and

(2) Be completed by the 10th day after a CPA receives a written request to transfer and the transferring CPA must forward it immediately to the requesting CPA.

(d) A closing summary must also:

(1) Include the reason the home is closing, including whether the CPA required the kinship foster home to close;

(2) Include any unresolved deficiencies that have not been corrected and a description of those deficiencies; and

(3) Be completed by the 20th day after a kinship foster home is closed.

§749.4515. Temporary Kinship Foster Home Verifications.

(a) A child-placing agency (CPA) may issue a temporary kinship foster home verification when a kinship foster home moves from one residence to another. Within 30 days of the kinship foster home moving to the new residence, the CPA must inspect the new residence for compliance with health and safety requirements in this subchapter.

(b) Before issuing the non-expiring kinship foster home verification, the CPA must ensure the kinship foster home is compliant with all requirements in this subchapter.

(c) A temporary kinship foster home verification is valid for a maximum of six months.

§749.4517. Capacity and Child/Caregiver Ratio.

(a) A kinship foster home may care for up to six children regardless of the number of caregivers or ages of the children in the home. This capacity includes kinship foster children, as well as adopted and biological children living in the home, children receiving respite services, and children for whom the kinship foster home provides daycare.

(b) A kinship foster home may care for seven or eight children as recommended and approved by the Texas Department of Family and Protective Services and a child-placing agency (CPA). To approve expanding the kinship foster home's capacity, the CPA must:

(1) Complete Form 4003 Foster Family Home Capacity Exception; and

(2) Request a variance from Child Care Regulation.

§749.4519. Supervision.

(a) The child placement management staff must ensure that supervision of a kinship foster child adequately accounts for:

(1) The specific needs of the kinship foster child, including any history of high- risk behaviors that would require additional supervision; and

(2) The environment where the supervision is taking place.

(b) A kinship caregiver is responsible for:

(1) Knowing which kinship foster children the kinship caregiver is responsible for;

(2) Providing the level of supervision necessary to ensure each kinship foster child's safety and well-being, including auditory and/or visual awareness of each kinship foster child's ongoing activity as appropriate;

(3) Being able to intervene when necessary to ensure each kinship foster child's safety; and

(4) Being aware of any special supervision needs based on the kinship foster child's developmental age, maturity, and service plan restrictions.

(c) When a kinship foster child participates in an unsupervised childhood activity, the kinship caregiver must know:

(1) Where the kinship foster child is scheduled to be, and who they will be with; and

(2) How and when the kinship foster child will be returning home.

§749.4521. Kinship Foster Children as Babysitters.

(a) A kinship foster child may serve as a babysitter for another kinship foster child if the child placement management staff approves the child to babysit and establishes limits with duration and frequency.

(b) A child-placing agency must consider:

(1) The developmental age of the child who will provide the babysitting; and

(2) Any known history of high-risk behaviors of the child providing the babysitting and the child who will be babysat.

§749.4523. Respite Child-Care Services.

(a) A kinship foster home may only provide respite services to a kinship foster child.

(b) The child placement management staff (CPMS) must approve any respite child-care and ensure that the placement will not cause a conflict of care for any child that is already placed in the home.

(c) The CPMS must ensure information is shared about the kinship foster children to ensure continuity of care, including any special supervision requirements or safety plans.

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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Chief Counsel

Health and Human Services Commission

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DIVISION 7. HEALTH AND SAFETY REQUIREMENTS, ENVIRONMENT, SPACE, AND EQUIPMENT

26 TAC §§749.4551, 749.4553, 749.4555, 749.4557, 749.4559, 749.4561, 749.4563, 749.4565, 749.4567, 749.4569, 749.4571, 749.4573, 749.4575, 749.4577, 749.4579, 749.4581

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §524.0151, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Human Resources Code §42.042(a) which requires HHSC to adopt rules to carry out the requirements of Texas Human Resources Code Chapter 42.

The repealed and new sections affect Texas Government Code §524.0151 and Texas Human Resources Code §42.042.

§749.4551. Documentation of Health and Safety Requirements.

A child-placing agency must document the following in the kinship foster home's record:

(1) The results of each health inspection or health and safety evaluation;

(2) The results of each fire inspection or fire safety evaluation; and

(3) A copy of the home's emergency preparedness plan, including any subsequent reviews.

§749.4553. Health and Fire Inspections.

(a) A kinship foster home must have either:

(1) A health inspection conducted by the local health authority; or

(2) A health and safety evaluation conducted by the child-placing agency's (CPA's) child placement staff using the Environmental Health Checklist for Kinship Foster Homes form.

(b) A kinship foster home must also have either:

(1) A fire inspection conducted by a state of local fire authority; or

(2) A fire safety evaluation developed and conducted by the CPA's child placement staff.

(c) A kinship foster home must correct any deficiencies documented during any inspection or evaluation and comply with any conditions or restrictions specified by the inspector or evaluator.

§749.4555. Emergency Plans.

(a) A kinship foster home must have a written plan for handling potential disasters and emergencies, including fire and severe weather. The child-placing agency (CPA) that verified the home must annually review and evaluate the plan with all kinship caregivers and kinship foster children in the home. The review of the plan must be provided in the kinship foster child's communication method.

(b) The CPA may develop the emergency plan with the kinship foster family or obtain a copy of the emergency plan the family developed with the Texas Department of Family and Protective Services or Single Source Continuum Contractor.

§749.4557. Fire Safety.

(a) A kinship foster home must have a working smoke detector in the following areas:

(1) The kitchen;

(2) Hallways or open areas outside of sleeping rooms; and

(3) On each level of a home with multiple levels.

(b) The kinship foster home must have one non-expired, operational fire extinguisher that is accessible in the case of emergency.

(c) The kinship foster home must ensure that exits to the home are not blocked.

§749.4559. Animals.

Any animal on the premises of a kinship foster home must not pose a health or safety threat to the kinship foster children.

§749.4561. Weapons, Firearms, Explosive Materials, and Projectiles in a Kinship Foster Home.

(a) Each child-placing agency (CPA) must have and enforce a policy that addresses the presence of weapons, firearms, explosive materials, and projectiles in a kinship foster home. The policy must contain specific requirements to ensure that a kinship foster child does not have unsupervised access to these items, including requiring a kinship foster parent to keep such items in locked storage when they are not in use.

(b) The CPA must determine whether it is appropriate for a specific kinship foster child to use weapons, firearms, explosive materials, or projectiles.

(c) No kinship foster child may use a weapon, firearm, explosive material, or projectile unless the kinship foster child is directly supervised by an adult knowledgeable about the use of the weapon, firearm, explosive material, or projectile that is to be used by the kinship foster child.

(d) The CPA must determine whether it is appropriate for a specific kinship foster child to use a toy that explodes or shoots.

(e) No kinship foster child may use or be around a toy that explodes or shoots unless the kinship foster child is directly supervised by an adult and the toy is age-appropriate for the kinship foster child.

§749.4563. Storage of Weapons, Firearms, Explosive Materials, or Projectiles in a Kinship Foster Home.

(a) When determining if weapons, firearms, explosive materials, and projectiles are stored so that a kinship foster child does not have unsupervised access to such items, the child-placing agency (CPA) must consider the age, history, emotional maturity, and background of the children in the kinship foster home.

(b) A CPA may not require the kinship foster home to disclose the specific types of firearms that are stored or otherwise present in the kinship foster home.

(c) Firearms that are inoperable and solely ornamental are exempt from the storage requirements in this rule.

§749.4565. Determining if Weapons, Firearms, Explosive Materials, or Projectiles are Present in a Kinship Foster Home.

(a) When a child-placing agency (CPA) completes a kinship foster home screening, the CPA must ask whether weapons, firearms, explosive materials, or projectiles are present in the kinship foster home. If these items are present, the CPA must review the CPA's weapons, firearms, explosive materials, and projectiles policy and requirements with the prospective kinship foster parents.

(b) The kinship foster home record must include documentation on:

(1) Whether weapons, firearms, explosive materials, or projectiles are present in the home; and

(2) Specific precautions the kinship caregivers will take to ensure kinship foster children do not have unsupervised access.

(c) The two-year evaluation of a kinship foster home's compliance with this chapter must include a discussion of whether the kinship foster home has weapons, firearms, explosive materials, or projectiles, and if so, how these items are stored.

(d) In complying with this rule, a CPA may not require the kinship foster home to disclose the specific types of firearms that are stored or otherwise present in the kinship foster home.

(e) In complying with this rule, a CPA may not require the kinship foster home to notify the CPA if there is any change in the types of firearms that are present in the home.

§749.4567. Transporting a Kinship Foster Child in a Vehicle Where Firearms, Explosive Materials, or Projectiles are Present.

(a) A kinship caregiver may transport a kinship foster child in a vehicle where firearms (other than handguns), other weapons, explosive materials, or projectiles are present if:

(1) All firearms are not loaded;

(2) The firearms, other weapons, explosive materials, or projectiles are inaccessible to the kinship foster child; and

(3) Possession of the firearm is legal.

(b) A kinship caregiver may transport a kinship foster child in a vehicle where a handgun is present if:

(1) The handgun is in the possession and control of the kinship caregiver; and

(2) The kinship caregiver is not prohibited by law from carrying a handgun.

§749.4569. Physical Environment of a Kinship Foster Home.

(a) A kinship foster home must ensure that indoor and outdoor space and equipment does not pose a safety risk to kinship foster children.

(b) Kinship caregivers must provide adequate supervision to prevent access to space or equipment that poses a safety risk to a kinship foster child as needed based on the kinship foster child's developmental age, maturity, and service plan restrictions.

§749.4571. Indoor Space: Sleeping Spaces and Sleeping Surfaces.

(a) Unless approved to share by the child placement management staff (CPMS), each kinship foster child must have the child's own:

(1) Sleeping space; and

(2) Sleep surface, which may include a bed, mattress, air mattress, futon, or couch.

(b) Before approving a kinship foster child to share a sleeping space or sleeping surface, the CPMS must determine and document in the kinship foster child's service plan there is no known risk of harm to the kinship foster child by sharing a sleeping space or sleeping surface with the other individual after assessing:

(1) The relationship between the kinship foster child and the individual;

(2) The ages and developmental levels of the kinship foster child and the individual, noting that after the kinship foster child's 18th birthday, the kinship foster child may share a bedroom with another youth who is 16 years of age or older, provided the age difference does not exceed two years;

(3) The behaviors of the kinship foster child and the individual;

(4) Any history of possible sexual trauma or sexually inappropriate behaviors of the kinship foster child and the individual; and

(5) Any other identifiable factors that may affect the appropriateness of the individual and the kinship foster child sharing a bedroom.

§749.4573. Indoor Space: Bathrooms.

A kinship foster home must have at least:

(1) one bathroom that allows for privacy;

(2) one toilet; and

(3) one bathroom sink and one tub or shower that have hot and cold running water.

§749.4575. Nutrition and Food Safety.

(a) Kinship caregivers must provide a kinship foster child with drinking water and food that is served in a safe and sanitary manner.

(b) A kinship home must ensure that all food items are stored in a manner that protects them from contamination, spoiling, and insects and rodents.

§749.4577. Transportation.

(a) Kinship caregivers must secure safe and reliable transportation for a kinship foster child.

(b) Special provisions must be made for transporting non-ambulatory and non-mobile children. When necessary, this may include locks for wheelchairs and hydraulic lifts.

(c) A kinship caregiver must secure each kinship foster child in an infant safety seat, rear-facing convertible child safety seat, forward-facing child safety seat, child booster seat, safety vest, harness, or a safety belt, as appropriate to the kinship foster child's age, height, and weight and according to the manufacturer's instructions.

§749.4579. Water Safety: Pools, Hot Tubs, and Bodies of Water.

(a) Any door that leads from the home to an area with a swimming pool, hot tub, or body of water must have:

(1) A door alarm; or

(2) A lock that is only accessible and operational by an adult unless:

(A) The state or local fire authority determines that the lock violates the fire code; and

(B) The child-placing agency keeps the fire authority's determination in the kinship foster home record.

(b) The bottom of a swimming pool must be always visible.

(c) Swimming pool chemicals and machinery rooms must be inaccessible to kinship foster children.

§749.4581. Swimming Supervision.

(a) Kinship caregivers must inform each kinship foster child about house rules for the use of a swimming pool, hot tub, or other body of water and appropriate safety precautions.

(b) Supervision and monitoring of safety features must be adequate to protect any kinship foster child from unsupervised access to the swimming pool, hot tub, or other body of water.

(c) Kinship caregivers must ensure that a kinship foster child has access to a lifesaving device when using a swimming pool, hot tub, or body of water.

(d) A personal flotation device (PFD) is a vest or suit designed to keep the wearer afloat in water and prevent drowning. A kinship foster child participating in a swimming activity who is unable to swim must wear a PFD that is U.S. Coast Guard-approved for use by a child that is the correct size for the child.

(e) Kinship caregivers must be able to clearly see all parts of the swimming pool or hot tub when supervising activity in the area.

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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