ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 3. OFFICE OF THE ATTORNEY GENERAL

CHAPTER 56. DISTRICT AND COUNTY ATTORNEY REPORTING REQUIREMENTS

1 TAC §§56.1 - 56.10

The Office of the Attorney General (OAG) adopts new chapter 56 in Title 1 of the Texas Administrative Code (TAC), relating to reporting requirements for district attorneys and county attorneys presiding in a district or county with a population of 400,000 or more persons. Adopted new chapter 56 consists of §§56.1 - 56.10. New chapter 56 is necessary to implement Government Code §41.006 and is in the public's interest. These new rules are adopted with changes to the proposed text as published in the September 13, 2024, issue of the *Texas Register* (49 TexReg 7139). The new rules will be republished. The changes are in response to public comments.

EXPLANATION OF AND JUSTIFICATION RULES

Texas Government Code §41.006 states that "[a]t the times and in the form that the attorney general directs, the district and county attorneys shall report to the attorney general the information from their districts and counties that the attorney general desires relating to criminal matters and the interests of the state." Adopted new chapter 56 helps ensure that county and district attorneys are consistently complying with statutory duties, including seeking justice for citizens who have been harmed by a criminal act, appropriately administering funds, and appropriately prosecuting crimes. Whether a public official and office whose purpose is to fairly prosecute crimes and keep communities safe is enforcing criminal prosecution laws is a criminal matter and within the interest of the state.

Section 41.006 also states that the information must be submitted to the OAG at the times and in the form the OAG directs. New chapter 56 is necessary to implement §41.006. The adopted chapter prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

SECTION-BY-SECTION SUMMARY

Adopted new §56.1 specifies that district attorneys and county attorneys presiding in a district or county with a population of 400,000 or more are required to submit initial, quarterly, and annual reports relating to criminal matters and the interests of the state to the OAG in a manner prescribed by the OAG.

Adopted new §56.2(1) defines the term "case file" as all documents, notes, memoranda, and correspondence, in any format such as handwritten, typed, electronic, or otherwise, including drafts and final copies, that were produced within or received by the reporting entity's office, including work product and otherwise privileged and confidential matters. A "case file" does not include a reporting entity employee's correspondence that is purely personal in nature and has no connection with the transaction of official business.

Adopted new §56.2(2) defines the term "correspondence" as any email, letter, memorandum, instant message, text message, or direct message, received or issued by an employee of the reporting entity. "Correspondence" does not include a reporting entity employee's correspondence that is purely personal in nature and has no connection with the transaction of official business.

Adopted new §56.2(3) defines the term "electronic copies" as a digital version of a record that can be stored on a computer device.

Adopted new §56.2(4) defines the term "reporting year" as the period of September 1 through August 31.

Adopted new §56.2(5) defines the term "report" as all information submitted to the OAG by a reporting entity under this chapter.

Adopted new §56.2(6) defines the term "reporting entity" as the office of a District Attorney or County Attorney serving a population of 400,000 or more persons.

Adopted new §56.2(7) defines the term "violent crime" to include capital murder, murder, other felony homicides, aggravated assault, sexual assault of an adult, indecency with a child, sexual assault of a child, family violence assault, aggravated robbery, robbery, burglary, theft, automobile theft, riot, any crime listed in Code of Criminal Procedure §17.50(3), and any attempt to commit such crimes.

Adopted new §56.3(a) specifies the content of the reports that must be electronically submitted to the OAG on a quarterly basis each reporting year.

Adopted new §56.3(b) specifies that reporting entities must submit an initial report containing the contents of the reports described in adopted new §56.3(a) for reporting events that occurred between January 1, 2021, and the effective date of this rule. This section provides exceptions to the initial report requirement.

Adopted new §56.4 specifies the content of the reports that must be electronically submitted to the OAG on an annual basis.

Adopted new §56.5(a) sets forth the deadlines for reporting entities to electronically submit each type of report. Quarterly reports must be submitted within 30 days of the beginning of each new reporting quarter. Annual reports must be submitted at the end of each reporting year and not later than September 30. The initial reports must be submitted within 90 days of the effective date of this rule. Adopted new §56.5(a) also provides that the OAG's

Oversight Committee may grant exceptions to the deadlines on a case-by-case basis if the reporting entity can establish good cause for not meeting the reporting deadlines.

Adopted new §56.5(b) establishes that a reporting entity must submit all reports under this chapter electronically. Information on how to submit reports electronically will be found on the OAG's website.

Adopted new §56.6 establishes that reporting entities must implement document retention policies reasonably designed to preserve all documents which are, or may be, subject to the requirements in this chapter. The retention policies must preserve documents for at least two years after the dates when they are due to be reported.

Adopted new §56.7 establishes that if an entity fails to comply with this chapter, the OAG may send notice to the reporting entity identifying the reporting entity of its failure to comply. A reporting entity must remedy the identified reporting failure within 30 days after receipt of notice. Any reporting entity that fails to timely comply with this chapter's reporting requirements may be identified on the OAG's website as being out of compliance with both this chapter as well as Texas Government Code §41.006.

Adopted new §56.8 establishes that if a district attorney or county attorney violates adopted new chapter 56, without limitation, the Attorney General may (1) construe the violation to constitute "official misconduct" under Local Government Code §87.011; (2) file a petition for quo warranto under Civil Practice and Remedies Code 66.002; or (3) file a petition for an injunction in a civil proceeding ordering the District Attorney or County Attorney to comply.

Adopted new §56.9 specifies the makeup and responsibilities of the Oversight Advisory Committee as it relates to adopted new chapter 56. The Oversight Advisory Committee is an internal OAG committee composed of OAG employees who will review, collect, and advise on the reports submitted under new adopted chapter 56. Adopted new §56.9 also states that the Oversight Advisory Committee may request entire case files from reporting entities based on submitted reports or any other information that the Oversight Advisory Committee desires relating to criminal matters and the interests of the state on a case-by-case basis, as consistent with Texas Government Code §41.006.

Adopted new §56.10 specifies that all provisions of new adopted chapter 56 are severable.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENT

Josh Reno, the Deputy Attorney General for Criminal Justice, has determined that for the first five-year period the adopted rules are in effect, enforcing or administering the rules does not have foreseeable implications relating to cost or revenues of state government.

Mr. Reno has determined that there may be minimal costs to local governments for gathering and submitting quarterly and annual reports to OAG. Because the content of the reports will differ between reporting entities, the OAG cannot predict the cost amounts but expects the cost to be minimal and likely absorbed into reporting entities' ongoing operations with minimal, if any, fiscal impact.

According to Texas SmartBuy, the cooperative purchasing program provided by the Texas Comptroller of Public Accounts, scanners range from $50 to $10,000, and the price will depend on the scanner's quality, speed, and if it is a portable or self-loading model. However, it is likely that reporting entities already maintain a scanner in their respective offices. Because the reporting entities are required to submit the information electronically, there will be no postage or printing cost to do so.

The OAG acknowledges it will take some time for county employees to compile the required reporting data. However, the OAG estimates such time will be minimal as the reporting entity should maintain standard law enforcement record keeping practices. The OAG estimates individual employee compensation for an administrative assistant to be $21.29 an hour, and the OAG estimates one to ten hours of work to scan and electronically submit documents to the OAG. This wage is based on the national median hourly wage for each classification as reported in the May 2023 National Industry Specific Occupational Employment and Wage Estimates. Bureau of Labor Statistics, Occupational Employment Statistics, United States Dep't of Labor (August 8, 2024 2:38 p.m.), www.bls.gov/oes/current/oes436014.htm.

PUBLIC BENEFIT AND COST NOTE

Mr. Reno has determined that for the first five-year period the adopted rules are in effect, the public will benefit because the rule will help ensure that county and district attorneys are consistently complying with statutory duties, appropriately administering funds, appropriately prosecuting crimes, and seeking justice for citizens who have been harmed by a criminal act.

Mr. Reno has also determined that for each year of the first five-year period the adopted rules are in effect, there are minimal anticipated costs to the county and district attorneys that are required to comply with the adopted rules. The costs detailed below are the same costs detailed in the Public Benefit and Cost Note section of this adoption order.

Because the content of the reports will differ between reporting entities, the OAG cannot predict the cost amounts but expects the cost to be minimal and likely absorbed into reporting entities' ongoing operations with minimal, if any, fiscal impact.

According to Texas SmartBuy, the cooperative purchasing program provided by the Texas Comptroller of Public Accounts, scanners range from $50 to $10,000, and the price will depend on the scanner's quality, speed, and if it is a portable or self-loading model. However, it is likely that reporting entities already maintain a scanner in their respective offices. Because the reporting entities are required to submit the information electronically, there will be no postage or printing cost to do so.

The OAG acknowledges it will take some time for county employees to compile the required reporting data. However, the OAG estimates such time will be minimal as the reporting entity should maintain standard law enforcement record keeping practices. The OAG estimates individual employee compensation for an administrative assistant to be $21.29 an hour, and the OAG estimates one to ten hours of work to scan and electronically submit documents to the OAG. This wage is based on the national median hourly wage for each classification as reported in the May 2023 National Industry Specific Occupational Employment and Wage Estimates. Bureau of Labor Statistics, Occupational Employment Statistics, United States Dep't of Labor (August 8, 2024 2:38 p.m.), www.bls.gov/oes/current/oes436014.htm.

IMPACT ON LOCAL EMPLOYMENT OR ECONOMY

Mr. Reno has determined that the adopted rules do not have an impact on local employment or economies because the adopted rules only impact governmental bodies. Therefore, no local em-

ployment or economy impact statement is required under Texas Government Code §2001.022.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL BUSINESSES, MICROBUSINESSES, AND RURAL COMMUNITIES

Mr. Reno has determined that for each year of the first five-year period the adopted rules are in effect, there will be no foreseeable adverse fiscal impact on small business, micro-businesses, or rural communities as a result of the adopted rules.

Since the adopted rules will have no adverse economic effect on small businesses, micro-businesses, or rural communities, preparation of an Economic Impact Statement and a Regulatory Flexibility Analysis, as detailed under Texas Government Code §2006.002, is not required.

TAKINGS IMPACT ASSESSMENT

The OAG has determined that no private real property interests are affected by the adopted rules, and the adopted rules do not restrict, limit, or impose a burden on an owner's rights to the owner's private real property that would otherwise exist in the absence of government action. As a result, the adopted rules do not constitute a taking or require a takings impact assessment under Texas Government Code §2007.043.

GOVERNMENT GROWTH IMPACT STATEMENT

In compliance with Texas Government Code §2001.0221, the agency has prepared a government growth impact statement. During the first five years the adopted rules are in effect, the adopted rules:

- will not create a government program;

- will not require the creation or elimination of employee positions;

- will not require an increase or decrease in future legislative appropriations to the agency;

- will not lead to an increase or decrease in fees paid to a state agency;

- will create a new regulation;

- will not repeal an existing regulation;

- will not result in a decrease in the number of individuals subject to the rule; and

- will not positively or adversely affect the state's economy.

PUBLIC COMMENTS

The OAG held a public hearing on November 18, 2024, and received verbal and written comments on the proposed rule from several county attorneys, district attorneys, organizations and individuals.

Comments regarding the OAG's authority

Commenters commented that the OAG lacks authority to adopt this rule. Commenters state that the Texas Legislature did not delegate express or implied authority to the OAG to adopt rules under Government Code §41.006.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the OAG has authority to implement Government Code §41.006.

Commenters also commented that the rule violates the nondelegation doctrine in Article 3, Section 56(2) of the Texas Constitution. Commenters state Government Code §41.006 is so broad and lacking in reasonable standards that it is an impermissible exercise of legislative authority.

OAG Response

The OAG considered the comment and declines to make changes to the rule as Article 3, Section 56(2) of the Texas Constitution does not apply to the rulemaking authority of the OAG, but instead it imposes requirements and limitations on the Legislature.

Commenters also commented that Government Code §41.006 does not authorize the OAG to remove duly elected district attorneys and county attorneys from office. Commenters stated Texas law already delineates a specific set of criteria for removing prosecuting attorneys from office under Local Government Code Chapter 87 and the definition of "official misconduct" that can result in removal from office does not include failure to make a report to the Office of the Attorney General.

OAG Response

The OAG reviewed the comments and declines to make changes to the rule as the OAG does not purport to have authority to remove district or county attorneys under Local Government Code Chapter 87. Under Local Government Code 87.012, only a district judge may remove a district or county attorney from office. The rule states the OAG may construe the violation to constitute "official misconduct." Section 87.015 sets forth procedures for petitioning a district court for the removal of an attorney. It does not state the OAG may remove a district or county attorney from office.

Commenters also commented that the OAG does not have original jurisdiction to prosecute state criminal offenses and has no legitimate law enforcement purpose in receiving or reviewing this information.

OAG Response

The OAG considered the comment and declines to make changes to the rule as the rule does not state the OAG has original jurisdiction to prosecute criminal offenses nor is there a "legitimate law enforcement purpose" requirement for receiving information under Government Code §41.006.

Comments regarding Separation of Powers

Commenters commented that the rule violates the separation of powers provision of the Texas Constitution because the respective duties of district and county attorneys shall be regulated by the Texas Legislature.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the OAG determined the requirements in the rule do not violate the separation of powers provision in the Texas Constitution. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Commenters further commented that the rule implies that the OAG has original jurisdiction over the criminal matters in the State of Texas.

OAG Response:

The OAG considered the comments and declines to make changes to the rule because the rule does not imply that the OAG has original jurisdiction over the criminal matters in the State of Texas. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Commenters also commented that the OAG misrepresents the primary duty of prosecuting attorneys under the Texas Constitution.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the rule does not make any representation of the primary duty of prosecuting attorneys. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Comments regarding fiscal impact, cost, and burden

Commenters commented that the rule is an unfunded mandate that imposes significant financial and operational burdens on reporting entities.

Commenters commented that compliance with the rule would require the diversion of significant resources from the essential functions of reporting entities and divert critical resources from the reporting entity's central purpose.

Commenters also commented that the rule is likely to cost counties and taxpayers millions of dollars in additional staff time and by acquiring new staff to comply with the initial and annual reporting requirements in the rule. Commenters commented that the rule's financial impact analysis underestimates operational, technology, and labor costs and fails to consider and specify cumulative costs.

Commenters further commented that compiling the initial report will require making case-by-case determinations in each case file as to whether the circumstances of a particular case fall within the parameters of the required reports, which would require enormous resources and could effectively bring everyday operations to a halt.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the OAG completed a fiscal impact analysis of the rule and concluded that costs should be minimal as complying with the rule could be absorbed into the reporting entities' ongoing operations. Because the content of the reports will differ between reporting entities, the OAG could not predict the exact cost amounts for each reporting entity but expects the cost to be minimal and likely absorbed into reporting entities' ongoing operations with minimal, if any, fiscal impact. Additionally, the OAG acknowledges it will take some time for employees to compile the required reporting data. However, the OAG estimates such time will be minimal as the reporting entity should maintain standard law enforcement record keeping practices.

Comments regarding the purpose of the rules

Commenters commented that the purpose of this rule is purely political and designed to allow the OAG to influence arrests, indictments, and prosecutions. Commenters also commented that the purpose of the rule is to target specific groups and organizations that the OAG disagrees with and to protect certain groups and organizations that the OAG agrees with. Commenters stated the purpose of the rule is for the OAG to determine who should or should not be prosecuted.

Commenters also commented that the purpose of the rule is to provide a method to remove elected district and county attorneys over failures to comply with the rule or scrutinize or remove district and county attorneys if the attorney general disagrees with a district or county attorneys' approach on a particular case.

Commenters also commented that the purpose of the rule is to gain information pertaining to elections because the Attorney General has not been successful in prosecuting election related crimes due to lack of information. Commenters stated that review of case files pertaining to elections serves to intimidate election workers around the state.

OAG Response

The OAG considered the comments and declines to make changes to the rule as the purpose of the rule is to prescribe the time, form, and content of reports the OAG requires from certain district and county attorneys' offices under Government Code §41.006.

Comments regarding confidential, sensitive, and privileged information

Commenters commented that the proposed rules, and broad definition of "case file," would require reporting entities to disclose to the OAG confidential information that they are not legally permitted to disclose. Commenters stated that reporting entities are not permitted to disclose specific information, including, but not limited to: Grand jury information, healthcare records, juvenile justice information, criminal history information, information pertaining to victims and child victims, and DNA information.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the OAG has not identified any instances in which a reporting entity would be prohibited from sharing information with the OAG. Reporting entities currently routinely submit their entire case files, including all of the types of information specified in the comments, to the OAG in various manners and in compliance with other statutes that only generally require disclosure of information to the OAG. The rule implements Government Code §41.006, which specifically states the district and county attorneys shall report to the attorney general the information the attorney general desires. The OAG is required to comply with the same confidentiality statutes for which the reporting entities are required to comply. Any confidential information provided to the OAG pursuant to the rule and §41.006 maintains its confidentiality under the respective confidentiality laws.

Commenters also commented that the rule may require reporting entities to submit information to the OAG that is subject to the work product or attorney-client privileges. Commenters state that once the privileged material has been knowingly and voluntarily disclosed to a third party, even in response to a governmental reporting requirement, the privilege as to that information is waived.

OAG Response:

The OAG has reviewed the comments and declines to make changes to the rule as submitting information to the OAG under the rule and Government Code §41.006 will not waive the work product or attorney-client privileges.

Commenters also commented that there is no provision in the rule to ensure the privacy of sensitive case information, including crime victim and witness information. Because of this, commenters state the rule will have a chilling effect on crime victims and witnesses from coming forward to report crimes, which could result in increased crime. Commenters stated that should these rules go into effect, victims will no longer be assured of how sensitive case information will be accessed, shared, or utilized.

OAG Response:

The OAG has reviewed the comments and declines to make changes to the rule as the law requires the OAG to comply with the same confidentiality statutes for which the reporting entities are required to comply.

Commenters commented that the rules violate Article 1. §30 of the Texas Constitution; Rights of Crime Victims.

OAG Response:

The OAG reviewed the comments and declines to make changes to the rule because the rule does not violate the Texas Constitution.

Comments regarding data storage:

Commenters commented that the rule does not indicate where and how the OAG will store the information received from reporting entities. Commenters commented that the rule does not provide assurances as to the security of the data it receives from reporting entities.

OAG Response:

The OAG considered the comments and declines to make changes to the rule because the OAG has a legal duty to, and does secure, safeguard, and properly maintain data.

Commenters further commented that it may not be possible for reporting entities to transmit electronically the volume of data required to be reported under the rule.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as reporting entities currently routinely submit electronically their entire case files to the OAG in various manners and in compliance with other statutes.

Comments regarding the population requirement for compliance with the rule

Several commenters commented that the fact that the reporting requirements are only for district attorneys and county attorneys presiding in a district or county with a population of 400,000 or more persons is arbitrary and lacks a statutory basis.

OAG Response:

The OAG considered the comments and declines to make changes to the rule. The population requirement for compliance with the rule allows the OAG to review data from the largest counties in the state which will indicate trends for all counties in the state.

Comments regarding the rule's definition of "violent crime"

Commenters commented that the fact that the definition of "violent crime" in §56.2(7) includes crimes the commenters described as nonviolent, such as theft, and any attempt to commit such crimes, is a misleading and overly broad re-categorization of the term violent crime. Commenters state this will generate statistical reports which might incorrectly imply to the public that there has been a significant increase in actual violent crimes. Commenters further state that defining "violent crime" is a legislative issue.

OAG Response:

The OAG reviewed the comments and declines to make changes to the rule because the definition of "violent crime" in §56.2(7) is only applicable to the reporting requirements in the rule. The rule does not purport to amend the definition of "violent crime" in any other context. Further, the rule does not speak to generation of statistical reports. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Comments regarding the Oversight Advisory Committee

Commenters commented that the work of the Oversight Advisory Committee has no scope at all in the rule.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as 1 TAC §56.9 specifies the makeup and responsibilities of the Oversight Advisory Committee.

Comments regarding Quarterly Reports

Commenters asked whether the quarterly reports should repeat information each quarter if the status of the cases has not changed. Commenters also asked whether cases that are declined initially but refiled upon further investigation should be included in the quarterly reports.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the rule does not require clarification. The quarterly reports must include a running list of the required reporting information, including cases that were declined initially but refiled upon further investigation.

Commenters commented that the quarterly reports are not "reports" but instead are quarterly demands by the OAG for any case file it wants.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as reporting requirements are only for information that relates to criminal matters and the interests of the state, which is consistent with Texas Government Code §41.006. The term "report" is defined in 1 TAC §56.2(5) as all information submitted to the OAG by a reporting entity under this chapter.

Comments regarding Annual Reports:

Commenters commented that §56.4(a)(2) is unclear and ask what state and federal ordinances would be responsive to the section.

OAG Response:

The OAG considered the comment and declines to make changes to the rule as the rule clearly identifies the information the OAG is requesting. The term ordinance is part of an inclusive list of actions that refers not just to actions of state and federal entities, but also to local and county entities who may pass ordinances.

Commenter commented §56.4(a)(4) and (5) are very unclear and asks if the requirement includes ARPA funds, government grants, or general fund disbursements.

OAG Response:

The OAG considered the comment and declines to make changes to the rule as §56.4(a)(4) and (5) specify the requested information relates to funds accepted by the commissioners court of their county pursuant to Texas Government Code §41.108. Section 41.108 states "the commissioners court of the county or counties composing a district may accept gifts and grants from any foundation or association for the purpose of financing adequate and effective prosecution programs in the county or district."

Comments regarding 1 TAC §56.3(a)(1)

Commenters asked whether the reporting requirement for indictment of police officers includes cases in which officers are indicted for personal conduct.

OAG Response:

The OAG considered the comment and included clarifying language in §56.3(a)(1) to indicate that the reporting requirement is only for indictment of a peace officer for conduct that occurred while the peace officer was conducting official duties.

Commenters commented that the rule creates a deterrent to the indictment of peace officers which will result in a risk of increased violence to Texans from law enforcement.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the rule does not regulate the indictment of peace officers. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Comments regarding 1 TAC §56.3(a)(2)

Commenters commented that the reporting requirement in §56.3(a)(2) regarding a decision to indict a poll watcher presents a conflict of interest for the OAG and a safety risk to voters.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the reporting requirement does not present a conflict of interest to the OAG nor a safety risk to individuals. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Commenters also commented that §56.3(a)(2) contains a typographical error as "Teas" is not a word.

OAG Response:

The OAG considered the comment and corrected the error to read "Texas" in §56.3.

Comments Regarding 1 TAC §56.3(a)(3)

Commenters commented that §56.3(a)(3) is unclear because it does not define how a defendant "raises a justification under Chapter 9 of the Penal Code."

OAG Response:

The OAG considered the comments and revised §56.3(a)(3) to clarify that the request is for the number of prosecutions involving a defendant's discharge of a firearm where any prosecutorial decision was based on Title 9 of the Penal Code.

Comments regarding 1 TAC §56.3(a)(4)

Commenters requested clarification as to what party recommends to a judicial body that a person subject to a final judgment of conviction be released from prison before the expiration of their sentence; resentenced to a lesser sentence; or granted a new trial based on a confession of error.

OAG Response:

The OAG considered the comment and included clarifying language in §56.3(a)(4) that the recommendation to a judicial body that a person subject to a final judgment of conviction be released from prison before the expiration of their sentence; resentenced to a lesser sentence; or granted a new trial based on a confession of error is a recommendation made by the reporting entity.

Comments regarding 1 TAC §56.3(a)(6)

Commenters commented that the language in §56.3(a)(6) regarding cases where "substantial doubt" for probable cause is extremely broad.

OAG Response:

The OAG considered the comment and declines to make changes as substantial doubt is at the discretion of the OAG's Oversight Advisory Committee.

Comments Regarding 1 TAC §56.3(a)(7)

Commenters commented that the requirement is unclear as to whether the section only refers to a violent crime or if it includes any case that was resolved by deferred prosecution or any case where all charges were dropped for cases that do not fall under the definition of violent crime.

OAG Response:

The OAG considered the comment and declines to make changes to the rule. The reporting requirement in 1 TAC §56.3(a)(7) only applies to arrests for violent crime as defined in the rule.

Comments Regarding 1 TAC §56.3(a)(11)

Commenters commented that 1 TAC §56.3(a)(11) is broad and unclear. Commenters ask whether the required communication include communications with the Children's Advocacy Center, local crisis shelters, and other community partners.

OAG Response

The OAG considered the comment and included clarifying language in 1 TAC §56.3(a)(11) that the reporting requirement is for correspondence with any non-profit organization, not for profit organization, and non-governmental organization regarding a decision to indict an individual. The requirement includes communications with the Children's Advocacy Center, local crisis shelters, and other community partners that are a non-profit organization, not for profit organization, and/or a non-governmental organization.

Comments regarding 1 TAC §56.3(a)(12)

Commenters commented that §56.3(a)(12) is unclear and does not define the term "complaint."

OAG Response:

The OAG considered the comments and revised §56.3(a)(12) to clarify that the information the OAG is requesting is all correspondence written at any time by an assistant district attorney or assistant county attorney regarding the attorney's resignation under a formal or informal complaint process. This section does not include communications regarding salary negotiations or retirement policies.

Comments regarding retention

Commenters commented that the reporting requirements for the initial report are impractical and legally dubious, as many reporting entities either do not maintain certain categories of information or have already disposed of records in accordance with lawful document retention policies.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as §56.3(b)(1) provides exceptions to the initial reporting requirement in §56.3(a). The exceptions include the option for reporting entities to provide a sworn affidavit that states the information cannot be produced because it was destroyed or otherwise discarded pursuant to a *bona fide* document retention policy that existed prior to the effective date of this rule and that is described in detail and transmitted to the Oversight Advisory Committee.

Commenters also commented that the rules seek information that reporting entities may not possess or have no existing obligation to track. Commenters further commented that the rule creates numerous new data and case information reporting requirements for prosecutor offices and require the collection, storage, documentation, and dissemination of records that are not ordinarily retained as part of a criminal case file.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as §56.6 establishes that reporting entities must implement document retention policies reasonably designed to preserve all documents which are, or may be, subject to the requirements in this Chapter. The retention policies must preserve documents for at least two years after the dates when they are due to be reported.

Commenters also commented that §56.6 requires retention of any documents required by this report but provides no exception for expunged matters which could cause a conflict with the penal violations for maintaining records which have been expunged. Additionally, the OAG's office will need to be included in future expunctions for any cases related to these reports.

OAG Response:

The OAG has considered the comment and declines to make changes to the rule as laws regarding expunged matters take precedence over administrative rules. Additionally, the OAG will implement a process to be included in future expunctions for any cases related to reports submitted to the OAG under the rule.

Comments Regarding Procedure

Commenters commented that providing only a seven-day notice of comment and hearing is insufficient and does not allow for the interests of our communities to be adequately represented.

OAG Response:

The OAG considered the comment and declines to make changes as the proposal was published on September 13, 2024, and provided for a 30-day public comment period.

Commenters also comment that the *Texas Register* notice fails to ensure that stakeholders understand the implications of this rule and that stakeholders won't understand that highly personal and confidential information from case files could be transmitted to the attorney general likely without notice or consent given the points in the process when this must occur, under a range of circumstances.

OAG Response:

The OAG reviewed the comment and declines to make changes to the rule as the proposal complies with the notice requirements in Government Code Chapter 2001.

Additional Comments

Commenters commented that if the OAG makes recommendations on charges in cases obtained under this rule and the county fails to obtain convictions in the resulting proceedings, the government would be exposed to greater financial and legal liabilities.

OAG Response:

The OAG has considered the comments and declines to make changes to the rule as the rule does not contemplate OAG recommendations on cases. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Commenters commented that the data collection in the rule focuses on "arrests" and very often an arrest is made that is not adequately supported by probable cause. A number of "arrests" should never be used as a measure of criminality because Americans are not guilty at the point of arrest. Commenters further stated that district attorneys have a responsibility to the Texas taxpayer to pursue only those indictments where probable cause clearly exists.

OAG Response:

The OAG has considered the comments and declines to make changes to the rule as the rule does not contemplate the measure of criminality or pursuit of indictments. The rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Commenters commented that the information required to be reported under the rule is too specific and at the same time so broad such that it will reveal very little about the actual performance of a district attorney's office.

OAG Response:

The OAG considered the comment and declines to make changes to rule as the rule implements Government Code §41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices. Government Code §41.006 authorizes the attorney general to direct districts and counties attorneys' offices to report the information that the attorney general desires.

Commenters also commented that the rule interferes with the professional responsibilities and discretion of local prosecutors.

OAG Response:

The OAG considered the comments and declines to make changes to the rule as the rule does not speak to how a local prosecutor executes their duties. The rule implements Government Code § 41.006 as it prescribes the time, form, and content of reports the OAG requires from certain district and county attorneys' offices.

Other changes

The OAG corrected identified, non-substantive typographical errors.

STATUTORY AUTHORITY

New 1 TAC Chapter 56 is adopted pursuant to Texas Government Code §41.006.

CROSS-REFERENCE TO STATUTE

This regulation clarifies Texas Government Code §41.006. No other rule, regulation, or law is affected by this proposed rule.

§56.1. General Reporting Requirements.

District Attorneys and County Attorneys presiding in a district or county with a population of 400,000 or more persons must submit an initial, and quarterly and annual reports relating to criminal matters, and the interest of the state, to the Office of the Attorney (OAG) in a manner prescribed by the OAG and as set forth in this chapter.

§56.2. Definitions.

The following words and terms, when used in this subchapter, have the following meanings:

(1) "Case file" means all documents, notes, memoranda, and correspondence, in any format such as handwritten, typed, electronic, or otherwise, including drafts and final copies, that were produced within or received by the reporting entity's office, including work product and otherwise privileged and confidential matters. A "case file" does not include a reporting entity employee's correspondence that is purely personal in nature and has no connection with the transaction of official business.

(2) "Correspondence" means any email, letter, memorandum, instant message, text message, or direct message, received or issued by an employee of the reporting entity. "Correspondence" does not include a reporting entity employee's correspondence that is purely personal in nature and has no connection with the transaction of official business.

(3) "Electronic copies" means a digital version of a record that can be stored on a computer device.

(4) "Reporting year" means the period of September 1 through August 31.

(5) "Report" means all information submitted to the OAG by a reporting entity under this chapter.

(6) "Reporting entity" means the office of a District Attorney or County Attorney serving a population of 400,000 or more persons.

(7) "Violent crime" includes capital murder, murder, other felony homicides, aggravated assault, sexual assault of an adult, indecency with a child, sexual assault of a child, family violence assault, aggravated robbery, robbery, burglary, theft, automobile theft, riot, any crime listed in Code of Criminal Procedure §17.50(3), and any attempt to commit such crimes.

§56.3. Quarterly and Initial Reporting Requirements.

(a) Content of reports. Reporting entities must submit electronic copies of the following information to the OAG quarterly in accordance with this chapter.

(1) The number of instances that the Reporting Entity indicted a peace officer for the peace officer's conduct during official duties;

(2) The number of instances that the reporting entity indicted an individual for a criminal violation under the Texas Election Code.

(3) The number of prosecutions involving a defendant's discharge of a firearm resulting in any prosecutorial decision based on Title 9 of the Penal Code;

(4) The case file for instances a recommendation made by the Reporting Entity is made to a judicial body that a person subject to a final judgment of conviction be released from prison before the expiration of their sentence; resentenced to a lesser sentence; or granted a new trial based on a confession of error;

(5) The case file for prosecutions for which the Texas Governor has announced that The Office of the Texas Governor is considering a pardon;

(6) Any case file for prosecutions relating to criminal matters and the interests of the state, as requested by the Attorney General through the Oversight Advisory Committee, including cases where there are substantial doubts by the Oversight Advisory Committee whether probable cause exists to support a prosecution;

(7) The number of instances that an arrest was made for a violent crime but no indictment was issued, the case was resolved by deferred prosecution or a similar program, or all charges were dropped;

(8) All correspondence requested by OAG's Oversight Advisory Committee for a matter listed in response to paragraph (7) of this subsection on a prior quarterly report;

(9) All correspondence and other documentation describing and analyzing a reporting entity's policy not to indict a category or sub-category of criminal offenses;

(10) All correspondence with any employee of a federal agency regarding a decision whether to indict an individual;

(11) All correspondence with any non-profit organization regarding a decision whether to indict an individual; and

(12) All correspondence written at any time by an assistant district attorney or assistant county attorney regarding the attorney's resignation under a formal or informal complaint process. This section does not include communications regarding salary negotiations or retirement policies.

(b) Initial Report. A reporting entity must submit an electronic copy of the information outlined in this section for which a reporting event occurred between January 1, 2021, and the effective date of this rule, unless:

(1) The reporting entity obtains a written exception, in whole or in part, from the OAG;

(2) The reporting entity provides a sworn affidavit that states the information:

(A) was the exclusive product of a previous District or County Attorney; and

(B) is not reflective of the reporting entity's current operations due to a formal change in the office's policies, and the formal

change is described in detail and transmitted to the Oversight Advisory Committee; or

(3) The reporting entity provides a sworn affidavit that states the information cannot be produced because it was destroyed or otherwise discarded pursuant to a *bona fide* document retention policy that existed prior to the effective date of this rule and that is described in detail and transmitted to the Oversight Advisory Committee.

§56.4. Annual Reports.

Reporting entities must submit electronic copies of the following information for the prior reporting year in accordance with this chapter.

(1) All policies, rules, and orders, including internal operating procedures and public policy documents, that were modified during the prior 12 months;

(2) A list of all local, county, state, and federal ordinances, statutes, laws, and rules for which the reporting entity files reports, whether that requirement is regular or arises upon the occurrence of an event;

(3) A list of individual expenditures and purchases made based on funds or assets received through civil asset forfeiture;

(4) All information regarding funds accepted by the commissioners court of their county pursuant to Texas Government Code §41.108 that were passed on to the reporting entity. The reporting entity must detail how much of the funds were passed on to the reporting entity and provide a detailed accounting of how the reporting entity disposed of any funds received; and

(5) All information regarding funds accepted by the commissioners court of their county pursuant to Texas Government Code §41.108 that were not passed on to the reporting entity, but were used to benefit the reporting entity, its personnel, or its operations. The report must include any correspondence regarding accepted funds, as well as a detailed account of how the funds were used to benefit the reporting entity, its personnel, or its operations.

§56.5. Report Submission Deadlines and Requirements

(a) Deadlines.

(1) The quarterly report under §56.3 of this chapter (relating to Quarterly and Initial Reporting Requirements) is due within 30 days of the beginning of each new reporting quarter for all reporting events that occurred in the prior reporting quarter.

(2) The reporting quarters are as follows:

(A) Quarter one: September through November;

(B) Quarter two: December through February;

(C) Quarter three: March through May; and

(D) Quarter four; June through August.

(3) The annual report under §56.4 of this chapter (relating to Annual Reports) is due at the end of each reporting year and no later than September 30.

(4) The initial report under this section is due within 90 days of the effective date of this rule.

(5) The Oversight Advisory Committee may grant an extension on a case-by-case basis if the reporting entity can establish good cause for not meeting the reporting deadlines.

(b) Electronic Submissions. A reporting entity submit all reports under this chapter electronically. Information on how to submit reports electronically can be found on the OAG's website.

§56.6. Document Retention.

Reporting entities must implement document retention policies reasonably designed to preserve all documents which are, or may be, subject to the requirements in this chapter. The retention policies must preserve documents for at least two years after the dates when they are due to be reported.

§56.7. Overdue reports.

If an entity fails to comply with this chapter, in whole or in part, the OAG may send notice to the reporting entity identifying the reporting entity of its failure to comply. A reporting entity must remedy the identified reporting failure within 30 days after receipt of notice. Any reporting entity that fails to timely comply with this chapter's reporting requirements may be identified on the OAG's website as being out of compliance with both this chapter as well as Texas Government Code §41.006.

§56.8. Compliance.

If a reporting entity violates this chapter, without limitation:

(1) The OAG may construe the violation to constitute "official misconduct" under Local Government Code §87.011;

(2) The OAG may file a petition for quo warranto under Civil Practice and Remedies Code §66.002 for the performance of an act that by law causes the forfeiture of the County or District Attorney's office; or

(3) The OAG may initiate a civil proceeding seeking to order the County or District Attorney to comply with this chapter.

§56.9. Oversight Advisory Committee.

(a) The Attorney General will establish an Oversight Advisory Committee composed of three members of the Office of the Attorney General designated by the Attorney General.

(b) The Oversight Advisory Committee may issue notifications of overdue reports under §56.7 of this chapter (relating to Overdue reports).

(c) The Oversight Advisory Committee may request entire case files based on submitted reports or any other information that the Oversight Advisory Committee desires relating to criminal matters and the interests of the state on a case-by-case basis,

(d) The Oversight Advisory Committee may waive any provision of this chapter if a reporting entity demonstrates that compliance would impose an undue hardship.

§56.10. Severability.

(a) All provisions of this chapter are severable.

(b) If any application of any provision of this rule is held to be invalid for any reason, all valid provisions are severable from the invalid provisions and remain in effect. If any section or portion of a section is held to be invalid in one or more of its applications, in all valid applications the provisions remain in effect and are severable from the invalid applications.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500891

Justin Gordon
General Counsel
Office of the Attorney General
Effective date: April 2, 2025
Proposal publication date: September 13, 2024
For further information, please call: (512) 475-4291

♦ ♦ ♦

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

1 TAC §353.1306

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to §353.1306, concerning Comprehensive Hospital Increase Reimbursement Program for Program Periods on or after September 1, 2021.

Section 353.1306 is adopted with changes to the proposed text as published in the September 13, 2024, issue of the *Texas Register* (49 TexReg 7143). This rule will be republished.

BACKGROUND AND JUSTIFICATION

HHSC has been working since September 2022 to evaluate the future of the Medicaid hospital financing system in a post-public health emergency environment. With the combination of new Medicaid fee-for-service and managed care rules at the federal level, the unwinding of the Medicaid caseload coverage from the public health emergency, and the interplay between directed payment programs and new supplemental payment programs (e.g., the private graduate medical education (GME) and Hospital Augmented Reimbursement program (HARP)), hospital financing in Medicaid and for the uninsured has been challenging to forecast. With the support of hospitals and their representatives, Medicaid managed care organizations and their representatives, and industry subject matter experts, HHSC made final decisions regarding the program design for CHIRP that will be implemented, beginning in state fiscal year (SFY) 2026.

Comprehensive Hospital Increase Reimbursement Program

Beginning in SFY 2025, CHIRP is composed of three components: Uniform Hospital Rate Increase Payment (UHRIP), Average Commercial Incentive Award (ACIA), and Alternate Participating Hospital Reimbursement for Improving Quality Award (APHRIQA). The amendment to §353.1306 updates the ACIA component calculation beginning in SFY 2026 to calculate the Average Commercial Reimbursement (ACR) gap on an aggregated, per-class basis. The amendment to §353.1306 also allocates available ACIA funds across hospital classes based on the proportion of the combined ACR gap of each hospital class within a Service Delivery Area (SDA) to the total ACR gap of all hospitals within the SDA. Lastly, the rule amendment to §353.1306 updates the maximum ACR Upper Payment Limit (UPL) percentage to 95 percent beginning in SFY 2027 and to 100 percent beginning in SFY 2028.

COMMENTS

The 31-day comment period ended October 15, 2024.

During this period, HHSC received comments regarding the proposed rule from three commenters: the Texas Association of Behavioral Health Systems, the Children's Hospital Association of Texas, and the Texas Hospital Association. A summary of comments relating to §353.1306 and HHSC's responses follow.

Comment: Multiple commenters requested that HHSC withdraw the CHIRP rule amendment due to new Federal reporting requirements and recent Centers for Medicare & Medicaid Services (CMS) guidance on the CHIRP program. Commenters believe that the CHIRP rule should be withdrawn and that HHSC should draft an alternative amendment to include greater details and clarity on CMS requirements for the program.

Response: HHSC appreciates the comment and understands the desire for greater clarity and transparency. The rule amendment, as proposed, describes the CHIRP Program as is; HHSC is continuing to work with CMS on requirements for future years. Depending on the outcomes of these discussions, additional rule amendments may be made in future years. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters requested that HHSC provide greater clarity and transparency for program definitions and descriptions including class definitions and separation by managed care programs in alignment with new CMS requirements for the CHIRP program.

Response: HHSC appreciates the comment and understands the desire for greater clarity and transparency. HHSC is continuing to work with CMS on requirements for future years. Depending on the outcomes of these discussions, additional rule amendments may be made in future years. No revision to the rule text was made in response to this comment.

Comment: A commenter stated that, in light of recent CMS requirements for the CHIRP program for SFY 2025, it is important to ensure that all CHIRP payments are capped at 100 percent of the average commercial rate for all program components.

Response: HHSC appreciates this comment. In the rule text, language is included to increase the percentage of ACR UPL to 100 percent by the program period beginning on or after September 1, 2027. No revision to the rule text was made in response to this comment.

Comment: A commenter requested clarifications to the language of the ACIA allocation of available funds to take into consideration UHRIP payments because the ACIA distribution occurs after the UHRIP distribution.

Response: HHSC appreciates the comment and has updated subsection (g)(3)(A) to clarify that the allocation of available funds across hospital classes will be proportional to the combined ACR gap less UHRIP payments of each hospital class within an SDA to the total ACR gap of all hospital classes within the SDA. In addition, (g)(3)(D) is updated to clarify that the ACIA payment example is for program periods beginning on or before September 1, 2024.

Comment: A commenter requested that HHSC oppose CMS's requirement to limit the Medicare UPL gap to ACR gap limits.

Response: This comment is outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: A commenter stated that they believed that the new federal rule does not explicitly limit CHIRP payments at the aggregate ACR rate for inpatient behavioral health services in an

Institution for mental diseases (IMD) and asks for HHSC to advocate for UHRIP rates up to aggregated Medicare UPL amounts for IMD classes in line with historical program operations.

Response: This comment is outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which authorizes the executive commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) In the application, the hospital must select whether it will participate in the optional program components described in subsections (g)(3) and (g)(4) of this section. A hospital cannot participate in the program component described in subsection (g)(3) or (g)(4) of this section without also participating in the program component described in subsection (g)(2) of this section. In the application, the hospital must also select whether the hospital elects to receive interim payments described by subsection (h)(2)(D) of this section.

(B) All hospitals must submit certain necessary data to calculate the ACR gap. However, a hospital may indicate that it does not wish to participate in the optional program component described in subsection (g)(3) of this section.

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

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

(2) The entity that owns the hospital must certify, on a form prescribed by HHSC, that no part of any payment made under the CHIRP will be used to pay a contingent fee and that the entity's agreement with the hospital does not use a reimbursement methodology that contains any type of incentive, directly or indirectly, for inappropriately

inflating, in any way, claims billed to the Medicaid program, including the hospitals' receipt of CHIRP funds. The certification must be received by HHSC with the enrollment application described in paragraph (1) of this subsection.

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

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

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

(d) Classes of participating hospitals.

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

(A) children's hospitals;

(B) rural hospitals;

(C) state-owned non-IMD hospitals;

(D) urban hospitals;

(E) non-state-owned IMDs; and

(F) state-owned IMDs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) In determining the percentage increases described under subsection (h)(1) of this section, HHSC will consider:

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on the amount of IGT the sponsoring governmental entities propose to transfer to HHSC to support the non-federal share of the increased rates for the first six months of a program period, as indicated on the applications described in subsection (c) of this section;

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

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

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

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

(F) hospital market dynamics within the SDA; and

(G) other HHSC goals and priorities.

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

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

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

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

(A) The total value of ACIA will be equal to a percentage of the ACR gap less payments received under UHRIP, subject to the limitations described by subparagraph (B) of this paragraph. For program periods beginning on or before September 1, 2024, for the purposes of this subparagraph, the ACR gap and UHRIP payment are based on the individual hospital's data. For program periods beginning on or after September 1, 2025, for the purposes of this subparagraph, the ACR gap and the UHRIP payment are based on the aggregated amounts by class; and the allocation of available funds across hospital classes will be proportional to the combined ACR gap less UHRIP payments of each hospital class within an SDA to the total ACR gap of all hospital classes within the SDA.

(B) The maximum ACIA payments for each class will be equal to a percentage of the total estimated ACR UPL for the class, less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA. The percentage for each program period is as follows.

(i) For program periods beginning on or before September 1, 2023, but on or after September 1, 2021, the percentage is 90 percent.

(ii) For the program periods beginning on September 1, 2024, and September 1, 2025, the percentage may not exceed 90 percent.

(iii) For the program period beginning on September 1, 2026, the percentage may not exceed 95 percent.

(iv) For program periods beginning on or after September 1, 2027, the percentage may not exceed 100 percent.

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

(D) For program periods beginning on or before September 1, 2024, the ACIA payment for each provider will be equal to the amount in subparagraph (A) of this paragraph multiplied by the amount determined in subparagraph (C) of this paragraph for the class divided by the sum of the preliminary ACIA payment determined in subparagraph (A) of this paragraph for the class, rounded down to the nearest percentage. For example, if two hospitals in a class in an SDA both have anticipated base payments of $100 and UHRIP payments of $50, but one hospital has an estimated ACR UPL of $400 and an ACR gap of $300 between its base payment and ACR UPL, and the other hospital has an estimated ACR UPL of $600 and an ACR gap of $500, HHSC will first reduce the gaps by the UHRIP payment of $50 to a gap of $250 and $450, respectively. The preliminary ACIA rates are 250 percent and 450 percent. These are the amounts available under subparagraph (A) of this paragraph. HHSC would then sum the ACR UPLs for the two hospitals to get $1000 available to the class and apply the percentage in subparagraph (B) of this paragraph (e.g., 50 percent of the gap), which results in an ACR UPL of $500. Then, HHSC will subtract the $200 in base payments and $100 in UHRIP payments from the reduced ACR UPL for a total of $200 of maximum ACIA payments under subparagraph (B) of this paragraph. The amount under subparagraph (A) for the class was $700 and the limit under subparagraph (B) of this paragraph is $200, so all provider in the SDA will have their ACIA percentage multiplied by $200 divided by $700 to stay under the $200 cap. The individual ACIA rates would be 71 percent (e.g., 200/700*250 percent) and 128 percent (e.g., 200/700*450 percent), respectively. The estimated ACIA payments would be $71 and $128. HHSC will then direct the MCOs to pay a percentage increase for the first hospital of 71 percent in addition to the 50 percent increase under UHRIP for the first hospital for a total increase of 121 percent above the contracted base rate, and 128 percent in addition to the 50 percent increase under UHRIP for the second hospital for a total increase of 178 percent.

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

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

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

(ii) a percentage of the total estimated ACR UPL, not to exceed the applicable percentage specified in paragraph (3)(B) of this subsection, on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

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

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

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

(h) Distribution of CHIRP payments.

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

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

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

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

(2) For program periods beginning on or after September 1, 2024, CHIRP final payments for the APHRIQA component will be

based on achievement of performance measures established in accordance with §353.1307 of this subchapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Filed with the Office of the Secretary of State on March 13, 2025

TRD-202500917
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 2, 2025
Proposal publication date: September 13, 2024
For further information, please call: (512) 487-3480

♦ ♦ ♦

CHAPTER 355. REIMBURSEMENT RATES
SUBCHAPTER J. PURCHASED HEALTH SERVICES

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments to §355.8065, concerning Disproportionate Share Hospital Reimbursement Methodology; §355.8070, concerning Hospital Augmented Reimbursement Program; and §355.8212, concerning Waiver Payments to Hospitals for Uncompensated Charity Care.

Sections 355.8065, 355.8070, and 355.8212 are adopted without changes to the proposed text as published in the September 13, 2024, issue of the *Texas Register* (49 TexReg 7150). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

HHSC has been working since September 2022 to evaluate the future of the Medicaid hospital financing system in a post-public health emergency environment. With the combination of new Medicaid fee-for-service and managed care rules at the federal level, the unwinding of the Medicaid caseload coverage from the public health emergency, and the interplay of new supplemental payment programs (e.g., the private graduate medical education (GME) and Hospital Augmented Reimbursement Program (HARP)), hospital financing in Medicaid and for the uninsured has been challenging to forecast. With the support of hospitals and their representatives, Medicaid managed care organizations and their representatives, industry subject matter experts, and the staff at the Centers for Medicare & Medicaid Services (CMS), HHSC made final decisions about strategies to ensure stability if the Uncompensated Care (UC) pool is reduced in the future.

Disproportionate Share Hospital Program

The amendment to §355.8065 makes clarifying updates to align the rule text with the current calculation methodology and adds rural hospitals to be deemed to qualify and exempt from the trauma system condition of participation beginning in Federal Fiscal Year (FFY) 2025. The amendment may allow rural hospitals to receive advance FFY 2025 Disproportionate Share Hospitals (DSH) payments if they are eligible based on the new deeming and trauma criteria. The amendment adds certain clarifying changes and updates the descriptions to accurately describe the Pool Three Pass One secondary payment, rural public and private pools, and advance payment for federal fiscal year 2025 and beyond.

Hospital Augmented Reimbursement Program

The amendment to §355.8070 adds the Medicare definition used by the Centers for Medicare & Medicaid Services (CMS) of a nominal charge provider. It includes clarifications to the payment methodology to limit HARP payments to ensure inpatient Medicaid payments will not exceed inpatient Medicaid charges for all providers except those who meet the Medicare definition of a nominal charge provider. The amendment updates codify the existing practice to increase transparency.

Uncompensated Care Program

The amendment to §355.8212 increases the size of the High Impecunious Charge Hospital (HICH) pool to a level that does not exceed $1 billion in total. It also updates the order of the HICH pool allocation to become the second hospital payment allocation made in UC. This amendment will enable any HICH hospital to receive payments before any non-HICH hospital.

COMMENTS

The 31-day comment period ended on October 15, 2024.

During this period, HHSC received comments regarding the proposed rules from 13 commenters, including the Texas Organization of Rural & Community Hospitals, Texas Association of Behavioral Health Systems, Teaching Hospital of Texas, Texas Association of Behavioral Health Systems, St. Luke's Health Memorial Hospital, Children's Hospital Association of Texas, Tenet Health, Texas Association of Voluntary Hospitals, Universal Health Services, El Paso County Hospital District, DHR Health, Texas Essential Healthcare Partnerships, and G5 (Baylor Scott & White Health, HCA Healthcare American Group, Memorial Hermann Health System, Tenet Healthcare, Texas Health Resources).

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

Comments regarding §355.8065 follow.

Comment: Multiple commenters have expressed support for the DSH rule amendment to deem rural hospitals eligible for DSH beginning in FFY 2025 and to exempt rural hospitals from the trauma system condition of participation.

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

Comment: A commenter expressed disagreement with the state payment cap definition, stating that it complicates the DSH program unnecessarily by using a state payment cap calculation that differs from the federal hospital-specific limit definition.

Response: The comment is outside the scope of the current rule proposal project. No revision to the rule text was made in response to this comment.

Commenter: A commenter expressed support for the proposed revision to the definition of Total Medicaid inpatient days, which would no longer exclude days attributable to Medicaid-eligible patients ages 21 through 64 in an Institution for mental diseases (IMD), as per current CMS guidance.

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

Comments regarding §355.8070 follow.

Comment: A commenter requested that HHSC include a state definition of a nominal charge provider.

Response: HHSC does not have a state definition for nominal charge provider and follows the Federal definition of nominal charge provider as currently codified in the rule amendment. No revision to the rule text was made in response to this comment.

Comments regarding §355.8212 follow.

Comment: Multiple commenters have stated that they believe the rule amendment for the UC HICH pool is premature and requested that HHSC withdraw the amendment to increase the HICH pool.

Response: HHSC disagrees with the comment. The amended rule language allows flexibility and does not limit HHSC's ability to adjust the HICH pool size on a program-year basis as needed. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters have stated that they believe the rule amendment for the UC HICH pool unfairly disadvantages private and IMD hospital classes.

Response: HHSC disagrees with the comment because private hospitals and IMDs are not excluded from eligibility for the HICH pool. Hospitals with an impecunious charge ratio that is equal to or greater than 27.5 percent are eligible for the HICH pool. No revision to the rule text was made in response to this comment.

Comment: A commenter requested for the HICH pool to be increased to $1.5 billion citing concerns about future potential UC funding reductions and impacts to rural and public urban hospitals.

Response: HHSC recognizes the importance of providing financial stability for providers which is why we created the HICH pool and are seeking to set it at $1 billion. All charity care costs are intended to be recognized through the UC program and all non-HICH providers are important in the delivery of healthcare provided across the state. All healthcare providers, including HICH providers, have access to UC. HICH providers are able to receive payments through UC for both HICH designated funds and other UC funds. HHSC does not believe it is prudent to allocate more than $1 billion to the HICH pool in order to ensure the overall financial stability of the program. HHSC will consider this comment in future rulemaking projects but declines to make changes in response to this comment.

Comment: Multiple commenters requested that the HICH pool be expanded by deeming transferring public hospitals eligible for the HICH pool or by creating a second tier of eligibility for the top quartile of HICH ratios for hospitals statewide.

Response: The HICH pool was created with the intention of targeting funding to hospitals that serve a large volume of uninsured persons as part of their patient-mix as well as rural and state-owned facilities. The 27.5 percent threshold was selected because it was meaningful representation of the small number of hospitals that serve a large volume of uninsured persons. Deeming additional hospital classes or creating a second tier of eligibility contradicts the original intention of the HICH pool. HHSC has no plans to expand eligibility criteria for the HICH pool currently. No rule text revision was made in response to this comment.

Comment: A commenter requested that the HICH pool determination process involve stakeholder engagement, including a formal public hearing and comment period.

Response: This comment is outside the scope of the rule amendment. No revision to the rule text was made in response to this comment.

Comment: Multiple commenters requested that HHSC hold a public hearing and formal comment period to allow all safety-net hospitals an opportunity to comment on a revised rule proposal.

Response: Both a public hearing and a formal comment period were provided to the public for the proposed rule amendments. The comment period occurred from September 13, 2024 through October 15, 2024, and a public hearing was held on September 26, 2024. Any future revisions to the rules will provide public notice and comment process as required by law. No rule text revision was made in response to this comment.

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8065, §355.8070

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.033, which authorizes the executive commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b-1), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Texas Human Resources Code Chapter 32.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500918
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 2, 2025
Proposal publication date: September 13, 2024
For further information, please call: (512) 487-3480

♦ ♦ ♦

DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8212

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which authorizes the executive commissioner of HHSC to adopt rules necessary to carry out HHSC's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to

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

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500919
Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Effective date: April 2, 2025
Proposal publication date: September 13, 2024
For further information, please call: (512) 487-3480

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 70. INDUSTRIALIZED HOUSING AND BUILDINGS

16 TAC §70.60

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rule at 16 Texas Administrative Code (TAC), Chapter 70, §70.60, regarding the Industrialized Housing and Buildings program, without changes to the proposed text as published in the November 29, 2024, issue of the *Texas Register* (49 TexReg 9686). This rule will not be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC, Chapter 70, implement Texas Occupations Code, Chapter 1202, Industrialized Housing and Buildings.

The adopted rule amendment at §70.60(e) allows an employee of a third-party inspection agency or design review agency to also be the team lead for the initial certification of a manufacturing plant. The adopted rule amendment expands the pool of candidates for this position to employees of the third-party inspection agency, responsible for regular in-plant inspections of the manufacturer, or the design review agency, responsible for review of the manufacturer's design package. The adopted rule amendment is necessary to allow the Department the possibility of focusing its limited resources on long-term, risk-based auditing of those plants.

SECTION-BY-SECTION SUMMARY

The adopted rule amends §70.60(e) to allow for an employee of a third-party inspection agency, which would be responsible for regular in-plant inspections, or design review agency, responsible for the review of the manufacturer's design package, to also be a team lead for the initial certification of a manufacturing plant.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rule to persons internal and external to the agency. The proposed rule was published in the November 29, 2024, issue of the *Texas Register* (49 TexReg 9686). The public comment period closed on December 30, 2024.

The Department did not receive any comments from interested parties on the proposed rule.

CODE COUNCIL RECOMMENDATIONS AND COMMISSION ACTION

The proposed rule was presented to and discussed by the Industrialized Housing and Buildings Code Council at its meeting on November 12, 2024. The Code Council voted and recommended that the proposed rule be published in the *Texas Register* for public comment. The Code Council also voted and recommended that, in the absence of public comment, the proposed rule be adopted by the Commission.

At its meeting on February 14, 2025, the Commission adopted the proposed rule as published in the *Texas Register*.

STATUTORY AUTHORITY

The adopted rule amendment is adopted under Texas Occupations Code, Chapters 51 and 1202, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adopted rule are those set forth in Texas Occupations Code, Chapters 51 and 1202. No other statutes, articles, or codes are affected by the adopted rule.

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

Filed with the Office of the Secretary of State on March 11, 2025.

TRD-202500855
Doug Jennings
General Counsel
Texas Department of Licensing and Regulation
Effective date: April 1, 2025
Proposal publication date: November 29, 2024
For further information, please call: (512) 463-3671

♦ ♦ ♦

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 97. PLANNING AND ACCOUNTABILITY

SUBCHAPTER AA. ACCOUNTABILITY AND PERFORMANCE MONITORING

19 TAC §97.1001

(Editor's note: In accordance with Texas Government Code, §2002.014, which permits the omission of material which is "cumbersome, expensive, or otherwise inexpedient," the figure in 19 TAC §97.1001 is not included in the print version of the

Texas Register. The figure is available in the on-line version of the March 28, 2025, issue of the Texas Register.)

The Texas Education Agency (TEA) adopts an amendment to §97.1001, concerning the accountability rating system. The amendment is adopted with changes to the proposed text as published in the January 10, 2025 issue of the *Texas Register* (50 TexReg 232) and will be republished. The amendment adopts in rule applicable excerpts of the *2025 Accountability Manual*. Earlier versions of the manual will remain in effect with respect to the school years for which they were developed.

REASONED JUSTIFICATION: TEA has adopted its academic accountability manual in rule since 2000 under §97.1001. The accountability system evolves from year to year, so the criteria and standards for rating and acknowledging schools in the most current year differ to some degree from those applied in the prior year.

The amendment to §97.1001 adopts excerpts of the *2025 Accountability Manual* into rule as a figure. The excerpts, Chapters 1-12 of the *2025 Accountability Manual*, specify the indicators, standards, and procedures used by the commissioner to determine accountability ratings for districts, campuses, and charter schools. These chapters also specify indicators, standards, and procedures used to determine distinction designations on additional indicators for Texas public school campuses and districts. Chapter 12 describes the specific criteria and calculations that will be used to assign 2025 Results Driven Accountability (RDA) performance levels. Ratings may be revised as a result of investigative activities by the commissioner as authorized under Texas Education Code (TEC), §39.056 and §39.003.

Following is a chapter-by-chapter summary of the changes for this year's manual. In every chapter, dates and years for which data are considered were updated to align with 2025 accountability and RDA. Edits for clarity regarding consistent language and terminology throughout each chapter are embedded within the adopted *2025 Accountability Manual*. Additionally, based on public comment, the extra blank pages were removed from the document and the page numbers were adjusted accordingly.

Chapter 1 gives an overview of the entire accountability system. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. Language has been adjusted to clarify the existing processes of the data validation system. Based on public comment, clarification was provided at adoption on page 7 in the Accountability Subset Rule section, page 8 in the STAAR EOC Retest Performance section, page 9 in the table for the TSDS PEIMS-Based Indicators section, and page 10 in the table for the Other Indicators section.

In addition, corrections were made at adoption on pages 5 and 11 to remove the redundant text regarding special investigations and accurately reflect the steps in a compliance review.

Chapter 2 describes the "Student Achievement" domain. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. Based on public comment, clarification was provided at adoption on page 18 in the Schedule for Phase-in of College Prep 12th Grade Requirement section; page 20 in the College, Career, and Military Readiness Component--Minimum Size Criteria and Small Numbers Analysis section; page 21 in the Graduation Rate Component section; page 22 in the Graduation Rate--Methodology; and page 24 in the AEA CCMR Rate--Methodology section.

In addition, a correction was made at adoption on page 18 to add the Texas First Early High School Completion Program with a Distinguished Level of Achievement to the list of graduation plans for advanced diplomas.

Chapter 3 describes the "School Progress" domain. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added.

Chapter 4 describes the "Closing the Gaps" domain. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. The language for methodology for English language proficiency has been updated. Based on public comment, clarification was provided at adoption on page 36 in the Two Lowest Performing Racial/Ethnic Groups from the Prior Year section; page 40 in the 0-4 Points section; page 47 in the College, Career, and Military Readiness Performance Status--Minimum Size Criteria and Small Numbers Analysis section; and page 48 in the Minimum Number of Evaluated Indicators section.

Chapter 5 describes how the overall ratings are calculated. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. Based on public comment, clarification was provided at adoption on page 58 in the Student Achievement Domain section; page 59 in the District Proportional Domain Methodology section; and page 60 in the Overall Rating (Districts and Campuses) section.

Chapter 6 describes distinction designations. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added.

Chapter 7 describes the pairing process and the AEA provisions. Dates and years for which data are considered have been updated.

Chapter 8 describes the process for appealing ratings. Dates and years for which data are considered have been removed. Edits for clarity regarding consistent language and terminology have been added. Based on public comment, clarification was provided at adoption on page 89 in the Appeals Timeline section.

Chapter 9 describes the responsibilities of TEA, the responsibilities of school districts and open-enrollment charter schools, and the consequences to school districts and open-enrollment charter schools related to accountability and interventions. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added.

Chapter 10 provides information on the federally required identification of schools for improvement. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. Based on public comment, clarification was provided at adoption on page 105 in the table for the Example Campus Identified for Targeted Support and Improvement section and page 110 in the Exit Criteria for Comprehensive Support and Improvement section.

Chapter 11 describes the local accountability system. Edits for clarity regarding consistent language and terminology have been added.

Chapter 12 describes the RDA system. Dates and years for which data are considered have been updated. Edits for clarity regarding consistent language and terminology have been added. Detailed language regarding the change of report only to performance level assignment indicators for Bilingual Education/English as a Second Language/Emergent Bilingual (BE/ESL/EB) Indicator for TELPAS Composite Rating Levels, Special Education Indicator for Out of School Suspension and Expulsion, and Special Education Indicator for In-School Suspension have been added. Detailed language discontinuing the Hold Harmless element of certain Other Special Populations have been added. Detailed language for indicators that will no longer be reported through RDA have been added. Detailed language regarding the change from report only to No in performance level assignment indicators have been added. Indicator numbers and data note numbers have been updated.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began January 10, 2025, and ended February 10, 2025. A public hearing on the proposal was held on January 31, 2025. Following is a summary of public comments received and agency responses.

Edits for Clarification

Comment: Three district administrators and lead4ward commented on various typographical and grammatical errors throughout the *2025 Accountability Manual* and suggested corrections.

Response: The agency agrees and has made various typographical and grammatical corrections to the manual, including adjusting the page numbers, adding a reference to Appendix H on page 21, and correcting a section title on page 60.

Comment: lead4ward suggested a change to sections throughout the *2025 Accountability Manual* (i.e., STAAR Component-Assessments and Measures Evaluated, Part A: Academic Growth-Assessments Evaluated, Part B: Relative Performance-Assessments and Measures Evaluated, Academic Achievement-Assessments and Measures Evaluated, Student Achievement Domain Score: STAAR Component Only-Assessments and Measures Evaluated) to clarify the data included, remove references to accommodations, and remove references to the English Language (EL) Performance Measure.

Response: The agency disagrees and has determined that the proposed language in the manual presents the clearest descriptions. In addition, maintaining language as proposed will ensure that the agency does not signal a change to methodology where there is not a change.

Comment: A district administrator and lead4ward requested changes to the descriptions of emergent bilingual (EB) students throughout the *2025 Accountability Manual* for consistency.

Response: The agency disagrees with making the changes to the *2025 Accountability Manual*. The agency has been in a transition from "English Learner" to "Emergent Bilingual" since the *2022 Accountability Manual* publication and is still using the description Emergent Bilingual (EB) Student/English Learner (EL) to define a student whose primary language is other than English and who is in the process of acquiring English. However, the agency will continue to work with stakeholders to consider changes to the descriptions for a future accountability cycle.

Comment: A district administrator and lead4ward requested clarity be added to the *2025 Accountability Manual* regarding the inclusion or exclusion of EB students from the various indicators and measures and that repetitive language regarding the use of the Test Information Distribution Engine (TIDE) for student demographic data be adjusted. lead4ward recommended revisions to EB inclusion/exclusion descriptions in STAAR Component-Inclusion of EB Students; College, Career, and Military Readiness Component; Graduation Rate-Methodology; Part A: Academic Growth-Inclusion of EB Students/ELs; Part B: Relative Performance-Inclusion of EB Students/ELs; AEA Part B: Inclusion/Exclusion of EB Students; and Closing the Gaps-Inclusion of EB Students/ELs.

Response: The agency disagrees that revisions are needed to the *2025 Accountability Manual*. Maintaining language as proposed will ensure that the agency does not signal a change to the inclusion and exclusion methodology where there is not a change. However, the agency will continue to work with stakeholders to consider the clarity of this information for a future accountability cycle.

Comment: lead4ward suggested edits throughout the *2025 Accountability Manual* to delete the reference to the EL performance measure (described by lead4ward as performance standard, not a separate assessment). The commenter also suggested adding an appendix to describe and define how the EL Performance Measure is calculated.

Response: The agency agrees that additional clarification would support stakeholder understanding of the EL Performance Measure. However, the agency disagrees with making changes to the *2025 Accountability Manual*. Maintaining language as proposed will ensure that the agency does not signal a change to methodology where there is not a change. Appendices are beyond the scope of the current rule proposal but will be considered for sharing this additional information.

Comment: lead4ward suggested a change to the *2025 Accountability Manual* in the Accountability System School Types table on page 6, proposing the example from a prior accountability year be removed and replaced with a more general table.

Response: The agency disagrees and has determined that the proposed language in the manual, including the example from a prior cycle, presents the clearest description. However, for future updates to the accountability manual, the agency will continue to work with stakeholders on communication of the school type determination methodology.

Comment: A district administrator and lead4ward suggested that clarity should be added to the *2025 Accountability Manual* regarding subset rules. The district administrator requested specific clarity on the subset used for the Texas English Language Proficiency Assessment System (TELPAS) results in the Closing the Gaps Domain. lead4ward requested specific clarity on the end-of-course (EOC) assessments' campus of assignment.

Response: The agency agrees and has made changes to the manual at adoption to add clarity on page 7 to indicate that the accountability subset rules apply to TELPAS results in addition to the State of Texas Assessments of Academic Readiness (STAAR®) results and to indicate under the assessment administration periods that results are for students enrolled "at that campus."

Comment: lead4ward requested clarity be added to the *2025 Accountability Manual* regarding the use of STAAR® EOC assessments in the School Progress domain, specifically that growth is only measured from first-time test attempts.

Response: The agency agrees and has added a statement to page 8 of the manual to provide clarity that only first-time STAAR® EOC assessments are included in School Progress: Part A, Academic Growth calculations.

Comment: A district administrator suggested adding a link to the performance reporting resource entitled "CCMR Accountability Data Sources" to help provide clarity under the section *TSDS PEIMS-Based Indicators* in the *2025 Accountability Manual*.

Response: The agency disagrees with adding the link to the "CCMR Accountability Data Sources" document on page 9 of the manual as it already links to the "Accountability Data Resources" webpage, but the agency will add the link to the webpage.

Comment: lead4ward suggested that in the *2025 Accountability Manual*, the wording be revised in the table *TSDS PEIMS data used for accountability indicators* as the "July 2023 administrations" is not applicable.

Response: The agency agrees and has updated the table on page 9 of the manual to change from a specific administration date to a school year to ensure clarity.

Comment: A district administrator suggested the table regarding other indicators for the College, Career, and Military Readiness (CCMR) component in the *2025 Accountability Manual* should include a line for the Texas Success Initiative Assessment (TSIA) and a line for TSIA2 to clarify when a student's score is allowable.

Response: The agency disagrees as the differentiation is not necessary in the table on page 10 of the manual since any TSIA or TSIA2 test within the date range would be allowable.

Comment: lead4ward suggested that in the *2025 Accountability Manual*, the wording be revised on the header for the table *Other data used for College, Career, and Military Readiness*.

Response: The agency agrees and has removed the language "for examinations taken as of" to ensure clarity of the table on page 10 of the manual.

Comment: lead4ward suggested a change to the phrasing of the *STAAR® Component--Minimum Size Criteria and Small Numbers Analysis* section on page 16 of the *2025 Accountability Manual*.

Response: The agency disagrees and has determined that the proposed language in the manual presents the clearest descriptions.

Comment: lead4ward suggested that the agency's references to dates of CCMR data as "following graduation" should be removed on page 17 of the *2025 Accountability Manual*.

Response: The agency disagrees. The language "following graduation" is correct in the manual.

Comment: An education service center (ESC) representative and lead4ward requested clarifying language be added to the *2025 Accountability Manual* regarding the source data for determining student grade for the grade level requirement to earn CCMR credit through the completion of a College Preparatory course.

Response: The agency agrees and has added clarification to page 18 of the manual that the grade of the student at the time of the course will be based on the grade submitted in the Texas Student Data System (TSDS) Public Education Information Management System (PEIMS) Summer submission.

Comment: In the section *Schedule for Phase-in of College Prep 12th Grade requirement* on page 18 of the *2025 Accountability Manual*, lead4ward suggested replacing "Class of 2025" or "Class of 2026" with "2024-2025 graduates" and "2025-2026 graduates."

Response: The agency disagrees and has determined that the proposed language in the manual presents the clearest descriptions in alignment with other references to annual graduates in the section *CCMR Credit Requirements for Annual Graduates by Accountability Year*.

Comment: lead4ward suggested renaming School Progress, Part B: Retest Growth for campuses evaluated under AEA methodology in the *2025 Accountability Manual* to "Part B: EOC Retest Performance" to clarify it is different from Academic Growth.

Response: The agency disagrees and has determined that the proposed language in the manual presents the clearest description.

Comment: lead4ward suggested an edit in the *2025 Accountability Manual* to indicate that Part A: Academic Growth evaluates the subject area assessments of reading language arts (RLA) and mathematics.

Response: The agency disagrees that an edit is needed as the manual already includes the statement "results for grades 4-8 in RLA and mathematics" on page 26.

Comment: lead4ward noted that the calculation used to identify the two lowest performing racial/ethnic groups is not an average as described in the *2025 Accountability Manual* and proposed a clarifying edit to the calculation.

Response: The agency agrees that the calculation is not an average. To ensure the methodology is clear to all stakeholders, the agency adjusted the language on page 36 of the manual and added steps to calculate the two lowest performing racial/ethnic groups from the lowest combined percentage.

Comment: lead4ward recommended a revision in the *2025 Accountability Manual* to clarify the percentage change needed to earn one point for minimal growth in the Closing the Gaps domain.

Response: The agency agrees additional clarification is needed and has revised the language on page 40 of the manual to ensure the methodology is clear to stakeholders.

Comment: lead4ward suggested the language in the *2025 Accountability Manual* regarding the small numbers analysis for the CCMR Component be changed to clarify the calculation is not an average, but it is the calculation of a single rate based on data cumulated across three years.

Response: The agency agrees the calculation is not an average. To ensure the methodology is clear to all stakeholders, the agency clarified that the calculation is based on three years of combined CCMR data on pages 20 and 47 of the manual.

Comment: lead4ward recommended language be added to the *2025 Accountability Manual* to clarify the methodology that the Closing the Gaps Domain is not evaluated if the Academic Achievement component does not include the minimum of four indicators.

Response: The agency agrees additional clarification is needed and has added language on page 48 of the manual to ensure the methodology is clear to stakeholders.

Comment: The Texas Center for School Accountability (TXCSA) suggested an edit to clarify the methodology used when a high school campus is missing both CCMR and graduation rate.

Response: The agency agrees and has provided clarity in the Student Achievement Domain section on page 58 of the manual.

Comment: lead4ward recommended that language be added to the *2025 Accountability Manual* regarding the steps defining the District Proportional Domain Methodology to specify and clarify the rounding rules.

Response: The agency agrees additional clarification is needed and has added rounding details to the District Proportional Domain Methodology steps on page 59 of the manual and in the example on page 60.

Comment: TXCSA and the Texas School Alliance (TSA) requested a live link to the appeals rule be embedded in the *2025 Accountability Manual*.

Response: The agency disagrees with adding a live link to the manual. Throughout the manual, the agency identifies relevant TEC or Texas Administrative Code (TAC) citations but does not embed direct web links. However, the agency has added more specific language to reference 19 TAC §97.1002 in "Chapter 8--Appealing the Ratings."

Comment: The TXCSA requested all dates in the *2025 Accountability Manual* reflect the current accountability cycle.

Response: The agency disagrees that all dates within the manual be updated each year as this enables the manual to remain more consistent from year to year.

Comment: A district administrator suggested consistency in the terms used for "October Snapshot" or "Fall Snapshot" and consistency in the section locations for minimum size criteria and small numbers throughout the *2025 Accountability Manual*.

Response: The agency disagrees with making this change in the *2025 Accountability Manual*. Maintaining language as proposed will ensure that the agency does not signal a change to snapshot methodology where there is not a change. However, the agency will work with stakeholders to consider changes to the terms and section locations used in a future accountability manual.

Comment: A district administrator suggested clarity in various terms used throughout Chapter 4, including indicating that "School Quality is Student Achievement Domain Score" and the "Student Success is CCMR Performance status."

Response: The agency disagrees with making these changes in the manual as the "School Quality" section of the manual already indicates "Student Achievement Domain Score: STAAR Component Only... as described in Chapter 2." Additionally, in Chapter 4 of the manual, it is clarified that the CCMR Performance Status component "differs from the CCMR component in the Student Achievement Domain."

Accountability Manual Development and Release

Comment: TXCSA requested that the meeting materials and minutes from ESC Advisory Group and the Results Driven Accountability (RDA) Integration Taskforce be made public in addition to the Texas Accountability Advisory Group meeting materials and minutes.

Response: This comment is outside the scope of the proposed rulemaking. The same meeting materials are shared with both advisory groups. The RDA Integration Taskforce is used to explore various considerations and proposals, and at the conclusion of their meetings a proposal will be made public.

Comment: Three district administrators and lead4ward requested publishing the appendices with the proposed *2025 Accountability Manual* and as part of future releases of the proposed manual, as well as adding an index.

Response: The agency disagrees as appendices are outside the scope of the proposed rulemaking. The appendices will be published as soon as it is feasible after the adoption of the manual.

Comment: The Texas Public Charter Schools Association (TPCSA) commented in support of the release of the *2025 Accountability Manual* for public comment earlier in the year but requested an August 2025 publication of the proposed *2026 Accountability Manual.*

Response: This comment is outside the scope of the proposed rulemaking. However, the agency agrees that for future updates to the accountability system, the agency will continue to work with stakeholders on communication timelines.

Comment: The Commit Partnership, along with the E3 Alliance, EdTrust in Texas, Dallas Regional Chamber, Democrats for Education Reform, Good Reason Houston, Teach Plus, and Texas 2036, commented in support of the release of the *2025 Accountability Manual* for public comment earlier in the year. The comment also supported the *2026 Accountability Manual's* anticipated release but requested the methodology for the next A-F refresh be communicated as soon as possible to allow for a successful transition.

Response: This comment is outside the scope of the proposed rulemaking. However, the agency agrees that for future updates to the accountability system, the agency will continue to work with stakeholders on communication timelines.

Comment: lead4ward referred to the proposed amendment to 19 TAC §74.1003 and recommended that any changes to the calculation of CCMR be introduced in future accountability manuals as early as possible.

Response: This comment is outside the scope of the proposed rulemaking. However, the agency agrees that for future updates to the accountability system, the agency will continue to work with stakeholders on improved communication timelines.

Identification of Schools in Improvement

Comment: An ESC representative recommended revisions to the *Example Campus Identified for Targeted Support and Improvement* table in the *2025 Accountability Manual*. The revisions were to add 2023 and 2024 to the table for Special Education (Former) and Continuously Enrolled groups, to change the percentages in the table to 0-4 points, and to add the "Count of Indicators Missed for 3 Consecutive Years" row that is included on accountability reports.

Response: The agency agrees and has made these changes at adoption to add clarity to the table on page 105 of the manual.

Comment: lead4ward requested that information be added to the *2025 Accountability Manual* regarding the exit criteria for campuses that escalated from additional targeted support (ATS) to comprehensive support and improvement (CSI).

Response: The agency agrees and has clarified on page 110 of the manual that if a campus was escalated to CSI after being identified ATS for three consecutive years, the campus must meet the CSI exit criteria.

Comment: The Fast Growth School Coalition (FGSC), TXCSA, and TSA commented that the federal school identifications should be eligible for appeal, specifically to update a federal identification if an appeal to state results is approved.

Response: The agency disagrees that the federal school identifications are appealable as this identification is based on the release of preliminary accountability data.

Comment: TXCSA recommended a revision to the table in the *2025 Accountability Manual* used to visualize the description that "Any Title I campus identified for ATS for three consecutive years will be identified for CSI the following school year."

Response: The agency disagrees. The table in the manual accurately depicts the identification for the following year. A campus that received a third ATS identification in the fall of 2024 based on 2023-2024 accountability data was identified for CSI as its interventions in school year 2024-2025.

Closing the Gaps (Domain 3)

Comment: FGSC, TXCSA, and TSA requested a change to the *2025 Accountability Manual* to allow appeals to the Closing the Gaps domain based on the two lowest performing student groups, specifically in situations of a new campus or re-zoned campus.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will review the appeals procedures for future consideration in the next refresh of the A-F system.

Comment: A district administrator, FGSC, lead4ward, TXCSA, and TSA recommended that the agency develop an evaluation framework specifically for new campuses and re-zoned campuses for Domain 3: Closing the Gaps or use a revised score table to address current methodology that new campuses in their first year of operation are evaluated for four, three, or zero points as they do not have prior year data. TXCSA suggested using the label "Not Rated--Domain 3: New/Closure/Consolidation Impact."

Response: The agency disagrees that it has the authority to measure campuses of these types differently under the Closing the Gaps domain. As the state uses the Closing the Gaps domain to fulfill federal requirements under the Every Student Succeeds Act, all campuses must be scored under the same methodology.

Comment: A district administrator recommended that newly opened high schools use district CCMR data from the prior year if the campus does not have its own data for the purposes of calculating Domain 3.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders to consider policy implementation for future accountability refresh cycles.

Comment: A district administrator recommended that newly opened high schools use district graduation data from the prior year if the campus does not have its own data for the purposes of calculating Domain 3.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders to consider policy implementation for future accountability refresh cycles.

Comment: A district administrator suggested the methodology used to identify student groups in the Closing the Gaps domain needs revising for a future accountability cycle suggesting a very small percentage of the school accounts for a large portion of the Domain 3 scoring. The commenter suggested changes to student minimum size or a percent of the overall population.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders to consider the Domain 3 methodology for future implementation in the next refresh of the A-F system.

Student Mobility

Comment: TPCSA recommended that for the 2028 A-F refresh, the agency reflect student mobility in outcomes, analyze mobility data, and model ways to account for it within achievement and growth.

Response: This comment is outside the scope of the proposed rulemaking. The agency will continue to research and analyze system measures of student groups, such as highly mobile students, for future implementation in the next refresh of the A-F system.

Comment: A district administrator suggested a CCMR subset based on the length of time a student is enrolled at a campus be added to the *2025 Accountability Manual* to reflect more mobile students.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders to consider the CCMR indicators for future implementation in the next refresh of the A-F system.

CCMR Indicators

Comment: A district administrator suggested students follow the CCMR methodology in place when they entered Grade 9.

Response: The agency disagrees as the most up-to-date and timely indicators for postsecondary success should be applied to students when CCMR is calculated upon their graduation.

Comment: Cushing Independent School District (ISD), TXCSA, and TSA suggested a revision to the CCMR methodology in the *2025 Accountability Manual* to include mid-year or December graduates in CCMR calculations.

Response: The agency disagrees that a revision to the manual is needed as the CCMR calculation already includes mid-year or early graduates.

Comment: The TXCSA recommended graduation code 56 be included in the *2025 Accountability Manual* under the CCMR indicator "Graduate with Completed Individualized Education Program (IEP) and Workforce Readiness" as a measure of "Career Ready."

Response: The agency disagrees. Code 56 "Completion of IEP And Access to Services, Employment, Or Education Outside of Public Education" is included in the manual under the CCMR indicator "Graduate under an Advanced Diploma Plan and be Identified as a Current Special Education Student."

Comment: The TXCSA commented that, based on TEC, §39.053, students who have completed an internship or practicum should be included in the CCMR calculation of the *2025 Accountability Manual*.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue

to work with stakeholders to consider the CCMR indicators for future implementation in the next refresh of the A-F system.

Comment: TXCSA suggested that the methodology in the *2025 Accountability Manual* for CCMR credit under Level I or Level II certification be modified to students who are "admitted" instead of "earning" a Level I or Level II certificate.

Response: The agency disagrees as admission requirements for Career and Technical Education (CTE) Certificate in TEC, §61.003(12)(C), varies by institution and program and does not imply successful completion of a workforce program offered by an institution of higher education.

Comment: The Commit Partnership, along with the E3 Alliance, EdTrust in Texas, Dallas Regional Chamber, Democrats for Education Reform, Good Reason Houston, Teach Plus, and Texas 2036, requested tiering CCMR indicators within the system to with greater weights for the most impactful indicators linked to greater postsecondary success.

Response: The agency agrees that some CCMR indicators are better aligned with postsecondary success or are more in demand than others. The agency studied this suggestion as part of the 2023 A-F Refresh stakeholder feedback process and has previously communicated that potential tiering of CCMR indicators will continue to be researched for future implementation into the next refresh of the A-F system.

Comment: TXCSA and TSA suggested that House Bill 773 does not require students to complete an aligned program of study in addition to successfully meeting industry-based certification (IBC) requirements and that the two should not be combined in the *2025 Accountability Manual* under the CCMR indicator.

Response: The agency disagrees that program of study completion and IBC attainment are as strong independently as indicators of a student's college or career readiness as they are when they are combined.

Comment: A district administrator suggested adding to the *2025 Accountability Manual* a one-year delay in the implementation of the requirement that only approved College Preparatory courses are eligible for CCMR credit, which would move it to the 2028 accountability year (Class of 2027).

Response: The agency disagrees as the College Preparatory courses that are currently planned to be offered should be high quality and meet faculty review and approval requirements. Districts will receive notification in March 2025, with time to adjust if a currently planned course is not approved.

Comment: Cushing ISD, TXCSA, and TSA suggested that the requirement for College Preparatory courses be completed in Grade 12 should not be applied and recommended that the 2026 accountability methodology as described in the *2025 Accountability Manual* (Grade 11 or 12 course completion is acceptable for CCMR) remain in place after 2026.

Response: The agency disagrees and reiterates the statutory requirement that College Preparatory courses be designed for Grade 12 students.

Comment: The Commit Partnership, along with the E3 Alliance, EdTrust in Texas, Dallas Regional Chamber, Democrats for Education Reform, Good Reason Houston, Teach Plus, and Texas 2036, commented in support of consistency and stability in the re-adoption of the 2024 accountability manual for 2025 and in support of efforts to maintain rigor in the CCMR criteria. The commenters requested the agency publish the approved list of College Preparatory courses by March 2025, with annual updates each December.

Response: The agency agrees to publish the list of College Preparatory courses by March 2025. The next cycle of consideration is anticipated to open in September 2025, with updates made on the College Preparatory Courses for CCMR website scheduled to occur by February 2026 for new approved College Preparatory Course for CCMR providers.

Comment: An ESC representative recommended a clarification to the *2025 Accountability Manual* in the example for the AEA CCMR rate example regarding previous dropouts.

Response: The agency agrees and has added clarifying language about previous dropouts to the example on page 24 of the manual.

Graduation Rates

Comment: A district administrator suggested a change to the scaling for graduation rate expectations in the *2025 Accountability Manual*.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders to consider the targets and cut points (scaling) for future implementation into the next refresh of the A-F system.

Comment: TPCSA requested that reporting of a Grade 9 "on track" to graduation indicator begin starting in the *2025 Accountability Manual* and considered for full inclusion into the 2028 A-F refresh.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. However, the agency will continue to work with stakeholders to consider policy implementation for future accountability refresh cycles.

Comment: lead4ward requested clarification regarding the definitions of a graduate included in the *2025 Accountability Manual*.

Response: The agency agrees and has removed the statement "a graduate is defined as" when providing clarity regarding graduation program requirements on page 22 of the manual.

Advanced Math Pathways and Accelerated Testers

Comment: The Commit Partnership, along with the E3 Alliance, EdTrust in Texas, Dallas Regional Chamber, Democrats for Education Reform, Good Reason Houston, Teach Plus, and Texas 2036, commented that there is a lack of recognition of Algebra I in middle school, particularly considering Senate Bill (SB) 2124, 88th Texas Legislature, Regular Session, 2023, and asked the agency to consider strategies to ensure legislative requirements are met and do not create misalignment in impact across middle and high school campuses.

Response: The agency agrees that research has shown the importance of access to advanced math pathways. However, the agency disagrees with making changes that are beyond the scope of the current rule proposal. The agency will continue to research and analyze alternatives, such as bonus points, for future implementation in the next refresh of the A-F system.

Comment: A district administrator requested to include Advanced Placement Biology as an additional assessment for accelerated testers.

Response: The agency disagrees that it has the authority to make such a change at this time. As indicated in the agency's

accelerated tester waiver with the United States Department of Education (USDE), "students completing an advanced course in middle school will continue to be assessed in high school with one of these assessments [SAT or ACT] in the applicable subject area. Students completing an advanced science course in middle school will continue to be assessed again in high school using the ACT science assessment."

Comment: The College Board requested that the SAT be included as an additional assessment for accelerated testers and added as an indicator for the distinction designation for Academic Achievement in Science.

Response: The agency disagrees that it has the authority to make such a change at this time. As indicated in the agency's accelerated tester waiver with the USDE, "Students completing an advanced science course in middle school will continue to be assessed again in high school using the ACT science assessment."

District and Campus Ratings

Comment: lead4ward suggested that the two steps in the Overall (District and Campus) Rating calculation called "3 Ds Rule" and "3 Fs Rule" be removed from the *2025 Accountability Manual*.

Response: The agency disagrees. The D and F requirement is aligned with the redefinition of acceptable and unacceptable performance in SB 1365, 87th Texas Legislature, Regular Session, 2021. The agency will continue to work with stakeholders to consider policy implementation for future accountability refresh cycles.

Comment: TPCSA requested that 2028 A-F refresh cut scores be communicated in advance of the school year in which the data will be collected for those indicators and the CCMR and Graduation Rate Components of the accountability system be communicated one year in advance of the accountability year or otherwise use a bonus-point for lagging indicators.

Response: This comment is outside the scope of the proposed rulemaking. However, the agency agrees that for future updates to the accountability system's cut scores, the agency will continue to work with stakeholders on improved communication timelines.

Comment: FGSC, TXCSA, and TSA requested a change to the *2025 Accountability Manual* in how an appeal is considered if a new campus appeals to be assigned a *Not Rated* label.

Response: The agency disagrees as appeals to assign a *Not Rated* label to campuses that are rated in their first year of operation are not considered.

Accountability of Special Populations, Including AEA/Dropout Recovery Schools (DRS), RDA

Comment: TXCSA proposed a change to the methodology in the *2025 Accountability Manual* for identifying students formerly receiving special education services, referring to the language in TEC, §39.053.

Response: The agency disagrees. Three years of TSDS PEIMS data are used to identify if a student has previously received special education services and then current year TSDS PEIMS data or TIDE data can be used to identify students who are no longer receiving special education services.

Comment: Betty M. School for Education Innovation suggested a new methodology be added to the *2025 Accountability Manual* to separate performance by test (STAAR® versus STAAR® Alternate 2) and by special education status.

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. The agency will continue to work with stakeholders regarding policy changes that impact students receiving special education services for future implementation into the next refresh of the A-F system.

Comment: TPCSA requested the agency run modeling using data from the graduating class of 2025 to study the methodology of the phase-in for IBCs and programs of study and its impacts on dropout recovery schools (DRS) measured under AEA to make any changes to the *2026 Accountability Manual.*

Response: This comment is outside the scope of the proposed rulemaking. However, the agency will continue to convene stakeholders with expertise in DRS and model and monitor data for future years of accountability.

Comment: TPCSA requested that the RDA taskforce consider whether RDA data will be integrated into campus ratings or district ratings for the 2028 A-F refresh and how the cut scores are set, exploring options for schools serving specific subsets of grade levels or specific student populations.

Response: This comment is outside the scope of the proposed rulemaking. However, the agency agrees with ensuring the RDA taskforce considers these topics, including RDA's district-only methodology and cut-point setting.

Distinction Designations

Comment: A district administrator suggested an edit to the distinction designations paragraph in the *2025 Accountability Manual* to refer to campus comparison groups.

Response: The agency disagrees and has determined that the proposed language in the manual presents the clearest description given the reference to see "Chapter 6--Distinction Designations" for more information.

Comment: TPCSA recommended that a new distinction designation based on postsecondary outcomes (student success after graduation) be added for the 2028 A-F Refresh and that a system of distinction designations be developed for DRSs. The commenter suggested 'badges' for areas such as arts, languages, advanced courses, CTE programs, and extra and co-curriculars.

Response: These comments are outside the scope of the proposed rulemaking. However, the agency will continue to convene stakeholders on distinction designation methodology and will explore adding AEA/DRS distinctions for future implementation into the next refresh of the A-F system.

Comment: lead4ward recommended that annual growth be added in the *2025 Accountability Manual* as an indicator for Academic Achievement Distinction Designations in RLA and mathematics

Response: The agency disagrees as policy changes are beyond the scope of the current rule proposal. However, the agency will continue to convene stakeholders on distinction designation methodology and will explore distinctions to add for future implementation into the next refresh of the A-F system.

Assessment Policies

Comment: A district administrator requested changes to the scoring of STAAR® student responses.

Response: This comment is outside the scope of the proposed rulemaking.

Comment: TXCSA requested an addition to the *2025 Accountability Manual* appendices to include condition codes from the automated scoring engine.

Response: This comment is outside the scope of the proposed rulemaking, and no exclusions are made to accountability based on condition codes.

STATUTORY AUTHORITY. The amendment is adopted under Texas Education Code (TEC), §7.021(b)(1), which authorizes the Texas Education Agency (TEA) to administer and monitor compliance with education programs required by federal or state law, including federal funding and state funding for those programs; TEC, §7.028, which authorizes TEA to monitor as necessary to ensure school district and charter school compliance with federal law and regulations, financial integrity, and data integrity and authorizes the agency to monitor school district and charter schools through its investigative process. TEC, §7.028(a), authorizes TEA to monitor special education programs for compliance with state and federal laws; TEC, §12.056, which requires that a campus or program for which a charter is granted under TEC, Chapter 12, Subchapter C, is subject to any prohibition relating to the Public Education Information Management System (PEIMS) to the extent necessary to monitor compliance with TEC, Chapter 12, Subchapter C, as determined by the commissioner; high school graduation under TEC, §28.025; special education programs under TEC, Chapter 29, Subchapter A; bilingual education under TEC, Chapter 29, Subchapter B; and public school accountability under TEC, Chapter 39, Subchapters B, C, D, F, and J, and Chapter 39A; TEC, §12.104, which states that a charter granted under TEC, Chapter 12, Subchapter D, is subject to a prohibition, restriction, or requirement, as applicable, imposed by TEC, Title 2, or a rule adopted under TEC, Title 2, relating to PEIMS to the extent necessary to monitor compliance with TEC, Chapter 12, Subchapter D, as determined by the commissioner; high school graduation requirements under TEC, §28.025; special education programs under TEC, Chapter 29, Subchapter A; bilingual education under TEC, Chapter 29, Subchapter B; discipline management practices or behavior management techniques under TEC, §37.0021; public school accountability under TEC, Chapter 39, Subchapters B, C, D, F, G, and J, and Chapter 39A; and intensive programs of instruction under TEC, §28.0213; TEC, §29.001, which authorizes TEA to effectively monitor all local educational agencies (LEAs) to ensure that rules relating to the delivery of services to children with disabilities are applied in a consistent and uniform manner, to ensure that LEAs are complying with those rules, and to ensure that specific reports filed by LEAs are accurate and complete; TEC, §29.0011(b), which authorizes TEA to meet the requirements under (1) 20 U.S.C. §1418(d) and its implementing regulations to collect and examine data to determine whether significant disproportionality based on race or ethnicity is occurring in the state and in the school districts and open-enrollment charter schools in the state with respect to the (a) identification of children as children with disabilities, including the identification of children as children with particular impairments; (b) placement of children with disabilities in particular educational settings; and (c) incidence, duration, and type of disciplinary actions taken against children with disabilities including suspensions or expulsions; or (2) 20 U.S.C. §1416(a)(3)(C) and its implementing regulations to address in the statewide plan the percentage of schools with disproportionate representation of racial and ethnic groups in special education and related services and in specific disability categories that results from inappropriate identification; TEC, §29.010(a),which authorizes TEA to adopt and implement a comprehensive system for monitoring LEA compliance with federal and state laws relating to special education, including ongoing analysis of LEA special education data; TEC, §29.062, which authorizes TEA to evaluate and monitor the effectiveness of LEA programs and apply sanctions concerning emergent bilingual students; TEC, §29.066, which authorizes PEIMS reporting requirements for school districts that are required to offer bilingual education or special language programs to include the following information in the district's PEIMS report: (1) demographic information, as determined by the commissioner, on students enrolled in district bilingual education or special language programs; (2) the number and percentage of students enrolled in each instructional model of a bilingual education or special language program offered by the district; and (3) the number and percentage of emergent bilingual students who do not receive specialized instruction; TEC, §29.081(e), (e-1), and (e-2), which define criteria for alternative education programs for students at risk of dropping out of school and subjects those campuses to the performance indicators and accountability standards adopted for alternative education programs; TEC, §29.201 and §29.202, which describe the Public Education Grant (PEG) program and eligibility requirements; TEC, §39.003 and §39.004, which authorize the commissioner to adopt procedures relating to special investigations. TEC, §39.003(d), allows the commissioner to take appropriate action under Chapter 39A, to lower the district's accreditation status or the district's or campus's accountability rating based on the results of the special investigation; TEC, §39.051 and §39.052, which authorize the commissioner to determine criteria for accreditation statuses and to determine the accreditation status of each school district and open-enrollment charter school; TEC, §39.053, which authorizes the commissioner to adopt a set of indicators of the quality of learning and achievement and requires the commissioner to periodically review the indicators for consideration of appropriate revisions; TEC, §39.054, which requires the commissioner to adopt rules to evaluate school district and campus performance and to assign a performance rating; TEC, §39.0541, which authorizes the commissioner to adopt indicators and standards under TEC, Chapter 39, Subchapter C, at any time during a school year before the evaluation of a school district or campus; TEC, §39.0543, which describes acceptable and unacceptable performance as referenced in law; TEC, §39.0546, which requires the commissioner to assign a school district or campus a rating of "Not Rated" for the 2021-2022 school year, unless, after reviewing the district or campus under the methods and standards adopted under TEC, §39.054, the commissioner determines the district or campus should be assigned an overall performance rating of C or higher; TEC, §39.0548, which requires the commissioner to designate campuses that meet specific criteria as dropout recovery schools and to use specific indicators to evaluate them; TEC, §39.055, which prohibits the use of assessment results and other performance indicators of students in a residential facility in state accountability; TEC, §39.056, which authorizes the commissioner to adopt procedures relating to monitoring reviews and special investigations; TEC, §39.151, which provides a process for a school district or an open-enrollment charter school to challenge an academic or financial accountability rating; TEC, §39.201, which requires the commissioner to award distinction designations to a campus or district for outstanding performance; TEC, §39.2011, which makes open-enrollment

charter schools and campuses that earn an acceptable rating eligible for distinction designations; TEC, §39.202 and §39.203, which authorize the commissioner to establish criteria for distinction designations for campuses and districts; TEC, §39A.001, which authorizes the commissioner to take any of the actions authorized by TEC, Chapter 39, Subchapter A, to the extent the commissioner determines necessary if a school does not satisfy the academic performance standards under TEC, §39.053 or §39.054, or based upon a special investigation; TEC, §39A.002, which authorizes the commissioner to take certain actions if a school district becomes subject to commissioner action under TEC, §39A.001; TEC, §39A.004, which authorizes the commissioner to appoint a board of managers to exercise the powers and duties of a school district's board of trustees if the district is subject to commissioner action under TEC, §39A.001, and has a current accreditation status of accredited-warned or accredited-probation; or fails to satisfy any standard under TEC, §39.054(e); or fails to satisfy any financial accountability standard; TEC, §39A.005, which authorizes the commissioner to revoke school accreditation if the district is subject to TEC, §39A.001, and for two consecutive school years has received an accreditation status of accredited-warned or accredited-probation, failed to satisfy any standard under TEC, §39.054(e), or failed to satisfy a financial performance standard; TEC, §39A.007, which authorizes the commissioner to impose a sanction designed to improve high school completion rates if the district has failed to satisfy any standard under TEC, §39.054(e), due to high school completion rates; TEC, §39A.051, which authorizes the commissioner to take action based on campus performance that is below any standard under TEC, §39.054(e); and TEC, §39A.063, which authorizes the commissioner to accept substantially similar intervention measures as required by federal accountability measures in compliance with TEC, Chapter 39A.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §§7.021(b)(1); 7.028; 12.056; 12.104; 29.001; 29.0011(b); 29.010(a); 29.062; 29.066; 29.081(e), (e-1), and (e-2); 29.201; 29.202; 39.003; 39.004; 39.051; 39.052; 39.053; 39.054; 39.0541; 39.0543; 39.0546; 39.0548; 39.055; 39.056; 39.151; 39.201; 39.2011; 39.202; 39.203; 39A.001; 39A.002; 39A.004; 39A.005; 39A.007; 39A.051; and 39A.063.

§97.1001. Accountability Rating System.

(a) The rating standards established by the commissioner of education under Texas Education Code (TEC), §§39.052(a) and (b)(1)(A); 39.053; 39.054; 39.0541; 39.0548; 39.055; 39.151; 39.201; 39.2011; 39.202; 39.203; 29.081(e), (e-1), and (e-2); and 12.104(b)(2)(L), shall be used to evaluate the performance of districts, campuses, and charter schools. The indicators, standards, and procedures used to determine ratings will be annually published in official Texas Education Agency publications. These publications will be widely disseminated and cover the following:

(1) indicators, standards, and procedures used to determine district ratings;

(2) indicators, standards, and procedures used to determine campus ratings;

(3) indicators, standards, and procedures used to determine distinction designations; and

(4) procedures for submitting a rating appeal.

(b) The procedures by which districts, campuses, and charter schools are rated and acknowledged for 2025 are based upon specific criteria and calculations, which are described in excerpted sections of the *2025 Accountability Manual* provided in this subsection.
Figure: 19 TAC §97.1001(b)

(c) Ratings may be revised as a result of investigative activities by the commissioner as authorized under TEC, §39.003.

(d) The specific criteria and calculations used in the accountability manual are established annually by the commissioner and communicated to all school districts and charter schools.

(e) The specific criteria and calculations used in the annual accountability manual adopted for prior school years remain in effect for all purposes, including accountability, data standards, and audits, with respect to those school years.

(f) In accordance with TEC, §7.028(a), the purpose of the Results Driven Accountability (RDA) framework is to evaluate and report annually on the performance of school districts and charter schools for certain populations of students included in selected program areas. The performance of a school district or charter school is included in the RDA report through indicators of student performance and program effectiveness and corresponding performance levels established by the commissioner.

(g) The assignment of performance levels for school districts and charter schools in the 2025 RDA report is based on specific criteria and calculations, which are described in the *2025 Accountability Manual* provided in subsection (b) of this section.

(h) The specific criteria and calculations used in the RDA framework are established annually by the commissioner and communicated to all school districts and charter schools.

(i) The specific criteria and calculations used in the annual RDA manual adopted for prior school years remain in effect for all purposes, including accountability and performance monitoring, data standards, and audits, with respect to those school years.

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

Filed with the Office of the Secretary of State on March 17, 2025.

TRD-202500948
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: April 6, 2025
Proposal publication date: January 10, 2025
For further information, please call: (512) 475-1497

♦ ♦ ♦

19 TAC §97.1002

The Texas Education Agency (TEA) adopts new §97.1002, concerning the accountability rating appeals process and timeline. The new section is adopted with changes to the proposed text as published in the January 10, 2025 issue of the *Texas Register* (50 TexReg 235) and will be republished. The new section adopts in rule the accountability ratings appeals process and timeline that will supersede the timelines referenced in Chapter 8 of the *2023 Accountability Manual* and *2024 Accountability Manual* and apply to all accountability rating appeals from 2023 and beyond until otherwise updated.

REASONED JUSTIFICATION: New §97.1002 adopts in rule the figure *Accountability Ratings Appeals Process and Timeline*.

The new figure specifies the process and timeline by which school districts and open-enrollment charter schools can challenge an agency decision relating to an academic rating that affects the district or school, including a determination of consecutive school years of unacceptable performance ratings in accordance with Texas Education Code, §39.151. The process and timeline supersede the timelines referenced in Chapter 8 of the *2023 Accountability Manual* and *2024 Accountability Manual* and apply to all accountability rating appeals from 2023 and beyond until otherwise updated.

As a result of public comment, edits to provide clarity and consistent language were made to the table in Figure: 19 TAC §97.1002(b) at adoption.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began January 10, 2025, and ended February 10, 2025. A public hearing on the proposal was held on January 31, 2025. Following is a summary of the public comment received and the agency response.

Comment: lead4ward recommended edits to provide clarity and consistent language to the table in Figure: 19 TAC §97.1002(b) regarding the annual timeline for appealing ratings.

Response: The agency agrees with the recommended edits and has made changes to the table in Figure: 19 TAC §97.1002(b).

STATUTORY AUTHORITY. The new section is adopted under Texas Education Code, §39.151, which provides a process for a school district or an open-enrollment charter school to challenge an academic or financial accountability rating.

CROSS REFERENCE TO STATUTE. The new section implements Texas Education Code, §39.151.

§97.1002. Accountability Rating Appeals Process and Timeline.

(a) The rating standards established by the commissioner of education under Texas Education Code (TEC), §§39.052(a) and (b)(1)(A); 39.053; 39.054; 39.0541; 39.0543; 39.0546; 39.0548; 39.055; 39.151; 39.201; 39.2011; 39.202; 39.203; 29.081(e), (e-1), and (e-2); 29.201; 29.202; and 12.104(b)(3)(L), shall be used to evaluate the performance of districts, campuses, and charter schools. The indicators, standards, and procedures used to determine ratings will be annually published in official Texas Education Agency publications. These publications will be widely disseminated and cover the following:

(1) indicators, standards, and procedures used to determine district ratings;

(2) indicators, standards, and procedures used to determine campus ratings;

(3) indicators, standards, and procedures used to determine distinction designations; and

(4) procedures for submitting a rating appeal.

(b) The process and timeline by which districts, campuses, and charter schools can appeal ratings are based upon the requirements described in the *Accountability Ratings Appeals Process and Timeline* adopted as a figure in this subsection. This figure supersedes the timelines referenced in Chapter 8 of the *2023 Accountability Manual* and *2024 Accountability Manual* and applies to all accountability rating appeals from 2023 and beyond until otherwise updated.
Figure: 19 TAC §97.1002(b)

(c) Ratings may be revised as a result of investigative activities by the commissioner of education as authorized under TEC, §39.003.

(d) The specific criteria and calculations used in the accountability manual are established annually by the commissioner and communicated to all school districts and charter schools.

(e) The specific criteria and calculations used in the annual accountability manual adopted for prior school years remain in effect for all purposes, including accountability, data standards, and audits, with respect to those school years.

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

Filed with the Office of the Secretary of State on March 17, 2025.

TRD-202500949
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: April 6, 2025
Proposal publication date: January 10, 2025
For further information, please call: (512) 475-1497

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 22. TEXAS STATE BOARD OF PUBLIC ACCOUNTANCY

CHAPTER 501. RULES OF PROFESSIONAL CONDUCT

SUBCHAPTER A. GENERAL PROVISIONS

22 TAC §501.52

The Texas State Board of Public Accountancy adopts an amendment to §501.52 concerning Definitions, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 617) and will not be republished.

The amendment deletes the reference to a section of the Board's rules that no longer exists. A reference is not needed.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500895
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §501.53

The Texas State Board of Public Accountancy adopts an amendment to §501.53, concerning Applicability of Rules of Professional Conduct, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 619) and will not be republished.

Licensees practicing through a practice privilege in this state must comply with all of the Board's rules of professional conduct. In addition, non-attest financials are not issued in accordance with accounting principles as they do not express and opinion and licensees not in the client practice of public accounting may issue non-attest transmittals without a firm license.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500896
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §501.55

The Texas State Board of Public Accountancy adopts an amendment to §501.55 concerning Definition of Acronyms, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 621) and will not be republished.

Government Auditing Standards is more accurately referred to as Generally Accepted Government Auditing Standards and that is added to the current acronym and TSBPA is added to the acronym in our rules.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500897
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

SUBCHAPTER B. PROFESSIONAL STANDARDS

22 TAC §501.60

The Texas State Board of Public Accountancy adopts an amendment to §501.60 concerning Auditing Standards, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 622) and will not be republished.

Auditing standards of the Public Company Accounting Oversight Board (PCAOB) also includes PCAOB rules.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500898
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §501.63

The Texas State Board of Public Accountancy adopts an amendment to §501.63 concerning Reporting Standards, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 623) and will not be republished.

Peer review does not apply to preparation engagements even though it is a very limited attest service.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500899
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

SUBCHAPTER C. RESPONSIBILITIES TO CLIENTS

22 TAC §501.79

The Texas State Board of Public Accountancy adopts new rule §501.79 concerning Transfer or Return of Files Resulting from the Sale, Transfer, Discontinuation or Acquisition of Practice, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 624) and will not be republished.

A licensee that sells its' client's files must notify the client of the change in firms when the licensee continues to practice with the new firm. A licensee who sell his firm's client files must obtain permission of the client prior to the transfer of the client files when the licensee does not work with the new firm as an employee or owner. A licensee that discontinues his practice must maintain the confidentiality of the client files and arrange for the return of the client files to the client when requested.

No comments were received regarding adoption of the new rule.

The new rule is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500900
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

SUBCHAPTER D. RESPONSIBILITIES TO THE PUBLIC

22 TAC §501.81

The Texas State Board of Public Accountancy adopts an amendment to §501.81 concerning Firm Licensing, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 625) and will not be republished.

A licensee may provide non-attest accounting services through a non-licensed firm and use the CPA credential in association with the firm but must include the notice that the firm is not a CPA firm and the firm is not regulated by Board each time the licensee uses the CPA credential.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500901
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

SUBCHAPTER E. RESPONSIBILITIES TO THE BOARD/PROFESSION

22 TAC §501.90

The Texas State Board of Public Accountancy adopts an amendment to §501.90 concerning Discreditable Acts, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 627) and will not be republished.

The current rules identify acts that the Board may consider discreditable and subject to disciplinary action. The rule also states that there could be additional acts that the Board may find discreditable. The rule is being revised to only include acts that it has identified. The practice has been to hold licensees accountable for only those acts identified. The licensee should have the right to know what behavior the Board believes is unacceptable and thus sanctionable.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500902
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §501.93

The Texas State Board of Public Accountancy adopts an amendment to §501.93 concerning Responses, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 628) and will not be republished.

The rule is being updated to recognize email communications with the Board in addition to postal service mail.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500903
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

CHAPTER 507. EMPLOYEES OF THE BOARD

22 TAC §507.4

The Texas State Board of Public Accountancy adopts an amendment to §507.4 concerning Confidentiality, without changes to the proposed text as published in the January 31, 2025, issue of the *Texas Register* (50 TexReg 629) and will not be republished.

Section 901.160 of the Public Accountancy Act states that information regarding a disciplinary action is confidential prior to the information going to public hearing. The proposed rule revision makes it clear that a complaint investigation that does not result in disciplinary action is also not public information. The purpose of the provision in the Public Accountancy Act is to protect unproven allegations from becoming public information.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Public Accountancy Act (Act), Texas Occupations Code, §901.151 and §901.655 which provides the agency with the authority to amend, adopt and repeal rules deemed necessary or advisable to effectuate the Act.

No other article, statute or code is affected by the adoption.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500904
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: April 2, 2025
Proposal publication date: January 31, 2025
For further information, please call: (512) 305-7842

♦ ♦ ♦

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 1. MISCELLANEOUS PROVISIONS SUBCHAPTER Y. ADVERSE LICENSING, LISTING, OR REGISTRATION DECISIONS

25 TAC §1.601

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §1.601, concerning Decisions Based on Interagency Records.

The amendment to §1.601 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9878). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 526.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500858
Karen Ray
Chief Counsel
Department of State Health Services
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 52. CONTRACTING FOR COMMUNITY SERVICES

SUBCHAPTER A. APPLICATION AND DEFINITIONS

26 TAC §52.1

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §52.1, concerning Application.

The amendment to §52.1 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9891). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500859
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 87. OMBUDSMAN SERVICES

The executive commissioner of the Texas Health and Human Services Commission (HHSC) adopts new rules in Texas Administrative Code, Title 26 (26 TAC), Part 1, Chapter 87, consisting of §§87.1, 87.3, 87.5, 87.7, 87.15, 87.17, 87.19, 87.21, 87.23, 87.25, 87.27, 87.29, 87.31, 87.33, 87.35, 87.41, 87.43, 87.51, 87.61, 87.71, 87.73, and 87.81, and the repeal of 26 TAC, Part 1, Chapter 87, consisting of §§87.101, 87.103, 87.105, 87.107, 87.109, 87.111, 87.113, 87.115, 87.117, 87.119, 87.201, 87.203, 87.205, 87.207, 87.209, 87.211, 87.213, 87.215, 87.217, 87.219, 87.301, 87.303, 87.305, 87.307, 87.309, 87.311, 87.313, 87.315, 87.317, 87.319, 87.321, 87.401, 87.403, 87.405, 87.407, 87.409, 87.411, 87.413, 87.415, 87.417, 87.419, 87.501, 87.503, 87.505, 87.507, 87.509, 87.511, 87.513, 87.515, 87.517, and 87.519.

The repeal of 26 TAC, Part 1, Chapter 87, and new 26 TAC, Part 1, Chapter 87 are adopted without changes to the proposed text as published in the December 20, 2024, issue of the *Texas Register* (49 TexReg 10218). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

The repealed and new rules implement changes made to Texas Government Code, Chapter 531, Subchapter Y, by House Bill (H.B.) 3462, 88th Legislature, Regular Session, 2023. H.B. 3462 consolidated ombudsman statutes by moving the laws requiring different ombudsman programs into the same subchapter of Texas Government Code, Chapter 531. The repealed and new rules clarify the duties and procedures for the Texas Health and Human Services Office of the Ombudsman (OO), including ombudsman programs for children and youth in foster care, managed care assistance, behavioral health access to care, and individuals with an intellectual or developmental disability.

The new rules ensure consistency with legislative changes, group together related subjects to facilitate navigation within the rules and remove duplicative language.

COMMENTS

The 31-day comment period ended January 20, 2025.

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

SUBCHAPTER A. PURPOSE, DEFINITIONS, AND ESTABLISHMENT OF OMBUDSMAN PROGRAMS

26 TAC §§87.1, 87.3, 87.5, 87.7

STATUTORY AUTHORITY

The new sections are adopted under 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 com-

missioner of HHSC with broad rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500925
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER B. PROVISIONS COMMON TO ALL OMBUDSMAN PROGRAMS

26 TAC §§87.15, 87.17, 87.19, 87.21, 87.23, 87.25, 87.27, 87.29, 87.31, 87.33, 87.35

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500926
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER C. PROVISIONS DIRECTING HHS AND DFPS

26 TAC §87.41, §87.43

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500927
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER D. OMBUDSMAN FOR MANAGED CARE ASSISTANCE

26 TAC §87.51

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500928
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER E. OMBUDSMAN FOR CHILDREN AND YOUTH IN FOSTER CARE

26 TAC §87.61

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500929

Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER F. OMBUDSMAN FOR BEHAVIORAL HEALTH ACCESS TO CARE

26 TAC §87.71, §87.73

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500930
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER G. OMBUDSMAN FOR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

26 TAC §87.81

STATUTORY AUTHORITY

The new sections are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500931
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER A. OFFICE OF THE OMBUDSMAN

26 TAC §§87.101, 87.103, 87.105, 87.107, 87.109, 87.111, 87.113, 87.115, 87.117, 87.119

STATUTORY AUTHORITY

The repeals are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500920
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER B. OMBUDSMAN MANAGED CARE ASSISTANCE

26 TAC §§87.201, 87.203, 87.205, 87.207, 87.209, 87.211, 87.213, 87.215, 87.217, 87.219

STATUTORY AUTHORITY

The repeals are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500921

Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER C. OMBUDSMAN FOR CHILDREN AND YOUTH IN FOSTER CARE

26 TAC §§87.301, 87.303, 87.305, 87.307, 87.309, 87.311, 87.313, 87.315, 87.317, 87.319, 87.321

STATUTORY AUTHORITY

The repeals are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500922
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER D. OMBUDSMAN FOR BEHAVIORAL HEALTH

26 TAC §§87.401, 87.403, 87.405, 87.407, 87.409, 87.411, 87.413, 87.415, 87.417, 87.419

STATUTORY AUTHORITY

The repeals are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500923
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

SUBCHAPTER E. INTELLECTUAL OR DEVELOPMENTAL DISABILITY OMBUDSMAN

26 TAC §§87.501, 87.503, 87.505, 87.507, 87.509, 87.511, 87.513, 87.515, 87.517, 87.519

STATUTORY AUTHORITY

The repeals are adopted under 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 rule-making authority; and Texas Government Code Chapter 531, Subchapter Y.

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

Filed with the Office of the Secretary of State on March 14, 2025.

TRD-202500924
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 3, 2025
Proposal publication date: December 20, 2024
For further information, please call: (512) 706-7120

♦ ♦ ♦

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

SUBCHAPTER A. DEFINITIONS, DESCRIPTION OF SERVICES, AND EXCLUDED SERVICES

26 TAC §259.5

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §259.5, concerning Definitions.

The amendment to §259.5 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9893). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid,

and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapters 521 and 543A.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500860
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 275. CONSUMER MANAGED PERSONAL ATTENDANT SERVICES (CMPAS) PROGRAM
SUBCHAPTER B. ELIGIBILITY AND SERVICE PLANS

26 TAC §275.29

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §275.29, concerning Assessment and Eligibility Determination.

The amendment to §275.29 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9903). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500861
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 306. BEHAVIORAL HEALTH DELIVERY SYSTEM

The Texas Health and Human Services Commission (HHSC) adopts amendments to §306.45, concerning Definitions; and §306.273, concerning MH Case Management Employee Competencies.

The amendments to §306.45 and §306.273 are adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9906). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. These adopted amendments update citations in the rules to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

SUBCHAPTER B. STANDARDS OF CARE IN CRISIS STABILIZATION UNITS
DIVISION 1. GENERAL REQUIREMENTS

26 TAC §306.45

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546 and 547.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500862
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

SUBCHAPTER E. MENTAL HEALTH CASE MANAGEMENT

26 TAC §306.273

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546 and 547.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500863
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 330. LIDDA ROLE AND RESPONSIBILITIES

26 TAC §330.17

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §330.17, concerning LIDDA Administrative Functions.

The amendment to §330.17 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9912). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 526.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500865
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 351. CHILDREN WITH SPECIAL HEALTH CARE NEEDS SERVICES PROGRAM

26 TAC §351.2

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §351.2, concerning Definitions.

The amendment to §351.2 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9914). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500867
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 358. CHILDREN'S AUTISM PROGRAM
SUBCHAPTER A. GENERAL RULES

26 TAC §358.103

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §358.103, concerning Legal Authority.

The amendment to §358.103 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9918). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 524.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500868
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 554. NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION
SUBCHAPTER X. REQUIREMENTS FOR MEDICAID-CERTIFIED FACILITIES

26 TAC §554.2302

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §554.2302, concerning Requirements for a Contracted Medicaid Facility.

The amendment to §554.2302 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9919). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 545.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500869
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 560. DENIAL OR REFUSAL OF LICENSE

26 TAC §560.3

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §560.3, concerning Adverse Licensing Record.

The amendment to §560.3 is adopted without changes to the proposed text as published in the December 6, 2024, issue of

the *Texas Register* (49 TexReg 9922). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 526.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500871
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 566. TEXAS HOME LIVING (TXHML) PROGRAM AND COMMUNITY FIRST CHOICE (CFC) CERTIFICATION STANDARDS

26 TAC §566.3

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §566.3, concerning Definitions.

The amendment to §566.3 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9923). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 543A.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500872
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 711. INVESTIGATIONS OF INDIVIDUALS RECEIVING SERVICES FROM CERTAIN PROVIDERS

The Texas Health and Human Services Commission (HHSC) adopts amendments to §711.1, concerning What is the purpose of this chapter; §711.3, concerning How are the terms in this chapter defined; §711.1402, concerning How are the terms in this subchapter defined; and §711.1406, concerning How is the term agency defined for the purpose of this subchapter.

The amendments to §§711.1, 711.3, 711.1402, and 711.1406 are adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9929). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. These adopted amendments update citations in the rules to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

During this period, HHSC received comments regarding the proposed rules from one individual commenter. A summary of comments relating to the rules and HHSC responses follow.

Comment: The commenter recommended substantive revisions to §§711.1 and 711.3. In §711.1, the commenter recommended adding language to provide that the purpose of the chapter is to protect the safety of individuals receiving services and to clarify the reference to Adult Protective Services, so it is clear which agency investigates allegations of abuse, neglect, and exploita-

tion. The commenter also recommended revising definitions in §711.3 to update terminology pertaining to investigations.

Response: HHSC declines to make the suggested substantive changes. The recommendations are outside the scope of this rule project, which is only updating references to the Texas Government Code that were amended by H.B. 4611.

SUBCHAPTER A. INTRODUCTION

26 TAC §711.1, §711.3

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 542 and 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500873
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

SUBCHAPTER L. EMPLOYEE MISCONDUCT REGISTRY

26 TAC §711.1402, §711.1406

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 542 and 546.

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

Filed with the Office of the Secretary of State on March 12, 2025

TRD-202500874
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 745. LICENSING

The Texas Health and Human Services Commission (HHSC) adopts amendments to §745.907, concerning What are the consequences of Licensing designating me as a controlling person; §745.911, concerning In what other circumstances may a person not serve as a controlling person at my operation; and §745.8605, concerning When can Licensing recommend or impose an enforcement action against my operation.

The amendments to §§745.907, 745.911, and 745.8605, are adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9934). These rules will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. These adopted amendments update citations in the rules to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

SUBCHAPTER G. CONTROLLING PERSONS

26 TAC §745.907, §745.911

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 526.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500875
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

SUBCHAPTER L. ENFORCEMENT ACTIONS
DIVISION 1. OVERVIEW OF ENFORCEMENT ACTIONS

26 TAC §745.8605

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 526.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500876
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 926. STATE FACILITY REQUIREMENTS TO ENHANCE THE SAFETY OF INDIVIDUALS RECEIVING SERVICES

SUBCHAPTER B. CRIMINAL HISTORY CHECKS AND REGISTRY CLEARANCES AT STATE FACILITIES

26 TAC §926.51

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §926.51, concerning Definitions.

The amendment to §926.51 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9936). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500877
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

CHAPTER 967. CLIENT CARE OF INDIVIDUALS RECEIVING SERVICES AT STATE SUPPORTED LIVING CENTERS

SUBCHAPTER A. STATE SUPPORTED LIVING CENTER INDEPENDENT MORTALITY REVIEW

26 TAC §967.1

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §967.1, concerning Independent Mortality Review.

The amendment to §967.1 is adopted without changes to the proposed text as published in the December 6, 2024, issue of the *Texas Register* (49 TexReg 9941). This rule will not be republished.

BACKGROUND AND JUSTIFICATION

House Bill (H.B.) 4611, 88th Legislature, Regular Session, 2023, made certain non-substantive revisions to Subtitle I, Title 4, Texas Government Code, which governs HHSC, Medicaid, and other social services as part of the legislature's ongoing statutory revision program. This adopted amendment updates citations in the rule to the Texas Government Code sections that become effective on April 1, 2025.

COMMENTS

The 31-day comment period ended January 6, 2025.

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

STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Chapter 546.

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

Filed with the Office of the Secretary of State on March 12, 2025.

TRD-202500878
Karen Ray
Chief Counsel
Health and Human Services Commission
Effective date: April 1, 2025
Proposal publication date: December 6, 2024
For further information, please call: (512) 221-9021

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 11. HEALTH MAINTENANCE ORGANIZATIONS

The commissioner of insurance adopts amendments to 28 TAC §§11.506, 11.901, 11.902, 11.1611, and 11.1612, concerning health maintenance organizations. The commissioner adopts §11.901 without changes to the proposed text published in the September 20, 2024, issue of the *Texas Register* (49 TexReg 7616). The section will not be republished. Sections 11.506, 11.902, 11.1611, and 11.1612 are adopted with changes to the proposed text to correct errors and in response to public comments. These sections will be republished.

REASONED JUSTIFICATION. The amendments are necessary to implement the following legislation:

- House Bill 711, 88th Legislature, 2023, which prohibits anti-competitive contract provisions;

- House Bill 1647, 88th Legislature, 2023, which provides protections for certain clinician-administered drugs;

- House Bill 3078, 85th Legislature, 2017, which transfers regulation of podiatrists to the Texas Department of Licensing and Regulation;

- Senate Bill 1003, 88th Legislature, 2023, which expands facility-based provider types that must be listed in provider directories;

- Senate Bill 1264, 86th Legislature, 2019, which creates new payment standards and balance billing protections for care provided by non-network facility-based providers in a network facility, diagnostic imaging and laboratory services in connection with care from a network provider, and emergency care; and

- Senate Bill 2476, 88th Legislature, 2023, which creates new payment standards and balance billing protections for emergency medical services.

The amendments remove payment rules that were invalidated by court order in *Texas Ass'n of Health Plans v. Texas Dept. of Insurance*, Travis County District Court No. D-1-GN-18-003846 (October 15, 2020), and update provisions for out-of-network care consistent with SB 1264 and SB 2476.

The amendments also make nonsubstantive changes to (1) add or amend Insurance Code citations for accessibility and consistency with agency rule drafting style preferences; and (2) correct and revise punctuation, capitalization, and grammar to reflect current agency drafting style and plain language preferences.

Descriptions of the amended sections follow.

Subchapter F. Evidence of Coverage

Section 11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate. The amendments add the title of §11.1611 to subsection (b)(2)(B) to conform to agency style and add the phrase "must be included" to subsection (b)(3) to clarify the meaning and complete the sentence. The Texas Department of Insurance (TDI) has declined to adopt proposed changes to subsection (b)(3)(A) and (D) that would have replaced "health status-related" with "health-status-related," because those changes would have conflicted with the term "health status-related factor" as defined in 28 TAC §11.2.

Amendments to subsection (b)(2)(C) implement SB 1264 by updating the disclosure related to facility-based physicians and other health care practitioners. In response to comments, TDI changed the proposed text to clarify that the required statement must be consistent with the rules in 28 TAC §21.4903, which implement the process by which a consumer may waive their balance billing protections. TDI also changed the disclosure as proposed to use language suggested by commenters that more closely matches statutory text.

Amendments to subsection (b)(3)(B)(iii) update rule citations to reflect amendments made to rules in Administrative Code Chapter 26.

An amendment to subsection (b)(13) adds the word "terminate" to the incontestability provision to align with terminology used in Insurance Code Chapters 843 and 1271.

In response to comments, TDI has declined to adopt the changes proposed to subsection (b)(14).

An amendment to subsection (b)(17) replaces the term "mental retardation" with "intellectual disability" to align with changes made throughout the Insurance Code by House Bill 446, 88th Legislature, 2023.

An amendment to subsection (b)(19) corrects an error in a citation to the Insurance Code.

Amendments to subsection (b)(24) expand and update the prescription drug coverage requirements by removing the references to formularies and requiring compliance with all of Insurance Code Chapter 1369 rather than solely Subchapter B of that chapter. These changes are needed because substantive coverage requirements exist throughout Chapter 1369, most of which are not contingent on formulary use.

Amendments remove parentheses from references to the titles of statutory citations and revise other punctuation to reflect this change; add apostrophes to denote possession, where appropriate; replace "percent" with "%"; correct verb tenses; update a title to Insurance Code Chapter 1369, Subchapter B; remove the title to a redundant Insurance Code citation; and otherwise align rule text with current agency drafting style and plain language preferences.

Subchapter J. Physician and Provider Contracts and Arrangements

Section 11.901. Required and Prohibited Provisions. The amendments to §11.901(a) remove the incorrect use of "of this title" in reference to an Insurance Code citation.

The amendments also delete a duplicative citation to an Insurance Code title in subsection (b)(3) and update the mailing address for the Managed Care Quality Assurance Office in subsection (b)(4). An amendment to subsection (b)(11) corrects the title of Insurance Code §1661.005 to read "Refund of Overpayment" instead of "Refunds of Overpayments."

An amendment to subsection (c)(1)(A) adds a reference to ICD-11-CM.

TDI changed subsection (d)(3) as proposed to replace "physician or provider's" with "physician's or provider's."

Amendments to subsection (e) replace "the effective date of this subsection" with "August 1, 2017," to provide the effective date of the last amendments to the subsection.

New subsection (g) is added to implement HB 711, including the prohibitions in Insurance Code §1458.101 on contractual anti-steering, anti-tiering, most favored nation, and gag clauses.

Amendments also remove parentheses from statutory citations for uniformity in formatting, add an apostrophe to denote possession, and revise unnecessary use of the words "hereby" and "hereafter."

Section 11.902. Prohibited Actions. An amendment designates subsection (a) to contain existing paragraphs (1) - (7), to allow for the addition of a subsection (b) to the section. An amendment to paragraph (4) replaces the outdated reference to the "Texas State Board of Podiatric Medical Examiners" with the "Texas Department of Licensing and Regulation," reflecting the enactment of HB 3078 in 2017.

Amendments implement HB 711 by adding new subsection (b). The new subsection prohibits an HMO from using steering or a tiered network to encourage an enrollee to obtain a health care service from a particular provider, unless it is done for the primary benefit of the enrollee or contract holder in compliance with the requirements of the Insurance Code, including Insurance Code §1458.101(i). New subsection (b) also defines "steering" and "tiered network" according to HB 711, clarifies that fiduciary duty violations will be determined by TDI on the basis of an assessment of the HMO's conduct, and provides non-exhaustive examples of conduct that would violate the fiduciary duty under Insurance Code §1458.101(i). In response to a comment, the reference in subsection (b)(1) to "providers" is changed from the text as proposed to reference "physicians or providers."

Amendments remove parentheses from the titles of statutory citations to reflect current agency drafting style.

Subchapter Q.

Other Requirements Section 11.1611. Out-of-Network Claims; Non-Network Physicians and Providers. To implement SB 1264 and SB 2476, amendments update requirements for out-of-network claims. An amendment replaces former subsection (a) with a new subsection (a) containing text with references to out-of-network payment standards in Insurance Code Chapter 1271. In response to a comment, TDI changed new subsection (a) as proposed to add a reference to Insurance Code Chapter 1467.

An amendment also replaces former subsection (b) with a new subsection (b) that provides requirements for an HMO in circumstances when medically necessary covered services are not available through a network physician or provider. In response to a comment questioning the meaning of "reasonably available," TDI changed the text of subsection (b) as proposed to delete the word "reasonably." TDI also changed the text of subsections (b) and (c) as proposed to add the phrase "within the applicable network adequacy standards" to each subsection. This language clarifies that the consumer protections apply even if care is available from a contracted physician or provider if that contracted physician or provider is located outside the applicable network mileage requirements. In response to a comment, TDI changed the proposed text to replace "were medically necessary" with "are medically necessary" to conform to the use of present tense elsewhere in rule and statute. New subsection (b)(1) requires an HMO to facilitate the enrollee's access to care and follow access plan procedures. New subsection (b)(2) requires an HMO to inform the enrollee of their rights to receive out-of-network care under the in-network benefit level and to advise the consumer to contact the HMO if they receive a balance bill. TDI changed subsection (b)(2) as proposed by replacing "inform the enrollee as follows" with "inform the enrollee of their rights under this section, including" to clarify that the HMO can adjust the contents of the notice to use plain language and reflect the enrollee's rights in a specific situation, consistent with the requirements in subsection (c)(4).

TDI changed subsection (b)(2)(B) as proposed to clarify that the enrollee can ask the HMO to recommend a physician or provider that the enrollee can use without being balance billed. In response to a comment, TDI changed paragraph (2) as proposed by merging proposed subparagraphs (B) and (C), and redesignating paragraphs proposed as (3)(A) and (B) as paragraphs (2)(C) and (D). As part of this clarification, changes to the proposed text also remove paragraph (3) and its language that limited the provision to enrollees in a point-of-service plan.

The proposed amendments to subsection (c) are changed in response to comments. First, to align with wording in subsection (b), TDI changed the proposed text to clarify that subsection (c) applies when in-network care is not available within the applicable network adequacy standards. TDI has declined to adopt proposed amendments to subsection (c)(1) that would have modified the existing requirements related to referrals under Insurance Code §1271.055, but instead adopts a cross-reference to clarify that referrals must be processed consistent with the statute. The proposed specification in subsection (c)(1) that a referral is to a "non-network" physician or provider is deleted to reduce confusion in cases where a referral is to a contracted provider outside the network adequacy milage requirements. For purposes of this section, a referral to a contracted provider outside the network mileage requirements is "non-network" and subject to the requirements addressed in §11.1611. In response to a commenter's concerns about the wording of paragraph (2), TDI changed the proposed text to delete that paragraph because it is unnecessary to restate the statute. Changes to the adopted text also move proposed requirements under subsection (c)(1) for an HMO to approve a network gap exception and facilitate access to care to subsection (c)(2) to clarify that the HMO must take those actions concurrent with the referral and ensure the enrollee can access a physician or provider that meets the specified criteria. These changes clarify the distinction between the statutory referral requirements and the additional requirements for the HMO to facilitate access to care when a network gap occurs. The adopted amendments specify that an HMO must allow an enrollee to use a physician or provider that has the necessary expertise, is reasonably available, and that the enrollee can use without being liable for additional cost-sharing.

In response to a comment expressing concern that an HMO's network gaps could leave enrollees with insufficient options, TDI changed the text as proposed to add subsections (c)(3) and (c)(4) to explain that the requirement for an HMO to recommend an additional physician or provider varies depending on whether the approved referral meets the rule's criteria. If the referral meets the rule's criteria, the HMO must provide the enrollee with another recommendation upon request. If the referral does not meet the rule's criteria--such as because the HMO is unable to achieve an agreement with that physician or provider that will protect the enrollee from being balance billed, or because the referral was to a physician that is not reasonably available considering the enrollee's location--the HMO must inform the enrollee

as to why the criteria is not met and the enrollee's right to request that the HMO recommend additional physicians or providers. These changes align with corresponding requirements for PPOs and EPOs in 28 TAC §3.3707(j) and ensure that an enrollee who confronts a network gap still has a choice of at least two physicians or providers.

Amendments strike former subsection (d), which was invalidated by court order and redesignate subsequent subsections. The subsections that follow it are redesignated to reflect the removal of former subsection (d).

Redesignated subsection (d) is amended to remove reference to subsections (a) - (c) and to revise a reference to the Consumer Protection Section to instead reference the TDI toll-free consumer information help line.

Redesignated subsection (e) is amended to remove former paragraph (1), relating to the methodology for usual and customary charges, because HMOs are required to make payments based on the usual and customary rate, rather than the usual and customary charge. Subsequent paragraphs under subsection (e) are renumbered as appropriate to reflect the change.

An amendment adds new subsection (f) to implement HB 1647 by referencing coverage requirements for clinician-administered drugs in Insurance Code Chapter 1369, Subchapter W, as added by HB 1647. If a clinician-administered drug is provided by a non-network provider and eligible to be covered under the plan's in-network benefit, the HMO must issue payment consistent with subsection (d).

Amendments update grammar and punctuation throughout to reflect current agency drafting style and plain language preferences.

Section 11.1612. Mandatory Disclosure Requirements. Amendments implement SB 1003 and SB 1264, remove duplicative or unnecessary requirements, and make nonsubstantive formatting and grammatical changes to improve readability.

Amendments to subsection (a) broaden the provisions to apply to all physician and provider directories, rather than only online directories. Some requirements that were previously required under subsection (h) are moved into subsection (a). Paragraph (1) is expanded to require a directory to indicate whether physicians and providers are accepting new patients, which was previously required under subsection (h)(2). Paragraph (2) is added to require a directory to explain limitations of accessibility and referrals to specialists, including those imposed by a limited provider network, which was previously required under subsection (h)(5). Paragraph (3) is added to require the directory to be dated and provided in at least 10-point type, which was previously required in subsection (h)(9) and (10). Subsequent paragraphs are renumbered as appropriate to reflect the addition of new paragraphs. Paragraph (8) is added to require the directory to include an email address and toll-free telephone number through which enrollees may notify an HMO of inaccurate information, which was previously required in subsection (h)(3). TDI changed paragraph (8) as proposed to replace the word "listing" with "directory" to be consistent with the terminology used in subsection (a).

An amendment to subsection (b) revises the wording in the last sentence for clarity. TDI changed the text of subsection (b) as proposed by replacing "physician or provider's" with "physician's or provider's."

Amendments to subsection (c) replace the word "font" with "type" and replace Figure: 28 TAC §11.1612(c). New Figure: 28 TAC §11.1612(c) reflects updated consumer protections enacted under SB 1264 and SB 2476 and uses plain language to improve consumer understanding of the notice. TDI changed new Figure: §11.1612(c) as proposed to clarify that the statement that protections do not apply for ground ambulance services should be included only if balance billing is permitted under applicable state and federal law.

Amendments in subsection (d) revise text to provide plainer language.

Amendments to subsection (e) modify formatting and punctuation; clarify that information may be provided for each service area or county; and remove former paragraph (2), which was duplicative of requirements in former paragraph (1). Because of the removal of paragraph (2), the text of former paragraph (1) is combined with the text following subsection (e), and the subparagraphs under former paragraph (1) are redesignated as paragraphs.

Amendments to subsection (f) provide plainer language by removing or revising wording that is repetitive or does not align with agency style.

Subsection (g) is amended to add a requirement that an HMO make restitution to an enrollee for any additional amount paid by the enrollee as a result of inaccurate provider information provided by the HMO. Also, former paragraph (4) is removed because it is repetitive of paragraph (1).

Subsection (h) is amended to reference, rather than restate, statutory requirements; exclude dental and vision networks, consistent with statute; and remove provisions that apply to all networks and are added to subsection (a). Paragraph (1) is deleted because consumers are now protected from balance billing at all network facilities. Paragraph (2) is deleted because the provision in it is added to subsection (a)(1). Paragraph (3) is also deleted because the provision in it is added to subsection (a)(8). To reflect the deletion of paragraphs (1) - (3), paragraph (4) is redesignated as paragraph (1). In addition, it is amended to add a reference to non-physician providers and a citation to Insurance Code §1451.504. Paragraph (5) is deleted because the provision in it is added to subsection (a)(2). Paragraph (6) is also deleted because it is unnecessary to restate the requirements of Insurance Code §1456.003(c). To reflect the renumbering of paragraph (4) and the deletion of paragraphs (5) and (6), paragraph (7) is renumbered as paragraph (2). In addition, it is amended to cite and align with Insurance Code Chapter 1456, use language more consistent with the statute, and replace the term "insurer" with "HMO." Paragraphs (8) and (9) are deleted and moved to subsection (a)(3). Paragraphs (10) and (11) are deleted because they unnecessarily restate the requirements of Insurance Code §1451.504(c) and (d).

Amendments to subsection (i) clarify and streamline the required disclosure. This includes removing paragraph (2) and the paragraph (1) designation, and incorporating the remaining text of paragraph (1) into the text that follows subsection (i). A reference to subsection (e)(2) is also revised to reflect the removal of former paragraph (2) from subsection (e).

Amendments to subsection (j) clarify that the disclosure of a substantial decrease in availability applies to both physicians and other providers, but that the decreases in numbers of physicians and other providers must be assessed separately. The requirement for HMOs to notify TDI by email of contract termi-

nations that do not impact network compliance is removed, with amendments to subsection (j)(2)(B) and the removal of subjection (j)(4)(C).

SUMMARY OF COMMENTS. TDI provided an opportunity for public comment on the rule proposal for a period that ended on October 21, 2024, and the proposal was published in the *Texas Register* (49 TexReg 7407) on September 20, 2024.

Commenters: TDI received comments from two commenters. Commenters in support of the proposal with changes were the Texas Association of Health Plans and the Texas Medical Association.

Comments on §11.506

Comment. Two commenters suggest clarifying the disclosure in §11.506(b)(2)(C) concerning facility-based physicians or other health care practitioners. One commenter suggests adding a cross-reference to the balance billing waiver rules in 28 TAC §21.4903 to make it clear that the new rule does not supersede it. Another commenter suggests that TDI simply repeat the text in Insurance Code §1456.006, rather than addressing the additional requirements in Insurance Code Chapter 1271 added by Senate Bill 1264. If TDI retains the broader disclosure, the commenter recommends using language closer to the statute and clarifying that the balance billing prohibition applies only to a covered service or supply.

Agency Response. TDI agrees with the commenters, in part, and has changed the text proposed for §11.506(b)(2)(C)(ii) to replace "affirmatively chooses a non-network facility-based physician or other health care practitioner" with "elects to receive out-of-network care and signs a waiver of balance billing protections." The adopted text also clarifies that the balance billing prohibition applies "for a covered service or supply provided in a network facility" and removes another reference to "in a network facility" to avoid duplication. These changes align more closely with statutory language. TDI has also changed the statement to ensure it is "consistent with 28 TAC §21.4903," enhancing clarity and ensuring compliance with relevant regulations.

Comment. One commenter opposes the proposed changes to §11.506(b)(14) and §11.1611(c) that remove the text "after receipt of reasonably requested documentation" in connection with the requirement to allow a referral to a non-network provider. The commenter states that, while the commenter agrees referral requests could be handled promptly, forcing HMOs to allow a referral without documentation that demonstrates that the out-of-network care is necessary could create an opportunity for providers to abuse the system and lead to increased costs for consumers. Another commenter supports the proposed change but asks TDI to clarify that the deadline is "from the date the request was sent."

Agency Response. TDI agrees with the first commenter that removing the requirement for reasonably requested documentation could have unintended consequences. Keeping this requirement ensures clarity in the referral process and protects enrollees' access to necessary services. TDI adopts §11.506(b)(14) without the proposed change and retains the phrase "after receipt of reasonably requested documentation" in §11.1611(c).

Comments on §11.902

Comment. One commenter notes that the reference to steering in §11.902(b)(1) only includes "providers," and recommends specifying "physicians or providers" to be consistent with terminology used throughout the rule.

Agency Response. TDI agrees and has made the suggested change.

Comments on §11.1611

Comment. One commenter states that the proposed amendments to §11.1611 are unclear in multiple respects; the commenter seeks additional information from TDI on its intent and requests another opportunity before adoption for notice and comment on the proposed section.

Agency Response. TDI does not agree with the commenter; the proposal's intent is clear. TDI declines to repropose the changes to §11.1611; however, TDI will monitor implementation of the section to determine whether additional rulemaking is necessary.

Comment. One commenter suggests modifying §11.1611(a) to specifically reference Insurance Code §§1271.155, 1271.157, 1271.158, or 1271.159, as applicable, rather than simply referencing the balance billing protections under Insurance Code Chapter 1271. The commenter also suggests adding a reference to the payment standards under Insurance Code Chapter 1467.

Agency Response. TDI disagrees that specific section references under Insurance Code Chapter 1271 are needed but agrees to add a reference to the payment standards under Insurance Code Chapter 1467, as applicable. Insurance Code §1271.159 is set to expire September 1, 2025, so if a specific reference was added, §11.1611 would quickly become outdated and require amendment.

Comment. One commenter asks whether the rule text in §11.1611(b) uses the past-tense "were" instead of "are" intentionally and whether TDI intends for the rule to apply to services that were already rendered if a referral is not subsequently denied.

Agency Response. The use of the past tense was inadvertent. To better align with Insurance Code §1271.055, TDI has changed the proposed text of §11.1611(b) to replace "were" with "are." TDI agrees that in some instances, where necessary care is time sensitive, retrospective approvals of referral requests may be appropriate.

Comment. One commenter notes that Insurance Code §1271.055 does not prohibit a physician or provider from balance billing, and requests that TDI modify §11.1611(b) to clarify the enrollee's responsibility for a balance bill when the enrollee does not choose a physician or provider recommended by an HMO. The commenter also expresses concerns that the language in §11.1611(c) may limit patient choice and reduce the likelihood of clinically driven referrals, especially when the HMO has an inadequate network. The commenter states that the HMO-recommended physician or provider should not be the only option available to the enrollee and that it is unfair for the HMO to offer the enrollee just one recommendation. The commenter notes that it may be entirely rational for the enrollee or the enrollee's requesting physician to choose someone other than the HMO-recommended physician or provider, and that an enrollee should not be penalized for choosing an alternative physician or provider that might better meet their needs.

Agency Response. The section does not change the statutory prohibitions on balance billing or imply that balance billing is prohibited under Insurance Code §1271.055. TDI agrees that enrollees should have the right to select a different physician or provider than the one recommended by an HMO. Therefore, TDI has changed §11.1611(b) as adopted to ensure that all enrollees

have the option to select an alternative physician or provider with the understanding that the enrollee may be responsible for a balance bill and not just those in a point-of-service plan. TDI expects HMOs to make good faith efforts to facilitate care without placing undue burdens on enrollees when the HMO has failed to meet network adequacy standards.

Comment. One commenter states that the "reasonably available" standard in §11.1611 is unclear and asks whether it requires an enrollee to travel beyond the mileage limits set for an adequate network.

Agency Response. The protections in §11.1611(b) and (c) apply when a network provider is not available within the established network adequacy standards. In response to this comment, TDI has changed these subsections as adopted to clarify this standard, which is consistent with a similar provision in §3.3708(b) for PPO and EPO plans. With respect to the availability of physicians and providers recommended by an HMO, TDI reviews access plans under §11.1611(j) to ensure that HMOs have appropriate procedures in place for delivering care when gaps exist.

Comment. One commenter asks whether the language in §11.1611(c) is intended to limit the statutory payment provisions in Insurance Code §1271.055 to situations where the referral is to a non-network physician or provider that the enrollee may use without being responsible for an amount in excess of their in-network cost-sharing. The commenter notes that §11.1611(b) and (c) require an HMO to provide an option where the enrollee will not be responsible for an amount in excess of the cost-sharing under the plan. The commenter presumes that these provisions intend for the HMO to reach an agreed upon amount with the recommended physician or provider in advance. The commenter asks TDI to confirm that the rule is not interpreting Insurance Code §1271.055 to impose a balance billing prohibition. The commenter strongly opposes such an interpretation.

Agency Response. The rule does not narrow application of Insurance Code §1271.055 and does not imply that balance billing is prohibited by that section. Balance billing prohibitions are outlined in the statute and remain unchanged by this rule. The rule maintains TDI's long-standing position that HMO plans provide comprehensive health care on a prepaid basis and must allow enrollees to access all medically necessary covered services without being responsible for amounts in excess of their plan's cost-sharing responsibilities. In cases of network gaps, HMOs typically facilitate an enrollee's access to care and negotiate single case agreements to prevent balance billing.

Comment. One commenter recommends revising §11.1611(c)(2) to replace "health care physician or provider" with "physician or health care provider." The commenter points out that the proposed phrasing is inconsistent with terms defined under Insurance Code §843.002 and appears to be an unintended error. The commenter also asks whether the language in subsection (c)(2) is adequately aligned with Insurance Code §1271.055(c) and recommends replacing the existing language with a reference to a "specialist of the same license and same or similar type of specialty."

Agency Response. Because it is unnecessary to restate the statute, in response to comments on this point TDI does not adopt §11.1611(c)(2) as proposed, and instead adds a cross-reference to Insurance Code §1271.055 in subsection (c)(1) to clarify that referrals must be processed consistent with the statutory requirements.

Comment. With respect to the requirement in §11.1611(c) for HMOs to recommend a physician or provider, one commenter acknowledges the usefulness of offering enrollees options where they are responsible for only plan cost-sharing, but notes that it should not be the enrollee's only option. The commenter expresses concern that the requirement could reduce the likelihood of the referral being clinically driven, as contemplated by Insurance Code §1271.055. The commenter has concerns with the language in (c)(1) as proposed because the focus on a network gap exception departs from the referral language in Insurance Code §1271.055 and raises questions about whether TDI is intending to narrow the statutory requirement. The commenter also states that it is unfair to an enrollee to provide only one physician or provider that the enrollee can use in the case of a network gap and recommends that the enrollee have at least three physicians or providers to choose from. The commenter suggests that setting a lower bar for network gaps than TDI sets when reviewing network adequacy standards causes plans to have deficient networks.

Agency Response. TDI appreciates the commenter's support for giving enrollees an option where they are responsible only for plan cost-sharing amounts. HMOs typically pursue single-case agreements based on the clinically driven referral. If an HMO is unsuccessful in reaching such an agreement, or the referral does not meet the rule's other requirements, the HMO must notify the enrollee and recommend other appropriate physicians or providers who are qualified and available to deliver the necessary care. TDI agrees with the commenter that combining the existing referral requirements with the new proposed requirements could create confusion, so in response TDI adopts §11.1611 with a cross-reference to Insurance Code §1271.055 in subsection (c)(1), moves new language requiring the HMO to approve a network gap exception and facilitate access to care to paragraph (2) of the subsection, and adds new paragraphs (3) and (4) to provide additional explanation of when the HMO is required to recommend an additional physician or provider. TDI agrees with the commenter that enrollees should have a choice of more than one physician or provider when faced with a network gap. New paragraphs (3) and (4) specify that an enrollee can ask the HMO for a recommendation in addition to a referral and clarify that enrollees should have a choice of at least two physicians or providers that meet the rule's criteria. This is consistent with requirements for PPO and EPO plans under §3.3707(j)(2). This change also gives the HMO flexibility to negotiate with alternative physicians or providers if they cannot reach a single case agreement with the referred-to physician or provider.

Comment. One commenter asks TDI to revise §11.1611 to clarify that when an HMO recommends a physician or provider, it is subject to the steering limitations and fiduciary duty set forth in §11.902(b).

Agency Response. TDI declines to make a change because the requirements in connection with steering are clearly addressed in §11.902(b) and Insurance Code §1458.101(i).

Comment. One commenter asks how the requirements in §11.1611(d) interact with the explanation-of-benefits requirements under SB 1264. The commenter also expresses concern that the rule makes it sound as though the physician does something wrong if they balance bill, even though there are instances when balance billing is permitted.

Agency Response. The requirements in §11.1611(d) are in addition to the balance billing prohibition notice in Insurance Code §1271.008 and the explanation-of-benefits requirements in 28

TAC §21.5040. TDI does not believe there is any conflict between the requirements and has not heard of these disclosures creating confusion for consumers.

SUBCHAPTER F. EVIDENCE OF COVERAGE

28 TAC §11.506

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.506 under Insurance Code §§843.151, 1271.152, 1456.006, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

Insurance Code §1271.152 authorizes the commissioner to adopt minimum standards relating to basic health care services.

Insurance Code §1456.006 authorizes the commissioner to prescribe disclosure requirements related to out-of-network care from facility-based physicians and providers.

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

§11.506. Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate.

(a) Each enrollee residing in Texas is entitled to an evidence of coverage under a health care plan. An HMO may deliver the evidence of coverage electronically but must provide a paper copy on request.

(b) Each group, individual, and conversion contract and group certificate must contain the following provisions:

(1) Face page. Where applicable, the name, address, website address, and phone number of the HMO must appear. The toll-free number referred to in Insurance Code §521.102, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, must appear on the face page.

(A) The face page of an agreement is the first page that contains any written material.

(B) If the agreements or certificates are in booklet form, the first page inside the cover is considered the face page.

(C) The HMO must provide the information regarding the toll-free number referred to in Insurance Code Chapter 521, Subchapter C, concerning Health Maintenance Organization or Insurer Toll-Free Number for Information and Complaints, in compliance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(2) Benefits. A schedule of all health care services that are available to enrollees under the basic, limited, or single service plan must be included, together with any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services.

(i) Each basic health care service HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50% of the total cost of services provided.

(ii) A basic health care service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200% of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.

(iii) The HMO must state the copayment, the limit on enrollee copayments, and the enrollee reporting responsibility in the group, individual, or conversion agreement and group certificate.

(B) Deductibles. A deductible must be for a specific dollar amount of the cost of the basic, limited, or single health care service. Except for a consumer choice benefit plan authorized by Insurance Code Chapter 1507, concerning Consumer Choice of Benefits Plans, an HMO may not charge a deductible for services received in the HMO's delivery network. Except in cases involving emergency care and services that are not available in the HMO's delivery network, as described in §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), an HMO may charge an out-of-network deductible for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.

(C) Facility-based physicians or other health care practitioners. In compliance with Insurance Code §1456.003, concerning Required Disclosure: Health Benefit Plan, a statement must be included that is consistent with §21.4903 of this title (relating to Out-of-Network Notice and Disclosure Requirements) and that provides notice that:

(i) a facility-based physician or other health care practitioner may not be included in the health benefit plan's provider network;

(ii) unless the enrollee elects to receive out-of-network care and signs a waiver of balance billing protections, a non-network facility-based physician or other health care practitioner may not balance bill the enrollee for amounts not paid by the health benefit plan for covered services or supplies provided in a network facility; and

(iii) if the enrollee receives a balance bill, the enrollee should contact the HMO.

(D) Immunizations. An HMO may not charge a copayment or deductible for immunizations as described in Insurance Code Chapter 1367, Subchapter B, concerning Childhood Immunizations, for a child from birth through the date the child is 6 years of age, except that a small employer health benefit plan as defined by Insurance Code §1501.002, concerning Definitions, that covers the immunizations may charge a copayment, and a consumer choice benefit plan under Insurance Code Chapter 1507 may charge a copayment and a deductible.

(3) Cancellation and nonrenewal. A statement must be included that specifies the following grounds for cancellation and nonrenewal of coverage and the minimum notice period that will apply.

(A) Unless otherwise prohibited by law, an HMO may cancel coverage of a subscriber in a group and the subscriber's enrolled dependents under circumstances described in this subparagraph, so long as the circumstances do not include health status-related factors:

(i) for nonpayment of amounts due under the contract, after not less than 30-days' written notice, except no additional written notice will be required for failure to pay premium;

(ii) after not less than 15-days' written notice, in the case of fraud or intentional misrepresentation of a material fact, except as described in paragraph (13) of this subsection;

(iii) after not less than 15-days' written notice, in the case of fraud in the use of services or facilities;

(iv) immediately, subject to continuation of coverage and conversion privilege provisions, if applicable, for failure to meet eligibility requirements other than the requirement that the subscriber reside, live, or work in the service area; and

(v) after not less than 30-days' written notice, where the subscriber does not reside, live, or work in the service area of the HMO or area for which the HMO is authorized to do business, but only if the HMO terminates coverage uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area.

(B) An HMO may cancel a group under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premium, at the end of the grace period as described in paragraph (12) of this subsection;

(ii) in the case of fraud on the part of the group, after 15-days' written notice;

(iii) for employer groups, for violation of participation or contribution rules, under §26.8 of this title (relating to Guaranteed Issue; Contribution and Participation Requirements) and §26.303 of this title (relating to Coverage Requirements);

(iv) for employer groups, under §26.16 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market) and §26.309 of this title (relating to Refusal to Renew and Application to Reenter Large Employer Market) on discontinuance of:

(I) each of its small or large employer coverages; or

(II) a particular type of small or large employer coverage;

(v) where no enrollee resides, lives, or works in the service area of the HMO or area for which the HMO is authorized to do business, but only if the coverage is terminated uniformly without regard to any health status-related factor of enrollees after 30-days' written notice; and

(vi) if membership of an employer in an association ceases, and if coverage is terminated uniformly without regard to the health status of an enrollee, after 30-days' written notice.

(C) A group or individual contract holder may cancel a contract in the case of a material change by the HMO to any provisions required to be disclosed to contract holders or enrollees under this chapter or other law after not less than 30-days' written notice to the HMO.

(D) An HMO may cancel an individual contract under circumstances described below, unless otherwise prohibited by law:

(i) for nonpayment of premiums under the terms of the contract, including any timeliness provisions, without written notice, subject to paragraph (12) of this subsection;

(ii) in the case of fraud or intentional material misrepresentation, except as described in paragraph (13) of this subsection, after not less than 15-days' written notice;

(iii) in the case of fraud in the use of services or facilities, after not less than 15-days' written notice;

(iv) after not less than 30-days' written notice where the subscriber does not reside, live, or work in the service area of the HMO or area in which the HMO is authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of enrollees, except that an HMO may not cancel coverage for a child who is the subject of a medical support order because the child does not reside, live, or work in the service area;

(v) in case of termination by discontinuance of a particular type of individual coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 90-days' written notice, in which case the HMO must offer to each enrollee on a guaranteed-issue basis any other individual basic health care coverage offered by the HMO in that service area; and

(vi) in case of termination by discontinuance of all individual basic health care coverage by the HMO in that service area, but only if coverage is discontinued uniformly without regard to health status-related factors of enrollees and dependents of enrollees who may become eligible for coverage, after 180-days' written notice to the commissioner and the enrollees, in which case the HMO may not re-enter the individual market in that service area for five years beginning on the date of discontinuance of the last coverage not renewed.

(4) Claim payment procedure. A provision that sets forth the procedure for paying claims, including any time frame for payment of claims that must comply with Insurance Code Chapter 542, Subchapter B, concerning Prompt Payment of Claims; Insurance Code §1271.005, concerning Applicability of Other Law; and rules adopted under these Insurance Code provisions.

(5) Complaint and appeal procedures. A description of the HMO's complaint and appeal process available to complainants, including internal adverse determination appeal and independent review procedures under Insurance Code Chapter 4201, concerning Utilization Review Agents, and Chapter 19, Subchapter R, of this title (relating to Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy).

(6) Definitions. A provision defining any words in the evidence of coverage that have other than the usual meaning. Definitions must be in alphabetical order.

(7) Effective date. A statement of the effective date requirements of various kinds of enrollees.

(8) Eligibility. A statement of the eligibility requirements for membership.

(A) The statement must provide that the subscriber must reside, live, or work in the service area and the legal residence of any enrolled dependents must be the same as the subscriber, or the subscriber must reside, live, or work in the service area and the residence of any enrolled dependents must be:

(i) in the service area with the person having temporary or permanent conservatorship or guardianship of the dependents, including adoptees or children who have become the subject of a suit for adoption by the enrollee, where the subscriber has legal responsibility for the health care of the dependents;

(ii) in the service area under other circumstances where the subscriber is legally responsible for the health care of the dependents;

(iii) in the service area with the subscriber's spouse; or

(iv) anywhere in the United States for a child whose coverage under a plan is required by a medical support order.

(B) The statement must provide the conditions under which dependent enrollees may be added to those originally covered.

(C) The statement must describe any limiting age for subscriber and dependents.

(D) The statement must provide a clear statement regarding the coverage of newborn children.

(i) No evidence of coverage may contain any provision excluding or limiting coverage for a newborn child of the subscriber or the subscriber's spouse.

(ii) Congenital defects must be treated the same as any other illness or injury for which coverage is provided.

(iii) The HMO may require that the subscriber notify the HMO during the initial 31 days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(iv) The HMO may not require that a newborn child receive health care services only from network physicians or providers after the birth if the newborn child is born outside the HMO service area due to an emergency or born in a non-network facility to a mother who does not have HMO coverage, but may require that the newborn be transferred to a network facility at the HMO's expense and, if applicable, to a network provider when the transfer is medically appropriate as determined by the newborn's treating physician.

(v) A newborn child of the subscriber or subscriber's spouse is entitled to coverage during the initial 31 days following birth. The HMO must allow an enrollee 31 days after the birth of the child to notify the HMO, either verbally or in writing, of the addition of the newborn as a covered dependent.

(E) The statement must include a clear statement regarding the coverage of the enrollee's grandchildren that complies with Insurance Code §1201.062, concerning Coverage for Certain Children in Individual or Group Policy or in Plan or Program, and §1271.006, concerning Benefits to Dependent Child and Grandchild.

(9) Emergency services. A description of how to obtain services in emergency situations, including:

(A) what to do in case of an emergency occurring outside or inside the service area;

(B) a statement of any restrictions or limitations on out-of-area services;

(C) a statement that the HMO will provide for any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an emergency medical condition exists in a hospital emergency facility or comparable facility;

(D) a statement that necessary emergency care services will be provided, including the treatment and stabilization of an emergency medical condition;

(E) a statement that where stabilization of an emergency condition originated in a hospital emergency facility or in a comparable facility, as defined in subparagraph (F) of this paragraph, treatment subject to stabilization must be provided to enrollees as approved by the HMO, provided that:

(i) the HMO must approve or deny coverage of post-stabilization care as requested by a treating physician or provider; and

(ii) the HMO must approve or deny the treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case may approval or denial exceed one hour from the time of the request; and

(F) for purposes of this paragraph, "comparable facility" includes the following:

(i) any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities and Rural Health Clinics that have licensed or certified or both licensed and certified personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care and a free-standing emergency medical care facility as that term is defined in Insurance Code §843.002, concerning Definitions;

(ii) for purposes of emergency care related to mental illness, a mental health facility that can provide 24-hour residential and psychiatric services and that is:

(I) a facility operated by the Texas Department of State Health Services;

(II) a private mental hospital licensed by the Texas Department of State Health Services;

(III) a community center as defined by Texas Health and Safety Code §534.001, concerning Establishment;

(IV) a facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;

(V) an identifiable part of a general hospital in which diagnosis, treatment, and care for persons with mental illness is provided and that is licensed by the Texas Department of State Health Services; or

(VI) a hospital operated by a federal agency.

(10) Entire contract, amendments. A provision stating that the form, applications, if any, and any attachments constitute the entire contract between the parties and that, to be valid, any change in the form must be approved by an officer of the HMO and attached to the affected form and that no agent has the authority to change the form or waive any of the provisions.

(11) Exclusions and limitations. A provision setting forth any exclusions and limitations on basic, limited, or single health care services.

(12) Grace period. A provision for a grace period of at least 30 days for the payment of any premium due after the first premium payment during which the coverage remains in effect. An HMO may add a charge to the premium for late payments received within the grace period.

(A) If payment is not received within the 30 days, coverage may be canceled after the 30th day and the terminated members may be held liable for the cost of services received during the grace period, if this requirement is disclosed in the agreement.

(B) Despite subparagraph (A) of this paragraph, provisions regarding the liability of group contract holder for an enrollee's premiums must comply with Insurance Code §843.210, concerning Terms of Enrollee Eligibility, and §21.4003 of this title (relating to Group Policyholder, Group Contract Holder, and Carrier Premium Payment and Coverage Obligations).

(13) Incontestability:

(A) All statements made by the subscriber on the enrollment application are considered representations and not warranties. The statements are considered truthful and made to the best of the subscriber's knowledge and belief. A statement may not be used in a contest to void, cancel, terminate, or nonrenew an enrollee's coverage or reduce benefits unless:

(i) it is in a written enrollment application signed by the subscriber; and

(ii) a signed copy of the enrollment application is or has been furnished to the subscriber or the subscriber's personal representative.

(B) An individual contract or group certificate may only be contested because of fraud or intentional misrepresentation of material fact made on the enrollment application. For small employer coverage, the misrepresentation must be other than a misrepresentation related to health status.

(C) For a group contract or certificate, the HMO may increase its premium to the appropriate level if the HMO determines that the subscriber made a material misrepresentation of health status on the application. The HMO must provide the contract holder 31-days' prior written notice of any premium rate change.

(14) Out-of-network services. Each contract between an HMO and a contract holder must provide that if medically necessary covered services are not available through network physicians or providers, the HMO must, on the request of a network physician or provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider and must fully reimburse the non-network provider at the usual and customary or an agreed rate.

(A) For purposes of determining whether medically necessary covered services are available through network physicians or providers, the HMO must offer its entire network, rather than limited provider networks within the HMO delivery network.

(B) The HMO may not require the enrollee to change primary care physician or specialist providers to receive medically necessary covered services that are not available within the limited provider network.

(C) Each contract must further provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the HMO may deny a referral.

(15) Schedule of charges. A statement that discloses the HMO's right to change the rate charged with 60-days' written notice under Insurance Code §843.2071, concerning Notice of Increase in Charge for Coverage, and Insurance Code Chapter 1254, concerning Notice of Rate Increase for Group Health and Accident Coverage.

(16) Service area. A description and a map of the service area, with key and scale, that identifies the county, or counties, or portions of counties to be served, and indicates primary care physicians, hospitals, and emergency care sites. A ZIP code map and a physician and provider list may be used to meet the requirement.

(17) Termination due to attaining limiting age. A provision that a child's attainment of a limiting age does not operate to terminate the child's coverage while that child is incapable of self-sustaining employment due to intellectual disability or physical disability, and chiefly dependent on the subscriber for support and maintenance. The HMO may require the subscriber to furnish proof of incapacity and dependency within 31 days of the child's attainment of the limiting age and subsequently as required, but not more frequently than annually following the child's attainment of the limiting age.

(18) Termination due to student dependent's change in status. A provision regarding coverage of student dependents that complies with Insurance Code Chapter 1503, concerning Coverage of Certain Students, if applicable.

(19) Conformity with state law. A provision that if the agreement or certificate contains any provision or part of a provision not in conformity with Insurance Code Chapter 1271, concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges, or other applicable laws, the remaining provisions and parts of provisions that can be given effect without the invalid provision or part of a provision are not rendered invalid but must be construed and applied as if they were in full compliance with Insurance Code Chapter 1271 and other applicable laws.

(20) Conformity with Medicare supplement minimum standards and long-term care minimum standards. Each group, individual, and conversion agreement, and group certificate must comply with Chapter 3, Subchapter T, of this title (relating to Minimum Standards for Medicare Supplement Policies), referred to in this paragraph as Medicare supplement rules, and Chapter 3, Subchapter Y, of this title (relating to Standards for Long-Term Care Insurance, Non-Partnership and Partnership Long-Term Care Insurance Coverage Under Individual and Group Policies and Annuity Contracts, and Life Insurance Policies That Provide Long-Term Care Benefits Within the Policy), referred to in this paragraph as long-term care rules, where applicable. If there is a conflict between the Medicare supplement or long-term care rules, or both, and the HMO rules, the Medicare supplement or long-term care rules will govern to the exclusion of the conflicting provisions of the HMO rules. Where there is no conflict, an HMO must follow the Medicare supplement, the long-term care rules, and the HMO rules where applicable.

(21) Nonprimary care physician specialist as primary care physician. A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to use a nonprimary care physician specialist as a primary care physician as set out in Insurance Code §1271.201, concerning Designation of Specialist as Primary Care Physician.

(22) Selected obstetrician or gynecologist. Group, individual, and conversion agreements, and group certificates, except small employer health benefit plans as defined by Insurance Code §1501.002, must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of Insurance Code Chapter 1451, Subchapter F, concerning Access to Obstetrical or Gynecological Care. An HMO may not prevent an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) An HMO must permit an enrollee who selects an obstetrician or gynecologist direct access to the health care services of the selected obstetrician or gynecologist without a referral by the enrollee's primary care physician or prior authorization or precertification from the HMO.

(B) Access to the health care services of an obstetrician or gynecologist includes:

(i) one well-woman examination per year;

(ii) care related to pregnancy;

(iii) care for all active gynecological conditions; and

(iv) diagnosis, treatment, and referral to a specialist within the HMO's network for any disease or condition within the scope of the selected professional practice of a properly credentialed obstetrician or gynecologist, including treatment of medical conditions concerning breasts.

(C) An HMO may require an enrollee who selects an obstetrician or gynecologist to select the obstetrician or gynecologist from within the limited provider network to which the enrollee's primary care physician belongs.

(D) An HMO may require a selected obstetrician or gynecologist to forward information concerning the medical care of the patient to the primary care physician. However, the HMO may not impose any penalty, financial or otherwise, on the obstetrician or gynecologist for failure to provide this information if the obstetrician or gynecologist has made a reasonable and good-faith effort to provide the information to the primary care physician.

(E) An HMO may limit an enrollee in the plan to self-referral to one participating obstetrician and gynecologist for both gynecological care and obstetrical care. The limitation must not affect the right of the enrollee to select the physician who provides that care.

(F) An HMO must include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in Insurance Code Chapter 1451, Subchapter F. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may instead receive obstetrical or gynecological services from the enrollee's primary care physician or primary care provider. The enrollee must have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) An enrollee who elects to receive obstetrical or gynecological services from a primary care physician (a family physician, internal medicine physician, or other qualified physician) must adhere to the HMO's standard referral protocol when accessing other specialty obstetrical or gynecological services.

(23) Diagnosis of Alzheimer's disease. An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease under Insurance Code Chapter 1354, concerning Eligibility for Benefits for Alzheimer's Disease, by a physician licensed in this state satisfies any requirement for demonstrable proof of organic disease.

(24) Drug coverage. An agreement that covers prescription drugs must comply with Insurance Code Chapter 1369, concerning Benefits Related to Prescription Drugs and Devices and Related Services, and Chapter 21, Subchapter V, of this title (relating to Pharmacy Benefits), as applicable.

(25) Inpatient care by nonprimary care physician. If an HMO or limited provider network provides for an enrollee's care by a physician other than the enrollee's primary care physician while the enrollee is in an inpatient facility, for example, hospital or skilled nursing facility, a provision that on admission to the inpatient facility a physician other than the primary care physician may direct and oversee the enrollee's care.

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

Filed with the Office of the Secretary of State on March 10, 2025.

TRD-202500842
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: March 30, 2025
Proposal publication date: September 20, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

SUBCHAPTER J. PHYSICIAN AND PROVIDER CONTRACTS AND ARRANGEMENTS

28 TAC §11.901, §11.902

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.901 and §11.902 under Insurance Code §§843.151, 1458.004, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

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

§11.902. Prohibited Actions.

(a) An HMO may not:

(1) require a physician to use a hospitalist for a hospitalized patient by contract under Insurance Code §843.320, concerning Use of Hospitalist;

(2) refuse to contract with a nurse first assistant to be part of a provider network or refuse to reimburse a nurse first assistant under Insurance Code §843.3045, concerning Nurse First Assistant;

(3) require a physician to use the services of a nurse first assistant as defined by Occupations Code §301.354, concerning Nurse First Assistants; Assisting at Surgery by Other Nurses;

(4) refuse to contract with a podiatrist licensed by the Texas Department of Licensing and Regulation who joins the professional practice of a contracted physician or provider under Insurance Code §843.319, concerning Certain Required Contracts;

(5) refuse a request to identify a physician assistant or advanced practice registered nurse as a provider in the HMO's network under Insurance Code §843.312, concerning Physician Assistants and Advanced Practice Nurses;

(6) employ an optometrist or therapeutic optometrist to provide a vision care product or service, pay an optometrist or therapeutic optometrist for a service not provided, or restrict or limit an optometrist's or therapeutic optometrist's choice of sources or suppliers of services or materials under Insurance Code §1451.156 (concerning Prohibited Conduct); or

(7) contract with a dentist to limit the fee the dentist may charge for a service that is not a covered service under Insurance Code §843.3115, concerning Contracts with Dentists.

(b) An HMO that uses steering or a tiered network to encourage an enrollee to obtain a health care service from a particular provider, as defined under Insurance Code Chapter 1458, concerning Provider Network Contract Arrangements, must do so in a manner that complies with the requirements of the Insurance Code, including the fiduciary duty imposed by Insurance Code §1458.101(i), concerning Contract Requirements, to act only for the primary benefit of the enrollee or contract holder. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific physicians or providers;

(2) "tiered network" refers to a network of contracted physicians and providers in which an HMO assigns contracted physicians and providers to tiers within the network that are associated with different levels of cost sharing; and

(3) violations of the fiduciary duty under Insurance Code §1458.101(i) will be determined by TDI based on an assessment of the HMO's conduct. Examples of conduct that would violate the HMO's fiduciary duty include, but are not limited to:

(A) using a steering approach or a tiered network to provide a financial incentive as an inducement to limit medically necessary services, to encourage receipt of lower quality medically necessary services or receipt of services, or in violation of state or federal law;

(B) failing to implement reasonable processes to ensure that the contracted physicians and providers that enrollees are encouraged to use within any steering approach or tiered network are not of a materially lower quality as compared with contracted physicians and providers that enrollees are not encouraged to use;

(C) failing to implement reasonable processes to ensure that the HMO does not make materially false statements or representations about a physician's or provider's quality of care or costs; or

(D) failing to use objectively and verifiably accurate and valid information as the basis of any encouragement or incentive under this subsection.

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

Filed with the Office of the Secretary of State on March 10, 2025.

TRD-202500843
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: March 30, 2025
Proposal publication date: September 20, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

SUBCHAPTER Q. OTHER REQUIREMENTS

28 TAC §11.1611, §11.1612

STATUTORY AUTHORITY. The commissioner adopts amendments to §11.611 and §11.1612 under Insurance Code §§843.151, 843.2015(c), 1271.152, and 36.001.

Insurance Code §843.151 authorizes the commissioner to adopt reasonable rules to implement various sections of the Insurance Code related to HMOs and ensure adequate access to health care services, including establishing physician-to-patient ratios and requirements relating to mileage, travel time, and appointment waiting times.

Insurance Code §843.2015(c) authorizes the commissioner to adopt rules necessary to implement the requirements for an HMO's online listing of physicians and providers, including rules that govern the form and content of information that must be provided under statute.

Insurance Code §1271.152 authorizes the commissioner to adopt minimum standards relating to basic health care services.

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

§11.1611. Out-of-Network Claims; Non-Network Physicians and Providers.

(a) For an out-of-network claim for which the enrollee is protected from balance billing under Insurance Code Chapter 1271, concerning Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges, the HMO must pay the claim according to that chapter and Insurance Code Chapter 1467, concerning Out-of-Network Dispute Resolution, as applicable.

(b) For an out-of-network claim that does not fall under subsection (a) of this section, if the services are medically necessary, covered under the plan, and not available through a network physician or provider within the applicable network adequacy standards, the HMO must pay the claim as required under Insurance Code §1271.055, concerning Out-of-Network Services, and:

(1) facilitate the enrollee's access to care consistent with subsection (c) of this section and the access plan and documented plan procedures specified in §11.1607(j) of this title (relating to Accessibility and Availability Requirements); and

(2) inform the enrollee of their rights under this section, including:

(A) the out-of-network care that the enrollee receives for the identified services will be covered under the same benefit level as though the services were received from a network physician or provider and will not be subject to any service area limitation;

(B) the enrollee can ask the HMO to recommend a physician or provider that the enrollee can use without being responsible for an amount in excess of the cost-sharing under the plan and the enrollee should contact the HMO if they receive a balance bill;

(C) if the enrollee chooses not to use the physician or provider the HMO recommends, they may choose to use an alternative non-network physician or provider with the understanding that the enrollee will be responsible for any balance bill amount the alternative non-network physician or provider may charge in excess of the HMO's usual and customary rate; and

(D) the amount of the HMO's usual and customary rate for the anticipated services.

(c) If medically necessary covered services, other than emergency care, are not available through a network physician or provider within the applicable network adequacy standards, on the request of a network physician or provider the HMO must:

(1) consistent with Insurance Code §1271.055, process a referral to a physician or provider within the time appropriate to the circumstances relating to the delivery of the services and the condition

of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation;

(2) concurrent with the referral, approve a network gap exception and facilitate access to care to ensure the enrollee can access a physician or provider that:

(A) has expertise in the necessary specialty;

(B) is reasonably available considering the medical condition and location of the enrollee; and

(C) the enrollee may use without being responsible for an amount in excess of the enrollee's cost-sharing responsibilities for care from a network physician or provider;

(3) if the HMO approves a referral to a physician or provider that meets the criteria in subsection (c)(2) of this section, the HMO must also, upon request from an enrollee or an individual acting on behalf of an enrollee and within the time appropriate to the circumstances, recommend at least one additional physician or provider that meets the criteria in subsection (c)(2) of this section; and

(4) if the HMO approves a referral to a physician or provider that does not meet the criteria in subsection (c)(2) of this section,

(A) the HMO must inform the enrollee of:

(i) why the physician or provider does not meet the criteria in subsection (c)(2) of this section; and

(ii) the enrollee's right to request that the HMO recommend physicians or providers that meet the criteria; and

(B) upon request by the enrollee or an individual acting on behalf of the enrollee and within the time appropriate to the circumstances, the HMO must recommend a choice of at least two physicians or providers that meet the criteria in subsection (c)(2) of this section.

(d) After determining that a claim from a non-network physician or provider for services provided under this section is payable, an HMO must issue payment to the non-network physician or provider at the usual and customary rate or at a rate agreed to by the HMO and the non-network physician or provider. If the rate was not agreed to by the physician or provider, the HMO must provide an explanation of benefits to the enrollee that includes a statement that the HMO's payment is at least equal to the usual and customary rate for the service, that the enrollee should notify the HMO if the non-network physician or provider bills the enrollee for amounts beyond the amount paid by the HMO, of the procedures for contacting the HMO on receipt of a bill from the non-network physician or provider for amount beyond the amount paid by the HMO, and the number for the department's toll-free consumer information help line for complaints regarding payment.

(e) Any methodology used by an HMO to calculate reimbursements of non-network physicians or providers for covered services not available from network physicians or providers must comply with the following:

(1) if based on claims data, then the methodology must be based on sufficient data to constitute a representative and statistically valid sample;

(2) any claims data underlying the calculation must be updated no less than once per year and not include data that is more than 3 years old; and

(3) the methodology must be consistent with nationally recognized and generally accepted bundling edits and logic.

(f) An HMO must cover a clinician-administered drug under the plan's in-network benefit if it meets the criteria under Insurance Code Chapter 1369, Subchapter Q, concerning Clinician-Administered Drugs.

§11.1612. Mandatory Disclosure Requirements

(a) Physician and provider directory. An HMO must develop and maintain a directory of contracting physicians and health care providers, display the directory on a public website maintained by the HMO, and ensure that a direct electronic link to the directory is conspicuously displayed on the electronic summary of benefits and coverage of each plan issued by the HMO. Any directory provided by the HMO, including an online directory, must:

(1) include the name, address, telephone number, and specialty, if any, of each physician and provider and indicate whether each contracted physician and provider is accepting enrollees as new patients or participates in closed provider networks serving only certain enrollees;

(2) include a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network;

(3) be dated and provided in at least 10-point type;

(4) clearly indicate each health benefit plan issued by the HMO that may provide coverage for services provided by each physician or provider included in the directory;

(5) when provided electronically, be searchable by physician or health care provider name and location;

(6) be publicly accessible without the necessity of providing a password, a username, or personally identifiable information;

(7) be reviewed on an ongoing basis and corrected or updated, if necessary, not less than once each month; and

(8) include an email address and a toll-free telephone number through which enrollees may notify the HMO of inaccurate information in the directory.

(b) Identification of limited networks and index. An HMO must clearly identify limited provider networks within its service area by providing a separate listing of its limited provider networks and an alphabetical listing of all the physicians and providers, including specialists, available in the limited provider network. An HMO must include an index of the alphabetical listing of all physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, within the HMO's service area, and must indicate the limited provider network or networks the physician or provider belongs to and the page number where the physician's or provider's name can be found.

(c) Notice of rights under an HMO plan required. An HMO must include the notice specified in Figure: 28 TAC §11.1612(c), in all evidences of coverage certificates, disclosures of plan terms, and member handbooks in at least 12-point type:
Figure: 28 TAC §11.1612(c)

(d) Disclosure concerning access to network physician and provider listing. An HMO must provide notice to all enrollees at least annually describing how the enrollee may access a current listing of all network physicians and providers on a cost-free basis. The notice must include, at a minimum, information about how to obtain a nonelectronic copy of the listing and a telephone number enrollees may call to get help during regular business hours to find available network physicians and providers.

(e) Disclosure concerning network information. An HMO must provide notice to all enrollees at least annually of information that is updated at least annually regarding the following network information for each service area or county, or for the entire state if the plan is offered on a statewide service-area basis:

(1) the number of enrollees in the service area or region;

(2) for each physician and provider area of practice, including at a minimum internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery, the number of contracted physicians and providers, an indication of whether an active access plan under §11.1607 of this title (relating to Accessibility and Availability Requirements) applies to the services furnished by that class of physician or provider in the service area or region, and how the access plan may be obtained or viewed, if applicable; and

(3) for hospitals, the number of contracted hospitals in the service area or region, an indication of whether an active access plan in compliance with §11.1607 of this title applies to hospital services in that service area or region, and how the access plan may be obtained or viewed, if applicable.

(f) Website disclosures. An HMO must provide information on its website for use by current or prospective enrollees that includes a:

(1) physician and provider listing for use by current and prospective enrollees; and

(2) listing of the state regions, counties, or three-digit ZIP code areas within the HMO's service area, indicating, as appropriate, for each region, county, or ZIP code area, as applicable, that the HMO has:

(A) determined that its network meets the network adequacy requirements of this subchapter; or

(B) determined that its network does not meet the network adequacy requirements of this subchapter.

(g) Reliance on physician and provider listing in certain cases. A claim for services rendered by a noncontracted physician or provider must be paid in the same manner as if no contracted physician or provider had been available under §11.1611 of this title (relating to Out-of-Network Claims; Non-Network Physicians and Providers), as applicable, and the HMO must make restitution to the enrollee for any amounts the enrollee demonstrates that they paid the physician or provider above what they would have paid a network physician or provider, if an enrollee demonstrates that:

(1) in obtaining services, the enrollee reasonably relied on a statement that a physician or provider was a contracted physician or provider as specified in:

(A) a physician and provider listing; or

(B) provider information on the HMO's website;

(2) the physician and provider listing or website information was obtained from the HMO, the HMO's website, or the website of a third party designated by the HMO to provide that information for use by its enrollees; and

(3) the physician and provider listing or website information was obtained not more than 30 days before the date of services.

(h) Additional listing-specific disclosure requirements. In all contracted physician and provider listings, including any web-based postings of information made available by the HMO to provide information to enrollees about contracted physicians and providers, the HMO must comply with the requirements in Insurance Code Chapter 1451, Subchapter K, and paragraphs (1) and (2) of this subsection. The requirements of this subsection do not apply to provider listings for a single health care service that provides coverage only for dental or vision care.

(1) The physician and provider information must provide a method by which enrollees may identify contracted facility-based physicians and providers able to provide services at contracted facilities, consistent with Insurance Code §1451.504, concerning Physician and Health Care Provider Directories.

(2) The physician and provider information must specifically identify any network facility at which the HMO has no contracts with a class of facility-based physician, specifying the applicable type of facility-based physician, consistent with Insurance Code Chapter 1456, concerning Disclosure of Provider Status.

(i) Annual enrollee notice concerning use of an access plan. An HMO operating a plan that relies on an access plan as specified in §11.1600 of this title (relating to Information to Prospective and Current Contract Holders and Enrollees) and §11.1607 of this title must provide notice of this fact to each enrollee participating in the plan at issuance and at least 30 days before renewal. The notice must include a link to any webpage listing of information on network waivers and access plans made available under subsection (e) of this section.

(j) Disclosure of substantial decrease in the availability of certain contracted physicians or providers. An HMO is required to provide notice as specified in this subsection of a substantial decrease in the availability of contracted facility-based physicians or providers at a contracted facility.

(1) A decrease is substantial if:

(A) the contract between the HMO and any facility-based physician or provider group that comprises 75% or more of the contracted physicians or providers for that specialty at the facility terminates; or

(B) the contract between the facility and any facility-based physician or provider group that comprises 75% or more of the contracted physicians or providers for that specialty at the facility terminates, and the HMO receives notice as required under §11.901 of this title (relating to Required and Prohibited Provisions).

(2) For purposes of this subsection, decreases in numbers of physicians and other providers must be assessed separately, but no notice of a substantial decrease is required if:

(A) alternative contracted physicians or providers of the same specialty as the physician or provider group that terminates a contract as specified in paragraph (1) of this subsection are made available to enrollees at the facility so the percentage level of contracted physicians or providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available before the substantial decrease; or

(B) the HMO determines that the termination of the contract has not caused the network to be noncompliant with the adequacy standards specified in §11.1607 of this title, as those standards apply to the applicable physician or provider specialty.

(3) An HMO must prominently post notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and the resulting decrease in availability of contracted physicians or providers on the portion of the HMO's website where its physician and provider listing is available to enrollees.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of physicians or providers must be maintained on the HMO's website until the earlier of:

(A) the date on which adequate contracted physicians or providers of the same specialty become available to enrollees at the facility at the percentage level specified in paragraph (2)(A) of this subsection; or

(B) six months from the date that the HMO initially posts the notice.

(5) An HMO must post notice as specified in paragraph (3) of this subsection and update its web-based contracted physician and provider listing as soon as practicable and in no case later than two business days after:

(A) the effective date of the contract termination as specified in paragraph (1)(A) of this subsection; or

(B) the later of:

(i) the date on which an HMO receives notice of a contract termination as specified in paragraph (1)(B) of this subsection; or

(ii) the effective date of the contract termination as specified in paragraph (1)(B) of this subsection.

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

Filed with the Office of the Secretary of State on March 10, 2025.

TRD-202500844
Jessica Barta
General Counsel
Texas Department of Insurance
Effective date: March 30, 2025
Proposal publication date: September 20, 2024
For further information, please call: (512) 676-6555

♦ ♦ ♦

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER O. STATE AND LOCAL SALES AND USE TAXES

34 TAC §3.330

The Comptroller of Public Accounts adopts amendments to §3.330, concerning data processing services, with changes to the proposed text as published in the September 13, 2024, issue of the *Texas Register* (49 TexReg 7307). The rule will be republished. The comptroller amends this section to clarify existing definitions; to add new definitions; to list examples of services that are included in and excluded from taxable data processing services; to describe data processing that is not taxable; to explain the incidence of the tax; and to update provisions related to the collection of local sales and use taxes on data processing services. The amendments implement language in Senate Bill 153, 87th Legislature, 2021, regarding payment processing. Other revisions improve the clarity and readability of the section.

During the public comment period, the comptroller received comments regarding adoption of the amendment from the following:

Oscar Rodriguez, President, Texas Assn. of Broadcasters

Renzo Soto, Executive Director, Texas and Southwest, TechNet

Michael J. Behm, Executive Director, The Payments Coalition

Peter Chandler, Executive Director, Internet Works

Stephen Long, Partner, Baker McKenzie

Helen Brantley, Legal Analyst, Texas Taxpayers and Research Assn. (TTARA)

Patrick Reynolds, President and Executive Director, Council on State Taxation (COST)

On December 6, 2024, the comptroller held a public hearing at the request of Helen Brantley on behalf of TTARA and Patrick J. Reynolds on behalf of COST.

The comptroller received comments at the public hearing from the following:

Brian Pannell, Tax Director, Dell Technologies

Stephen Long, as an individual

Helen Brantley, TTARA

Jennifer Rabb, President, TTARA

Leonore Heavey, Senior Tax Counsel, COST

Ben Geslison, Partner, Baker Botts

Asha Kangralkar, Founder of Avacraft

Mohamad Sam, COO of Purifyou LLC

The individual comments will be addressed throughout the preamble.

Subsection (a) provides definitions. The comptroller amends the general definition of "data processing service" in paragraph (1) to list the operative words included as examples of "data processing service" in Tax Code, §151.0035(a)(1) ("Data Processing Service"). The comptroller amends and moves the examples to subsection (b). The comptroller deletes existing language regarding internet access services as they are no longer taxable.

The comptroller adds new subparagraph (A) listing services that are specifically included in data processing service under Tax Code, §151.0035.

The comptroller adds new subparagraph (B) listing services that are specifically excluded from data processing service under Tax Code, §151.0035, including services added by Senate Bill 153.

The comptroller received a comment from Michael Behm regarding the examples included for payment processing. Mr. Behm believes the intent of Senate Bill 153 is to broadly exclude fees for electronic payment transactions, including those between a merchant and a payment processor. The comptroller declines to add additional language that is not present in Senate Bill 153. If the merchant does not meet the definitions of one of the enumerated parties, their services are not excluded from data processing services based on Senate Bill 153.

The comptroller adds new subparagraph (C) to exclude some data processing that might otherwise be included in "data processing service" as described in Tax Code, §151.0035. The comptroller adds subparagraph (C) under its exclusive jurisdiction to interpret taxable services, as provided in Tax Code, §151.0101(b) ("Taxable Services").

Subparagraph (C) provides that a data processing service will not be taxable if it is sold for a single charge with another service, the data processing service does not have a separate value, and the data processing service is ancillary to the other service.

New clause (i) provides that if the data processing service is sold for a single charge with another service that does not have a separate value, and the other service is ancillary to the data processing service, the entire charge will be taxable as a data processing service.

New clause (ii) provides that if the data processing service has a separate value and is sold or purchased for a single charge with a nontaxable related service, subsection (e) applies.

New clause (iii) identifies factors that the comptroller may consider in determining whether the data processing service has a "separate value." The "separate value" requirement is drawn from *Rylander v. San Antonio SMSA Ltd. P'ship.,* 11 S.W.3d 484, 488 (Tex. App.-Austin 2000, no pet.). The opinion uses the "separate value" concept in evaluating whether services could be segregated for taxation purposes.

The "separate value" requirement of clause (iii) is also consistent with the comptroller's longstanding rule, retained in subsection (e)(3), which provides for the segregation of nontaxable and taxable services sold or purchased for a single charge.

The comptroller explains the "ancillary" requirement in new clause (iv). The requirement is similar to the current provision that excludes data processing service if it "facilitates the performance" of another service. But clause (iv) identifies specific factors, which are not in the current rule. Clause (iv) also states that the test for determining whether a data processing service is "ancillary" to a nontaxable service is not an essence of the transaction test. The essence of the transaction test attempts to determine what the buyer ultimately wants. *Combs v. Chevron, Inc.,* 319 S.W.3d 836, 843 (Tex. App.-Austin 2010, pet. denied) ("underlying goal"). Instead, the evaluation is based on what the service provider is doing.

The comptroller received comments from Michael Behm, Renzo Soto, Patrick Reynolds, Leonore Heavey, Helen Brantley, Jennifer Rabb, Brian Pannell, and Benjamin Geslison regarding the "ancillary" standard instead of the "essence of the transaction test." Mr. Reynolds and Ms. Heavey commented that the change was made without the involvement of the Texas Legislature. Both were concerned that there would be an expansion of the sales tax base to more services. They requested that the comptroller allow the Texas Legislature to make the change instead of adopting the proposed language.

Ms. Heavey also commented that the proposed amendments primarily target business purchases. She states that imposing sales tax on business-to-business transactions specifically violates the tax policy principles of neutrality, equity, simplicity, and transparency, and causes economic distortion. The comptroller declines to add an exception to taxable data processing services for business-to-business transactions as this type of change would require a legislative change.

Ms. Brantley commented that the comptroller lacks the authority to promulgate subsection (a)(1)(C) because the new test would conflict with the essence of the transaction text under *Bullock v. Statistical Tabulating Corp.,* 549 S.W.2d 166 (1977) Additionally, she commented the agency does not have "exclusive jurisdiction to interpret taxable services," but shares that jurisdiction with the courts and states that a comptroller interpretation cannot conflict with judicial jurisprudence. She also states the comptroller may not interpret terms in a manner contrary to the Tax Code, citing to *Hegar v. CheckFree Servs. Corp*. She requests that subsection (a)(1)(C)(iii) be revised to clarify that the phrase "commonly provided" is to be applied in the context of the seller's industry.

Ms. Brantley also requested that subsection (a)(1)(C) be rephrased to clarify that the taxpayer's burden is only to rebut the comptroller's prima facie case that a service is a taxable data processing service. She commented that proposed subsection (a)(1)(C) creates an exclusion from the definition of data processing services and then purports to shift the burden to the taxpayer to prove that a service falls within the exclusion, which she commented improperly shifts the comptroller's burden to make a prima facie case that a service is taxable. She proposes that this paragraph be rephrased to state that "if the comptroller makes a prima facie showing that a service is a taxable data processing service because it is not ancillary to a nontaxable related service and has a separate value, then the taxpayer has the burden to prove that the data processing is ancillary and has no separate value."

Ms. Brantley also commented that focusing on the "ancillary" test rather than the "essence of the transaction" test may sometimes violate Internet Tax Freedom Act (ITFA), as it may ultimately tax services with non-digital analogs that are not taxed in Texas because it focuses on how the service is performed rather than the nature of the service itself.

The comptroller declines to make Ms. Brantley's suggested changes regarding burden of proof. While the rule explains the basis for determining whether a service is data processing, it does not change the burden of proof. The comptroller will still be required to show a service involves computerized data entry, data retrieval, data search, information compilation, or other computerized information storage or manipulation. Additionally, taxing data processing services does not violate ITFA because the basis for taxing these services is that they are computerized and not that they are provided over the internet.

Ms. Rabb commented that the "ancillary," "separate value," and "repetitive or routine manipulation of data" tests are not supported by any action of the legislature or Texas courts as it does not flow from the *Black, Mann & Graham* case. Mr. Geslison commented that in repudiating the common law "essence of the transaction" test, and instead imposing an "ancillary service" with no "separate value" test, the comptroller is giving the impression that only those taxpayers with the means to pursue extended litigation will be able to benefit from showing that data processing is not the essence of their customer transaction.

Mr. Pannell commented that the characterization in the preamble of the proposed rule that a buyer "would never want the manipulation of data for its own sake" was not reflective of current technology in such areas as artificial intelligence and data migration services. The comptroller is not using this sentence in the preamble to the adopted rule.

The comptroller declines to make any additional changes to subsection (a)(1)(C). The 3rd Court of Appeals in Austin, and

now the 15th Court of Appeals, have not ruled on whether the essence of the transaction test is appropriate for distinguishing taxable data processing services from other nontaxable services. In the *Instill* opinion, and in *Black, Mann & Graham* opinion, the 3rd Court of Appeals stated that it would be "assuming, for the sale of argument," and that it would "assume without deciding" that the essence of the transaction test applied. *Instill Corp. v. Hegar,* No. 03-18-00374-CV at *13 (Tex. App. Austin May 31, 2019, pet. denied); *Hegar v. Black, Mann, & Graham. L.L.P.,* No. 03-20-00391-CV (Tex. App.- Austin 2022) (mem. op.) at *27. Additionally, *Statistical Tabulating Corp, supra,* that is relied upon by the commentors applied the essence of the transaction test in a different context- to determine whether an indivisible transaction is a taxable sale or rental of tangible personal property or a nontaxable intangible. *Statistical Tabulating Corp, supra,* predates the taxation of services, and thus does not contain a robust analysis that addresses the sale of taxable services combined with the sale of nontaxable services.

The *Check-Free* case is the only decision holding that the essence of the transaction test is appropriate to determine whether an indivisible transaction was a taxable data processing service or a nontaxable service. *Hegar v. CheckFree Servs. Corp.,* No. 14-15-00027-CV (Tex. App. Houston [14th Dist.] Apr. 19, 2016, no pet.) (mem. op.) But *CheckFree* was decided by the 14th Court of Appeals, and the 3rd Court of Appeals was not bound, and now the 15th Court of Appeals is not bound, by the decision of a sister court. *See, Satterfield v. Crown Cork & Seal Co., Inc.,* 268 S.W.3d 190, 207 (Tex. App. Austin 2008, no pet.) ("we are not bound to follow the decision of another court of appeals").

Furthermore, the 3rd Court of Appeals, when it was the intermediate appellate court with primary appellate jurisdiction, indicated that the essence of the transaction test was inappropriate regarding taxable data processing services. The Court stated that the reference to purpose in the current rule "did not create an independent 'purpose' prong that must be satisfied in every case," and the imposition of such a requirement "could raise questions about its validity." *Hegar v. Black, Mann, & Graham. L.L.P.,* No. 03-20-00391-CV (Tex. App.- Austin 2022) (mem. op.) at *10 and n. 11. Therefore, "basic purpose," "ultimate object," or "underlying goal" should not be used as a determining factor. The operative words of the statute focus on what the vendor is doing, and so does the adopted rule.

Therefore, in determining whether a data processing service is "ancillary" to a nontaxable service, the comptroller will focus on what the seller is doing, and not the buyer's purpose. The repetitive or routine manipulation of data by the seller is a factor suggesting that the activity is not ancillary and should be taxable as a data processing service, while the manipulation of data that depends on the external knowledge and discretionary judgment of the seller suggests that the activity is ancillary and should not be taxable as a data processing service.

For example, the insertion of data into form title or loan documents for a client would ordinarily be a taxable data processing service. The primary service is the compilation, retrieval, and accurate manipulation of the data into the forms, even though there may be an ancillary element of independent judgement in correctly entering the data. However, the preparation of a title opinion would not ordinarily be a taxable data processing service. The primary service is the application of legal knowledge and judgement to a set of facts, even though there may be ancillary elements of data processing. The "ultimate goal" of the preparation of loan documents and the preparation of title opinions may be the same - to close a real estate deal. But one service is a taxable data processing service because it requires the repeated application of the same process to different data, albeit with skill and expertise; and the other service is not a taxable data processing service because it produces a solitary result based on legal principles. These examples are illustrated in the recent opinion in *Hegar v. Black, Mann, & Graham, L.L.P.,* No. 03-20-00391-CV, 2022 WL 567853 (Tex. App. Austin Feb. 25, 2022, no pet.).

The comptroller amends paragraph (2) to delete the definition of "internet" as that term is already defined in Tax Code, §151.00393 (Internet). The comptroller adds a new definition of "downstream payment processor" based on the language in Senate Bill 153 that incorporates the definition in 7 TAC §33.4(c) (Payment Processors) as that provision existed on January 1, 2021.

The comptroller amends paragraph (3) to delete the definition of "internet access services" as the statutory reference to that definition is now listed in subsection (a)(1)(B)(i) and a separate definition is no longer necessary. The comptroller adds a new definition of "point of sale payment processor" based on the language in Senate Bill 153 that incorporates the definition in 7 TAC §33.4(d) as that provision existed on January 1, 2021.

The comptroller adds new paragraph (4) to add a definition of "settling of an electronic payment transaction" based on the language in Senate Bill 153.

The comptroller moves the existing text of current subsection (b) to amended subsection (c)(2), with changes. Amended subsection (b) provides examples that apply the definition of "data processing service."

The comptroller adds new paragraphs (1)-(3) to restate text from current subsection (a)(1) that payroll services, business accounting, and the preparation of financial statements are data processing services. The comptroller includes revised example language from existing subsection (a)(1) in new paragraph (3).

The comptroller adds new paragraph (4) based on the holding in *Hegar v. Black, Mann, & Graham, L.L.P.,* No. 03-20-00391-CV, 2022 WL 567853 (Tex. App. Austin Feb. 25, 2022, no pet.), which held the preparation of form title or loan documents is taxable data processing.

The comptroller adds new paragraph (5) to clarify that marketplace providers may provide data processing services to their customers if they enter, retrieve, search, manipulate, and store data or information in the course of their business. This paragraph will not become effective until October 1, 2025.

The comptroller received public comments or public testimony during the hearing on December 6, 2024, regarding this paragraph from Helen Brantley, Renzo Soto, Peter Chandler, Mohamad Sam, and Asha Kangralkar.

Mr. Soto, Mr. Chandler, Mr. Sam, and Ms. Kangralkar commented that taxing the data processing services of marketplace providers would have an adverse impact on marketplace sellers.

Mr. Soto commented that many online marketplace platforms are offered nationally, and the proposed changes might violate ITFA by specifically targeting electronic commerce as commissions earned by auctioneers of oil and gas leases, consignment stores, and real estate agents using computers remain untaxed. Mr. Soto also commented that many online marketplace

providers are "already absorbing Texas sales taxes for taxable goods or services" and taxing marketplaces in the data processing definition would be double taxation. The comptroller declines to make any changes based on these comments. Taxing these services as data processing is not discriminatory and does not violate ITFA, as the basis for taxing the services is that they are computerized and not that they are provided over the internet. The sale of an item through a marketplace is separate from the sale of data processing services to a seller who makes sales on the marketplace and the collection of sales or use tax on those separate transactions is not "double taxation."

Ms. Brantley commented that classifying marketplace provider services as taxable data processing does not apply the "essence of the transaction" test and that it would wrongly convert many charges akin to a nontaxable auctioneer or broker service into a taxable data processing service. Ms. Brantley also proposed that the comptroller clarify that the exclusion of charges by marketplace providers from the "settling of an electronic payment transaction" does not mean the charges are taxable data processing.

The comptroller declines to make any changes to new paragraph (5) as the statutory language is clear that marketplace provider services are not included in the exclusion from data processing for the settling of an electronic payment transaction based on Senate Bill 153. Marketplaces provide taxable data processing as their services involve computerized data storage and manipulation for their customers. For example, their services may include storing product listings and photographs, maintaining records of transactions, processing product orders, and compiling analytics. All of these activities fall under the definition of taxable data processing services. The comptroller adopts a delayed implementation of this paragraph to October 1, 2025, to allow the Texas Legislature time to consider addressing this issue.

The comptroller adds new paragraph (6) to clarify that internet hosting as defined by Tax Code, §151.108 (Internet Hosting) is taxable data processing.

The comptroller adds new paragraph (7) to clarify that video streaming subscriptions are taxable cable television services under Tax Code, §151.0033 ("Cable Television Service"). See also §3.313 of this title (relating to Cable Television Service and Bundle Cable Service).

The comptroller adds new paragraph (8) to clarify that streaming video gaming subscriptions are taxable amusement services as set forth in Tax Code, §151.0028 ("Amusement Services") and in STAR Accession No. 201405957L (May 28, 2014). These services are not taxable data processing services.

The comptroller adds new paragraph (9) to provide that the compilation of nontaxable opinion polls and survey information as described by §3.342 of this title (relating to Information Services), is not taxable data processing if the data processing is ancillary to the acquisition of the information and the service provider's expertise is not managing data, such as in an inventory management service.

The comptroller adds new paragraph (10) to provide that the compilation of nontaxable information derived from laboratory, medical, or exploratory testing or experimentation as described by §3.342 of this title is not taxable data processing if the data processing is ancillary to the provision of the information.

The comptroller adds new paragraph (11) to add an example from Comptroller's Decision No. 118,253 (2024) regarding the taxability of data migration services. This example is different from the example in the proposed rule published in the September 13, 2024 issue of the *Texas Register* (49 TexReg 7307) concerning computerized three-dimensional rendering. The comptroller deletes the earlier example as it did not provide adequate guidance for taxpayers, as some three-dimensional rendering may instead be graphic art, described in §3.312 of this title, (relating to Graphic Art or Related Occupations; Miscellaneous Activities).

The comptroller adds new paragraph (12) to include website creation, repair, and maintenance as examples of data processing when they involve the storage, manipulation, compilation, and entry of data. These examples are based on Comptroller's Decision Nos. 115,774 (2021) and 44,736 (2005), as well as STAR Accession Nos. 200009755L (September 27, 2000), 202010013L (October 22, 2020) and 202402020L (February 20, 2024).

Mr. Rodriguez commented that subsection (b)(12) states search engine optimization, social media marketing and lead generation are taxable data processing, but that we do not define these services or offer any rationale that justifies categorizing them as taxable data processing. He believes that the language clarifying that they are taxable only "when they involve the storage, manipulation, compilation, and entry of data" is too broad to distinguish taxable services from nontaxable ones. Mr. Rodriguez requests we either delete these services from paragraph (b)(12) or define them in subsection (a) and add language in subsection (b) that states they are only taxable data processing services if the services are performed by computers and compromise edits to the purchaser's website, the services are not proprietary information services, and the services are not advertising. Mr. Rodriguez also commented that subsection (b)(12) regarding social media marketing is a violation of ITFA and Texas law as it may contain nontaxable advertising.

Ms. Brantley also requested that we define the terms "search engine optimization," "social media marketing," and "lead generation" in subsection (a).

The comptroller agrees to remove the terms "social media marketing," "lead generation," and "search engine optimization" from subsection (b)(12) as they did not provide sufficient guidance to taxpayers. However, the comptroller will review these on a case-by-case basis to determine whether a taxpayer's services meet the definition of data processing. Additionally, subsection (b)(12) does not violate ITFA, as the basis for taxing the services is that they are computerized and not that they are provided over the internet.

The comptroller moves current subsection (c) to amended subsection (d), with changes, and titles new subsection (c) "Imposition of tax, permits."

The comptroller adds new paragraph (1) to provide that the use of data processing service is subject to state sales and use tax and that local sales and use tax may also be imposed.

The comptroller adds new paragraph (2) that contains language moved from current subsection (b) and restates that providers of data processing services must obtain a Texas sales and use tax permit. The paragraph includes the permitting safe harbor for small remote sellers as set forth in §3.286(b)(2) of this title (relating to Seller's and Purchaser's Responsibilities).

The comptroller adds new paragraph (3) that contains language moved from current subsection (a)(1) stating that a data processing service is taxable regardless of the ownership of the computer or whether that data is provided by the customer or the customer's authorized designee.

The comptroller adds new paragraph (4) to restate the language from current subsection (b) which exempts 20% of the amount charged for data processing services from sales and use tax based on Tax Code, §151.351 (Information Services and Data Processing Services).

The comptroller amends relettered subsection (d), formerly subsection (c), to update the storage medium used in the example from a magnetic tape to a Universal Serial Bus (USB) drive.

The comptroller amends relettered subsection (e), formerly subsection (d). The substantive effect of subsection (e) is the same as former subsection (d). However, the comptroller replaces the term "unrelated service" with the term "nontaxable related service" to conform to the ordinary usage of the terms. Subsection (e) applies when multiple services are sold or purchased for a single charge. Because the services are sold or purchased for a single charge, the services are in some manner going to be "related," as that term is ordinarily used, even if they are also distinct. When services are related by a common charge, and the services are each also commonly provided on a stand-alone basis, and the performances are distinct and identifiable, then the single charge may be segregated under the conditions described in subsection (e).

Ms. Brantley commented that the language in subsection (e) using "unrelated services" should not be changed to "nontaxable related services" as it takes it out of alignment with other rules. The comptroller declines to adopt Ms. Brantley's suggestion to continue using the existing language, as the other administrative rules will be updated in the future to reflect the changes in amended subsection (e).

The comptroller reletters subsection (f), formerly subsection (e).

The comptroller amends relettered subsection (g), formerly subsection (f) and retitles it "Determining the incidence of the tax." The comptroller moves current text in subsection (g) regarding local taxes to relettered subsection (h). Relettered subsection (g) also includes additional nonsubstantive changes to further clarify how a purchaser may substantiate a multistate benefit.

The comptroller amends paragraph (1) to restate the statutory definition of "use" in Tax Code, §151.011 ("Use" and "Storage"). The comptroller deletes the current presumption language in paragraph (1) regarding a separate, identifiable segment of a customer's business. The comptroller replaces current presumption language by the presumption in paragraph (2) that more closely follows the statutory presumption in Tax Code, §151.104(a) (Sale for Storage, Use, or Consumption Presumed).

The comptroller amends paragraph (2) to restate statutory language in Tax Code, §151.104(a) regarding presumption of use in Texas. The comptroller moves language in current paragraph (2) regarding business conducted both inside and outside the state to amended paragraph (3) and moves language regarding multistate customers' method of allocation to new paragraph (6).

The comptroller amends paragraph (3) and adds new subparagraphs (A) and (B) to restate statutory language in Tax Code, §151.104 and §151.330 (Interstate Shipments, Common Carriers, and Services Across State Lines). The comptroller moves language in current paragraph (3) regarding a multistate customer providing an exemption certificate to new paragraph (6).

The comptroller amends paragraph (4) to restate statutory language in Tax Code, §151.101 (Imposition of Use Tax) and to be consistent with the interpretation of statute in Comptroller's Decision No. 116,293 (2022). The comptroller deletes language in current paragraph (4) regarding identifiable segments of a business as the revised subsection follows the statutory guidelines more closely.

The comptroller amends paragraph (5) to restate statutory language in Tax Code, §151.303(c) (Previously Taxed Items: Use Tax Exemption or Credit) and §3.338 of this title (relating to Multistate Tax Credit and Allowance of Credit for Tax Paid to Suppliers). The comptroller deletes language in current paragraph (5) regarding services that cannot be assigned to an identifiable segment of a business, as the revised subsection follows the statutory guidelines more closely.

The comptroller adds new paragraph (6) to restate language moved from current paragraph (3) regarding multistate customers issuing exemption certificates, with non-substantive changes to improve readability.

The comptroller adds new subparagraph (A) to restate language moved from current paragraph (2) regarding the method used for business records to allocate a data processing service used both within and outside Texas.

The comptroller adds new subparagraph (B) to add language regarding the good faith acceptance of an exemption certificate as set forth in §3.287 of this title (relating to Exemption Certificates).

Mr. Pannell commented that the deletion of "separate and identifiable segment of business" from the multistate benefit section of the section will greatly streamline taxpayer compliance and audit processes.

Ms. Brantley commented that the language in subsection (g) is not clear and does not follow the language in Tax Code, §151.330. She additionally comments that inconsistent sourcing rules across jurisdictions will lead to double taxation and increase costs for businesses. Mr. Soto also expressed that the sourcing provisions in subsection (g) and subsection (h) are unclear and requested the comptroller provide sourcing guidance specific to marketplace providers for both state and local taxes. Mr. Long commented that the sourcing of data processing services in real property marketplaces in subsections (g) and (h) can lead to different results for similar real property rentals depending on where the sale "is consummated" or the data processing service is "used." Mr. Long proposes adding presumption language to subsections (g) and (h) that would source the data processing services to the location of the property. The comptroller declines to make any changes based on these comments, as the language in subsection (g) simply adopts the provisions of Tax Code, §§151.011 (Use and Storage), 151.104 (Sale for Storage, Use, or Consumption Presumed), and 151.330 (Interstate Shipments, Common Carriers, and Services Across State Lines) within the context of data processing services. Any inconsistent sourcing language is a result of multiple statutes with conflicting language.

For example, Tax Code, §151.104(a) establishes a presumption that the agency must follow for state sales tax. This section states "A sale of a taxable item by a person for delivery in this state is presumed to be a sale for storage, use, or consumption in this state unless a resale or exemption certificate is accepted

by the seller." The agency must also follow the local tax consummation principles of Tax Code, Chapter 321.203 (Consummation of Sale), which do not allow for Mr. Long's proposed presumption. Under that section, local sales taxes are sourced based on the seller's set of facts which may result in sales sourced to where an order is received, to where an order is fulfilled, or to where an order is delivered.

The comptroller amends relettered subsection (h), formerly (g) regarding local taxes.

The comptroller amends paragraph (1) to provide general guidance on the consummation of sale for local sales tax and directs taxpayers to §3.334 of this title (relating to Local Sales and Use Taxes) and deletes the existing language.

The comptroller amends paragraph (2) to provide general guidance on determining local use tax and directs taxpayers to §3.334 of this title and to delete language that is now located in §3.334 of this title.

Language in former subparagraph (A) remains as new paragraph (3). The comptroller deletes subparagraph (B) as that language is now located in new subsection (g)(6).

The comptroller adds subsection (i) to restate former subsection (h) and to make minor changes for readability.

The comptroller adds new paragraphs (1) and (2) to clarify when a customer is responsible to report use tax due on the purchase of taxable data processing services under Tax Code, §151.101.

In addition to the specific comments addressed throughout the preamble, the following general comments were made: Mr. Chandler commented that there is no legislative or judicial action that supports the amendments, and the proposed changes should instead be addressed by the legislature. He stated that if the comptroller goes forward with the amendment to the rule it should only be applied prospectively. Ms. Heavey also commented that policy changes should be prospective only as "administrative changes imposing new or increased tax liabilities attributable to prior periods is fundamentally unfair...."

Mr. Reynolds and Mr. Soto also commented that the changes in administrative policy should only be applied prospectively. The comptroller declines to make any changes based on these comments, as §3.330 formally adopts current policy regarding services that meet and that do not meet the definition of data processing. The policy related to these services has been communicated through agency letters and upheld in Comptroller's Decisions.

The comptroller adopts the amendments under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture), which provide the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of provisions of Tax Code, Title 2 (State Taxation), and taxes, fees, or other charges or refunds which the comptroller administers under other law.

The amendments implement Tax Code, §§151.0035 ("Data Processing Services"), 151.0101 (Taxable Services), 151.105 (Importation for Storage, Use, or Consumption Presumed), 151.330 (Interstate Shipments, Common Carriers, and Services Across State Lines), 151.351 (Information Services and Data Processing Services), 321.203 (Consummation of Sale), and 321.205 (Use Tax).

§3.330. Data Processing Services.

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

(1) Data processing service--the computerized entry, retrieval, search, compilation, manipulation, or storage of data or information.

(A) Data processing service includes:

(i) word processing;

(ii) payroll and business accounting data production;

(iii) the performance of a totalizator service with the use of computational equipment required by Occupations Code, Subtitle A-1, Title 13, (Texas Racing Act); and

(iv) the use of a computer or computer time for data processing whether the processing is performed by the provider of the computer or computer time or by the purchaser or other beneficiary of the service.

(B) Data processing services do not include:

(i) Internet access service as defined by Tax Code, §151.00394 (Internet access service);

(ii) the transcription of medical dictation by a medical transcriptionist;

(iii) the display of a classified advertisement, banner advertisement, vertical advertisement, or link on an Internet website owned by another person;

(iv) services exclusively to encrypt electronic payment information for acceptance onto a payment card network that allows a person to accept a specific brand of debit or credit card by routing information and data to settle an electronic payment transaction, to comply with standards set by the Payment Card Industry Security Standards Council; or

(v) settling of an electronic payment transaction by:

(I) a downstream payment processor or point of sale payment processor or point of sale payment processor that routes electronic payment information to an entity described in subclause (II) or (III) of this clause;

(II) a federally insured financial institution, as defined by Finance Code, §201.101 (Definitions), that is organized under the laws of Texas, another state, or the United States, or an affiliate of the institution;

(III) a payment card network that allows a person to accept a specific brand of debit or credit card by routing information and data to settle an electronic payment transaction;

(IV) a person who has entered into a sponsorship agreement with an entity described in subclause (II) of this clause for the purpose of processing that entity's electronic payment transactions through a payment card network; or

(V) a person who is engaged in the business of money transmission and required to obtain a license under Finance Code, §152.101 (Money Transmission License Required).

(C) Under its exclusive jurisdiction to interpret taxable services, the comptroller excludes from the definition of "data processing service," data processing that is sold for a single charge with another service if the data processing service does not have a separate value, and the data processing service is ancillary to the other service.

The burden is on the taxpayer to demonstrate that the data processing service does not have a separate value and is ancillary to the other service.

(i) If the data processing service is sold for a single charge with another service that does not have a separate value, and the other service is ancillary to the data processing service, the entire charge will be taxable as a data processing service.

(ii) If the data processing service is sold for a single charge with another service that has a separate value, subsection (e) of this section applies.

(iii) In determining whether the data processing service and the other service have separate values, the comptroller will consider whether the services are distinct and identifiable and whether each service is of a type that is commonly provided on a stand-alone basis or commonly provided as an additional service for a greater single charge.

(iv) In determining whether the data processing service is ancillary to another service, or conversely, whether the other service is ancillary to the data processing service, the comptroller may consider the extent to which the service provider exercises discretion or judgment in individual applications of the processed data based on knowledge of the physical sciences, accounting principles, law, or other fields of study. The routine or repetitive manipulation of data by the seller is a factor suggesting that the data processing activity is not ancillary to another service and should be taxable as a data processing service. The manipulation of data that depends on the external knowledge and discretionary judgment of the service provider in individual applications suggests that the data processing activity is ancillary to another service and should not be taxable as a data processing service. The provider's skill, experience, or expertise, in processing data or information is not a factor. Other factors may be considered, and the weight of the factors may vary from case to case. The evaluation is based on what the service provider is doing, not on what the customer wants.

(2) Downstream payment processor--A payment processor that acts as an intermediary between a consumer-facing entity that has incurred an outstanding money transmission obligation to a consumer, and the consumer's designated recipient.

(3) Point of sale payment processor--A payment processor that receives funds from a consumer on behalf of a consumer-facing entity that either sells goods or services other than money services or accepts charitable donations.

(4) Settling of an electronic payment transaction--The authorization, clearing, or funding of a payment made by credit card, debit card, gift card, stored value card, electronic check, virtual currency, loyalty program currency such as points or miles, or a similar method. The term does not include charges by a marketplace provider, as that term is defined by Tax Code, §151.0242 (Marketplace Providers and Marketplace Sellers).

(b) Examples of services that are and are not taxable data processing services.

(1) Payroll services, such as maintaining records of employee work time, computing and preparing payroll checks, filing payroll tax returns, and completing pre-printed employee-related forms such as W-2s, are taxable data processing services because they involve the routine and repeated simultaneous application of the same process to different data. The service provider's skill, experience, or expertise with payroll documents is not determinative.

(2) The production of business accounting data, such as inventory reports, is a taxable data processing service because it involves the routine and repeated simultaneous application of the same process to different data. The service provider's skill, experience, or expertise with business reports is not determinative.

(3) The preparation of financial statements kept in accordance with generally accepted accounting principles, is not a taxable data processing service, even though it has elements of data processing, because the categorization and characterization of the data is variable and depends upon the discretion and certified opinion of an accounting professional. For example, the use of a computer by a certified accounting firm, enrolled agent, or bookkeeping firm to produce a financial report or to prepare federal income tax or state franchise or sales tax returns is not taxable data processing services.

(4) The insertion of data into form title or loan documents for a client is taxable data processing because it involves the repeated application of the same process to different data. The service provider's skill or experience with title or loan documents is not determinative. The preparation of a title opinion is not included in taxable data processing, even though it has elements of data processing, because the result is solitary and depends upon the opinion or skills of a legal professional.

(5) Effective October 1, 2025, marketplace provider services may be included in taxable data processing services when they involve the computerized entry, retrieval, search, compilation, manipulation, or storage of data or information provided by the purchaser or the purchaser's designee. For example, services provided by a marketplace provider to its marketplace seller that store product listings and photographs, maintain records of transactions, and compile analytics are taxable data processing services.

(6) Internet hosting, as defined by Tax Code, §151.108 (Internet Hosting), is a taxable data processing service when the user stores data on the service provider's hardware, or processes data on software that is owned, licensed, or leased by the user or provider. An example is the provision of servers and operating systems that are used by a customer to store software applications and content that can be accessed by the customer's customers.

(7) Streaming video subscriptions are taxable as a cable television service but not as data processing services. See also §3.313 of this title (relating to Cable Television Service and Bundle Cable Service).

(8) Streaming video game subscriptions are taxable as an amusement service but not as data processing services. See also §3.298 of this title (relating to Amusement Services).

(9) The compilation of information that the service provider acquires from unrelated third parties through nontaxable opinion polls and surveys as described by §3.342 of this title (relating to Information Services) is not a taxable data processing service if the data processing is ancillary to the main service of data acquisition and the data processing does not have a separate value. However, if the service provider acquires and compiles data from the customer or the customer's designees, and the service provider's expertise is in managing the data, such as in inventory management, the main service is data processing and the service is taxable.

(10) The compilation of nontaxable information primarily derived from the service provider's laboratory, medical, or exploratory testing or experimentation or any similar method of direct scientific observation of physical phenomena as described by §3.342 of this title (relating to Information Services) is not a taxable data processing service if the data processing is ancillary to the main service and the data

processing does not have a separate value. Examples may be geophysical surveys, polygraph tests, and the recording and tracking of vital signs in medical treatment.

(11) Data migration services that transfer data from one storage device to another storage device is taxable data processing.

(12) Website creation, repair, and maintenance are taxable data processing services when they involve the storage, manipulation, compilation, and entry of data. However, simply developing a blueprint or plan for a website is not data processing services.

(c) Imposition of tax, permits.

(1) State sales and use tax and any applicable local sales and use tax are imposed on each sale or use of a data processing service in Texas.

(2) Except for small remote sellers described in §3.286(b)(2)(B) of this title (relating to Seller's and Purchaser's Responsibilities), a seller of data processing services must obtain a Texas sales and use tax permit and collect and remit tax on charges for data processing services, or accept properly completed resale, exemption, or direct pay permit certificates in lieu of collecting tax. See §3.285 of this title (relating to Resale Certificate; Sales for Resale); §3.287 of this title (relating to Exemption Certificates); §3.288 of this title (relating to Direct Payment Procedures and Qualifications).

(3) A charge for data processing services is taxable regardless of the ownership of the computer or whether the data is provided by the customer or the customer's authorized designee.

(4) Twenty percent of the total amount charged for data processing services is exempted from tax. If the data processing service is also taxable as another type of taxable service other than an information service, the twenty percent exemption does not apply.

(d) Resale certificates.

(1) Providers of data processing services may issue a resale certificate in lieu of tax to suppliers of tangible personal property only if care, custody, and control of the property is transferred to the client. For example, a service provider purchases a Universal Serial Bus (USB) drive to transfer the results of data processing services to customers. The USB drive is transferred to the customer, and the customer owns and uses the USB drive to review the results of the data processing service. The service provider may purchase the USB drive tax free by issuing a resale certificate. Tax is due on the total amount charged the customer, including amounts for the USB drive and for the services.

(2) A resale certificate may be issued for a service if the buyer intends to transfer the service as an integral part of taxable services. A service will be considered an integral part of a taxable service if the service purchased is essential to the performance of the taxable service and without which the taxable service could not be rendered.

(3) A resale certificate may be issued for a taxable service if the buyer intends to incorporate the service into tangible personal property which will be resold. If the entire service is not incorporated into the tangible personal property, it will be presumed the service is subject to tax and the service will only be exempt to the extent the buyer can establish the portion of the service actually incorporated into the tangible personal property. If the buyer does not intend to incorporate the entire service into the tangible personal property, no resale certificate may be issued, but credit may be claimed at the time of sale of the tangible personal property to the extent the service was actually incorporated into the tangible personal property.

(e) Nontaxable related services.

(1) A service will be considered as a nontaxable related service if:

(A) it is neither a data processing service, nor a service taxed under other provisions of the Tax Code, Chapter 151;

(B) each of the services provided are of a type which are commonly provided on a stand-alone basis; and

(C) the performance of the service is distinct and identifiable. Examples of such a service would be consultation, development of and preparation of feasibility studies, design and development, or training.

(2) Where nontaxable related services and taxable services are sold or purchased for a single charge and the portion relating to taxable services represents more than 5.0% of the total charge, the total charge is presumed to be taxable. The presumption may be overcome by the data processing service provider at the time the transaction occurs by separately stating to the customer a reasonable charge for the taxable services. However, if the charge for the taxable portion of the services is not separately stated at the time of the transaction, the service provider or the purchaser may later establish for the comptroller, through documentary evidence, the percentage of the total charge that relates to nontaxable related services. The service provider's books must support the apportionment between exempt and nonexempt activities based on the cost of providing the service or on a comparison to the normal charge for each service when provided alone. If the charge for exempt services is unreasonable when the overall transaction is reviewed considering the cost of providing the service or a comparable charge made in the industry for each service, the comptroller will adjust the charges and assess additional tax, penalty, and interest on the taxable services.

(3) Charges for services or expenses directly related to and incurred while providing the taxable service are taxable and may not be separated for the purpose of excluding these charges from the tax base. Examples would be charges for meals, telephone calls, hotel rooms, or airplane tickets.

(f) If both the data processing service provider and the customer are located in Texas, Texas tax is due.

(g) Determining the incidence of the tax.

(1) With respect to a taxable service, "use" means the derivation in Texas of direct or indirect benefit from the service.

(2) The sale of a data processing service that is delivered in Texas is presumed to be a sale for storage, use, or consumption in Texas until the contrary is established.

(3) A data processing service performed in Texas is subject to Texas sales tax unless an exemption applies.

(A) A data processing service performed in Texas for use entirely outside of Texas is exempt from sales tax.

(B) A data processing service performed in Texas for use both within and outside of Texas is exempt to the extent that the service is used outside Texas.

(4) A data processing service performed outside of Texas is subject to Texas use tax to the extent that the service is for use in Texas, unless an exemption applies.

(5) A purchaser of a data processing service performed outside of Texas for use in Texas may claim a credit for a similar tax paid in another state if that state provides a similar credit for a taxpayer in Texas.

(6) A purchaser asserting the use of a data processing service at its business locations in multiple states may issue to the service provider a form promulgated by the comptroller, or a substantially similar document that asserts the purchaser's concurrent multistate business use and represents that the purchaser will report and pay the state and local tax on the portion that is taxable and is not exempt.

(A) The multistate purchaser may use a reasonable and consistent method supported by its business records to allocate the service between its business locations.

(B) A service provider that accepts a multistate use certificate in good faith is relieved of responsibility for collecting and remitting Texas state and local sales and use taxes on transactions subject to the certificate.

(h) Local taxes.

(1) Local sales tax is due in a local jurisdiction where the sale is consummated. The sale may be consummated at a place of business of the seller where the order is received, a place of business of the seller where the order is fulfilled, or at the location to which the service is delivered. See §3.334 of this title (relating to Local Sales and Use Taxes).

(2) Local use tax may also be due in a local jurisdiction where a direct or indirect benefit from the service is derived if the 2.0% local tax cap has not been exceeded. See also §3.334 of this title.

(3) An in-state customer purchasing data processing services for the benefit of locations in more than one local taxing entity is responsible for issuing to the data processing service provider an exemption certificate claiming a multi-city benefit and for determining the extent of benefit for each entity. The local use tax for each entity must be reported, allocated, and paid by the customer. A data processing service provider that accepts in good faith an exemption certificate claiming a multi-city benefit is relieved of responsibility for collecting and remitting local tax on transactions to which the certificate relates.

(i) Use tax. The customer is responsible to report and pay use tax if the service provider:

(1) is not required to collect and remit the sales or use tax; or

(2) does not collect the correct amount of sales or use tax.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500892
Jenny Burleson
Director, Tax Policy
Comptroller of Public Accounts
Effective date: April 2, 2025
Proposal publication date: September 13, 2024
For further information, please call: (512) 475-2220

♦ ♦ ♦

CHAPTER 7. PREPAID HIGHER EDUCATION TUITION PROGRAM

SUBCHAPTER N. TEXAS ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) PROGRAM

34 TAC §7.198

The Comptroller of Public Accounts adopts amendments to §7.198, concerning ABLE program advisory committee, without changes to the proposed text as published in the December 27, 2024, issue of the *Texas Register* (49 TexReg 10490). The rule will not be republished.

The amendments to subsections (a) and (b) expand the categories of individuals eligible to serve on the committee to include representatives of the business, legal, or veteran community.

The amendment to subsection (e) allows the comptroller the flexibility of not appointing a replacement member to the committee provided the requirements of subsection (b) have been met.

The amendment to subsection (f) allows the presiding officer or comptroller flexibility in determining how frequently the committee meets.

The amendment to subsection (g) reduces the number of members required to be present to constitute a quorum.

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

The amendments are adopted under Education Code, §54.6181, which authorizes the Texas Prepaid Higher Education Tuition Board by rule to establish advisory committees to make recommendations on programs, rules, and policies administered by the board.

The amendments implement Education Code, §54.6181.

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

Filed with the Office of the Secretary of State on March 13, 2025.

TRD-202500894
Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Effective date: April 2, 2025
Proposal publication date: December 27, 2024
For further information, please call: (512) 475-2220

♦ ♦ ♦