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

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 353. MEDICAID MANAGED CARE

SUBCHAPTER A. GENERAL PROVISIONS

1 TAC §353.2, §353.4

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §353.2, concerning Definitions; and §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers.

BACKGROUND AND PURPOSE

The purpose of the proposed amendment to §353.4 is to require Medicaid health care managed care organizations (MCOs) to reimburse an out-of-network physician for providing Medicaid telemedicine medical services to a child in a primary or secondary school-based setting without prior authorization, even if the physician is not the child's primary care provider. This requirement is in accordance with Texas Government Code §531.0217(c-4) and is currently implemented through contracts between health care MCOs and HHSC. Texas Government Code §531.0217(c-4) was added by House Bill 1878, 84th Legislature, Regular Session, 2015, and amended by Senate Bill 670, 86th Legislature, Regular Session, 2019.

The proposed amendment to §353.2 adds definitions of "nursing facility," "nursing facility add-on services," "nursing facility services," and "nursing facility unit rate." The proposed amendment also removes a definition not used in the chapter.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.2 adds the definitions for "Nursing facility," "Nursing facility add-on services," "Nursing facility services," and "Nursing facility unit rate" to provide definitions of terms used in §353.4 and to align the definitions with language in managed care contracts. The proposed amendment removes the definition for "Main dental home provider" because this term is not used in the chapter.

The proposed amendment to §353.4 adds paragraph (3) to subsection (b) to include requirements for health care MCOs to reimburse out-of-network physicians for delivering a telemedicine medical service to a child in a primary or secondary school-based setting, even if the physician is not the child's primary care provider. The proposed amendment to add paragraph (3) to subsection (b) implements Texas Government Code §531.0217(c-4) and further aligns rule language with language in managed care contracts.

The proposed amendment to §353.4 reformats paragraph (1) of subsection (f) so that subparagraph (A) provides out-of-network nursing facilities that are located within the MCO's service area must be reimbursed at or above 95 percent of the nursing facility unit rate and subparagraph (B) provides out-of-network nursing facilities that are located outside of the MCO's service area must be reimbursed at or above 100 percent of the nursing facility unit rate. The proposed amendment also removes existing language in subparagraph (B) from paragraph (1) of subsection (f) as that language pertains to the definition of nursing facility unit rates, which is now defined in paragraph (77) of §353.2.

The proposed amendments to §353.2 and §353.4 also reformat the rules as necessary and make minor editorial changes.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

MCOs are currently contractually required to reimburse an out-of-network physician providing school-based telemedicine medical services. Therefore, HHSC will not be required to adjust the MCO capitation payment.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed rules will expand existing rules;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities to comply with the proposed rules. The rules only

apply to Medicaid MCOs and no Texas Medicaid MCO qualifies as a small business, micro-business, or rural community.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules do not impose a cost on regulated persons and are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit will be more clarity about what is required of health care MCOs regarding reimbursement for out-of-network physicians who provide telemedicine medical services in school-based settings.

Trey Wood has also determined that for the first five years the rules are in effect, there are no expected economic costs for those required to comply because there are no requirements to alter current business practices and there are no new fees or costs imposed on a health care MCO.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 701 W. 51st Street, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhs.texas.gov.*

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R038" in the subject line.

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules as necessary to carry out the commission's duties; Human Resources Code §32.021 and Texas Government Code §531.021(a), which authorize HHSC to administer the federal medical assistance (Medicaid) program; and Texas Government Code §533.002, which authorizes HHSC to implement the Medicaid managed care program.

§353.2. Definitions.

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

(1) Action--

(A) An action is defined as:

(i) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(ii) the reduction, suspension, or termination of a previously authorized service;

(iii) the failure to provide services in a timely manner;

(iv) the denial in whole or in part of payment for a service; or

(v) the failure of a managed care organization (MCO) to act within the timeframes set forth by the Texas Health and Human Services Commission (HHSC) and state and federal law.

(B) "Action" does not include expiration of a time-limited service.

(2) Acute care--Preventive care, primary care, and other medical or behavioral health care provided by the provider or under the direction of a provider for a condition having a relatively short duration.

(3) Acute care hospital--A hospital that provides acute care services.

(4) Adoption Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter H (relating to Adoption Assistance Program).

(5) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(6) Allowable revenue--All managed care revenue received by the MCO pursuant to the contract during the contract period, including retroactive adjustments made by HHSC. This would include any revenue earned on Medicaid managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated networks.

(7) Appeal--The formal process by which a member or his or her representative requests a review of the MCO's action.

(8) Applicant Provider--A physician or other health care provider applying for expedited credentialing as defined in Texas Government Code §533.0064.

(9) Behavioral health service--A covered service for the treatment of mental, emotional, or substance use disorders.

(10) Capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is responsible for payment.

(11) Capitation rate--A fixed predetermined fee paid by HHSC to the MCO each month, in accordance with the contract, for each enrolled member in exchange for which the MCO arranges for or provides a defined set of covered services to the member, regardless of the amount of covered services used by the enrolled member.

(12) CFR--Code of Federal Regulations.

(13) Children's Medicaid Dental Services--The dental services provided through a dental MCO to a client birth through age 20.

(14) Clean claim--A claim submitted by a physician or provider for health care services rendered to a member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A clean claim must meet all requirements for accurate and complete data as further defined under the terms of the contract executed between the MCO and HHSC.

(15) Client--Any Medicaid-eligible recipient.

(16) CMS--The Centers for Medicare & Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

(17) Complainant--A member, or a treating provider or other individual designated to act on behalf of the member, who files a complaint.

(18) Complaint--Any dissatisfaction expressed by a complainant, orally or in writing, to the MCO about any matter related to the MCO other than an action. Subjects for complaints may include:

(A) the quality of care of services provided;

(B) aspects of interpersonal relationships such as rudeness of a provider or employee; and

(C) failure to respect the member's rights.

(19) Consumer Directed Services (CDS) option--A service delivery option (also known as self-directed model with service budget) in which an individual or legally authorized representative employs and retains service providers and directs the delivery of certain program services.

(20) Covered services--Unless a service or item is specifically excluded under the terms of the state plan, a federal waiver, a managed care services contract, or an amendment to any of these, the phrase "covered services" means all health care, long term services and supports, or dental services or items that the MCO must arrange to provide and pay for on a member's behalf under the terms of the contract executed between the MCO and HHSC, including:

(A) all services or items comprising "medical assistance" as defined in §32.003 of the Human Resources Code; and

(B) all value-added services under such contract.

(21) Credentialing--The process through which an MCO collects, assesses, and validates qualifications and other relevant information pertaining to a Medicaid enrolled health care provider to determine whether the provider may be contracted to deliver covered services as part of the network of the managed care organization.

(22) Cultural competency--The ability of individuals and systems to provide services effectively to people of various disabilities, cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

(23) Day--A calendar day, unless specified otherwise.

(24) Default enrollment--The process established by HHSC to assign a Medicaid managed care enrollee to an MCO when the enrollee has not selected an MCO.

(25) Dental contractor--A dental MCO that is under contract with HHSC for the delivery of dental services.

(26) Dental home--A provider who has contracted with a dental MCO to serve as a dental home to a member and who is responsible for providing routine preventive, diagnostic, urgent, therapeutic, initial, and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can serve as dental homes are federally qualified health centers and individuals who are general dentists or pediatric dentists.

(27) Dental managed care organization (dental MCO)--A dental indemnity insurance provider or dental health maintenance organization licensed or approved by the Texas Department of Insurance.

(28) Dental service--The routine preventive, diagnostic, urgent, therapeutic, initial, and primary care provided to a member and included within the scope of HHSC's agreement with a dental contractor. For purposes of this chapter, "dental service" does not include dental devices for craniofacial anomalies; treatment rendered in a hospital, urgent care center, or ambulatory surgical center setting for craniofacial anomalies; or emergency services provided in a hospital, urgent care center, or ambulatory surgical center setting involving dental trauma. These types of services are treated as health care services in this chapter.

(29) DFPS--The Texas Department of Family and Protective Services.

(30) Disability--A physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, socializing, or working.

(31) Disproportionate Share Hospital (DSH)--A hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

(32) Dual eligible--A Medicaid recipient who is also eligible for Medicare.

(33) Elective enrollment--Selection of a primary care provider (PCP) and MCO by a client during the enrollment period established by HHSC.

(34) Emergency behavioral health condition--Any condition, without regard to the nature or cause of the condition, that in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(A) requires immediate intervention and/or medical attention without which the client would present an immediate danger to themselves or others; or

(B) renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

(35) Emergency medical condition--A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) serious jeopardy to the health of a pregnant woman or her unborn child.

(36) Emergency service--A covered inpatient and outpatient service, furnished by a network provider or out-of-network provider that is qualified to furnish such service, that is needed to evaluate or stabilize an emergency medical condition and/or an emergency behavioral health condition. For health care MCOs, the term "emergency service" includes post-stabilization care services.

(37) Encounter--A covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. This also includes value-added services.

(38) Enrollment--The process by which an individual determined to be eligible for Medicaid is enrolled in a Medicaid MCO serving the service area in which the individual resides.

(39) EPSDT--The federally mandated Early and Periodic Screening, Diagnosis, and Treatment program defined in 25 TAC Chapter 33 (relating to Early and Periodic Screening, Diagnosis, and Treatment). The State of Texas has adopted the name Texas Health Steps (THSteps) for its EPSDT program.

(40) EPSDT-CCP--The Early and Periodic Screening, Diagnosis, and Treatment-Comprehensive Care Program described in Chapter 363 of this title (relating to Texas Health Steps Comprehensive Care Program).

(41) Exclusive provider benefit plan (EPBP)--An MCO that complies with 28 TAC §§3.9201 - 3.9212, relating to the Texas Department of Insurance's requirements for EPBPs, and contracts with HHSC to provide Medicaid coverage.

(42) Expedited Credentialing--The process under Texas Government Code §533.0064 in which an MCO allows an applicant provider to provide Medicaid services to members on a provisional basis pending completion of the credentialing process.

(43) Experience rebate--The portion of the MCO's net income before taxes that is returned to the State in accordance with the MCO's contract with HHSC.

(44) Fair hearing--The process adopted and implemented by HHSC in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules) in compliance with federal regulations and state rules relating to Medicaid fair hearings.

(45) Federal Poverty Level (FPL)--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services under the authority of 42 U.S.C. §9902(2) and as in effect for the applicable budget period determined in accordance with 42 C.F.R. §435.603(h). HHSC uses the FPL to determine an individual's eligibility for Medicaid.

(46) Federal waiver--Any waiver permitted under federal law and approved by CMS that allows states to implement Medicaid managed care.

(47) Federally Qualified Health Center (FQHC)--An entity that is certified by CMS to meet the requirements of 42 U.S.C. §1395x(aa)(3) as a Federally Qualified Health Center and is enrolled as a provider in the Texas Medicaid program.

(48) Former Foster Care Children (FFCC) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS, administered in accordance with Chapter 366, Subchapter J of this title (relating to Former Foster Care Children's Program).

(49) Functional necessity--A member's need for services and supports with activities of daily living or instrumental activities of daily living to be healthy and safe in the most integrated setting possible. This determination is based on the results of a functional assessment.

(50) Habilitation--Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks based on the individual's person-centered service plan.

(51) Health and Human Services Commission (HHSC)--The single state agency charged with administration and oversight of the Texas Medicaid program or its designee.

(52) Health care managed care organization (health care MCO)--An entity that is licensed or approved by the Texas Department of Insurance to operate as a health maintenance organization or to issue an EPBP.

(53) Health care provider group--A legal entity, such as a partnership, corporation, limited liability company, or professional association, enrolled in Medicaid, under which certified or licensed individual health care providers provide health care items or services.

(54) Health care services--The acute care, behavioral health care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health, including, at a minimum, emergency services and inpatient and outpatient services.

(55) Health maintenance organization (HMO)--An organization that holds a certificate of authority from the Texas Department of Insurance to operate as an HMO under Chapter 843 of the Texas Insurance Code, or a certified Approved Non-Profit Health Corporation formed in compliance with Chapter 844 of the Texas Insurance Code.

(56) Hospital--A licensed public or private institution as defined in the Texas Health and Safety Code at Chapter 241, relating to hospitals, or Chapter 261, relating to municipal hospitals.

(57) Intermediate care facility for individuals with an intellectual disability or related condition (ICF-IID)--A facility providing care and services to individuals with intellectual disabilities or related conditions as defined in §1905(d) of the Social Security Act (42 U.S.C. 1396(d)).

(58) Legally authorized representative (LAR)--A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and may, depending on the circumstances, include a parent, guardian, or managing conservator of a minor, or the guardian of an adult, or a representative designated pursuant to 42 C.F.R. 435.923.

(59) Long term service and support (LTSS)--A service provided to a qualified member in his or her home or other community-based setting necessary to allow the member to remain in the most integrated setting possible. LTSS includes services provided under the Texas State Plan as well as services available to persons who qualify for STAR+PLUS Home and Community-Based Program services or Medicaid 1915(c) waiver services. LTSS available through an MCO in STAR+PLUS, STAR Health, and STAR Kids varies by program model.

~~[(60) Main dental home provider--See definition of "dental home" in this section.]~~

(60) [~~(61)~~] Main dentist--See definition of "dental home" in this section.

(61) [~~(62)~~] Managed care--A health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization.

(62) [~~(63)~~] Managed care organization (MCO)--A dental MCO or a health care MCO.

(63) [~~(64)~~] Marketing--Any communication from an MCO to a client who is not enrolled with the MCO that can reasonably be interpreted as intended to influence the client's decision to enroll, not to enroll, or to disenroll from a particular MCO.

(64) [~~(65)~~] Marketing materials--Materials that are produced in any medium by or on behalf of the MCO that can reasonably be interpreted as intending to market to potential members. Materials relating to the prevention, diagnosis, or treatment of a medical or dental condition are not marketing materials.

(65) [~~(66)~~] MDCP--Medically Dependent Children Program. A §1915(c) waiver program that provides community-based services to assist Medicaid beneficiaries under age 21 to live in the community and avoid institutionalization.

(66) [~~(67)~~] Medicaid--The medical assistance program authorized and funded pursuant to Title XIX of the Social Security Act (42 U.S.C. §1396 et seq) and administered by HHSC.

(67) [~~(68)~~] Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of DFPS, administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(68) [~~(69)~~] Medical Assistance Only (MAO)--A person who qualifies financially and functionally for Medicaid assistance but does not receive Supplemental Security Income (SSI) benefits, as defined in Chapters 358, 360, and 361, of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities, Medicaid Buy-In Program, and Medicaid Buy-In for Children Program).

(69) [~~(70)~~] Medical home--A PCP or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to members participating in an MCO contracted with HHSC.

(70) [~~(71)~~] Medically necessary--

(A) For Medicaid members birth through age 20, the following Texas Health Steps services:

(i) screening, vision, dental, and hearing services; and

(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and

(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.

(B) For Medicaid members over age 20, non-behavioral health services that are:

(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;

(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(iv) consistent with the member's medical need;

(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(vi) not experimental or investigative; and

(vii) not primarily for the convenience of the member or provider.

(C) For Medicaid members over age 20, behavioral health services that:

(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(iv) are the most appropriate level or supply of service that can safely be provided;

(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;

(vi) are not experimental or investigative; and

(vii) are not primarily for the convenience of the member or provider.

(71) [~~(72)~~] Member--A person who is eligible for benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the Medicaid managed care program, and is enrolled in a Medicaid MCO.

(72) [~~(73)~~] Member education program--A planned program of education:

(A) concerning access to health care services or dental services through the MCO and about specific health or dental topics;

(B) that is approved by HHSC; and

(C) that is provided to members through a variety of mechanisms that must include, at a minimum, written materials and face-to-face or audiovisual communications.

(73) [~~(74)~~] Member materials--All written materials produced or authorized by the MCO and distributed to members or potential members containing information concerning the managed care program. Member materials include member ID cards, member handbooks, provider directories, and marketing materials.

(74) [~~(75)~~] Non-capitated service--A benefit available to members under the Texas Medicaid program for which an MCO is not responsible for payment.

(75) Nursing facility--As defined in §358.103 of this title (relating to Definitions) and 26 TAC §554.101 (relating to Definitions), an entity or institution, also called nursing home or skilled nursing facility, that provides organized and structured nursing care and services and is subject to licensure under Texas Health and Safety Code Chapter 242.

(76) Nursing facility add-on services--The types of services that are provided in a nursing facility setting by a nursing facility provider or another provider, but are not included in the nursing facility unit rate, including emergency dental services, physician-ordered rehabilitative services, customized power wheel chairs, augmentative

communication devices, tracheostomy care for youth under age 22, and ventilator care.

(77) Nursing facility services--The services included in the nursing facility unit rate, nursing facility Medicare coinsurance, and nursing facility add-on services.

(78) Nursing facility unit rate--The rate for the type of services included in the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as defined in 26 TAC §554.2601 (relating to Vendor Payment (Items and Services Included)), including room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes applicable nursing facility staff rate enhancements as described in §355.308 of this title (relating to Direct Care Staff Rate Component), and professional and general liability insurance add-on payments as described in §355.312 of this title (relating to Reimbursement Setting Methodology--Liability Insurance Costs). The nursing facility unit rate excludes nursing facility add-on services.

(79) [~~(76)~~] Outside regular business hours--As applied to FQHCs and rural health clinics (RHCs), means before 8 a.m. and after 5 p.m. Monday through Friday, weekends, and federal holidays.

(80) [~~(77)~~] Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(81) [~~(78)~~] Permanency Care Assistance Program--The program administered by DFPS in accordance with 40 TAC Chapter 700, Subchapter J, Division 2 (relating to Permanency Care Assistance Program).

(82) [~~(79)~~] Person-centered care--An approach to care that focuses on members as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment.

(83) [~~(80)~~] Person-centered planning--A documented service planning process that includes people chosen by the individual, is directed by the individual to the maximum extent possible, enables the individual to make choices and decisions, is timely and occurs at times and locations convenient to the individual, reflects cultural considerations of the individual, includes strategies for solving conflict or disagreement within the process, offers choices to the individual regarding the services and supports they receive and from whom, includes a method for the individual to require updates to the plan, and records alternative settings that were considered by the individual.

(84) [~~(81)~~] Post-stabilization care service--A covered service, related to an emergency medical condition, that is provided after a Medicaid member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. §438.114(b) and (e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid member's condition.

(85) [~~(82)~~] Primary care provider (PCP)--A physician or other provider who has agreed with the health care MCO to provide a medical home to members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

(86) [~~(83)~~] Provider--A credentialed and licensed individual, facility, agency, institution, organization, or other entity, and its employees and subcontractors, that has a contract with the MCO for the delivery of covered services to the MCO's members.

(87) [~~(84)~~] Provider education program--Program of education about the Medicaid managed care program and about specific health or dental care issues presented by the MCO to its providers through written materials and training events.

(88) [~~(85)~~] Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(89) [~~(86)~~] Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(90) [~~(87)~~] Rural Health Clinic (RHC)--An entity that meets all of the requirements for designation as a rural health clinic under §1861(aa)(1) of the Social Security Act (42 U.S.C. §1395x(aa)(1)) and is approved for participation in the Texas Medicaid program.

(91) [~~(88)~~] Service area--The counties included in any HHSC-defined service area as applicable to each MCO.

(92) [~~(89)~~] Significant traditional provider (STP)--A provider identified by HHSC as having provided a significant level of care to the target population, including a DSH.

(93) [~~(90)~~] STAR--The State of Texas Access Reform (STAR) managed care program that operates under a federal waiver and primarily provides, arranges for, and coordinates preventive, primary, acute care, and pharmacy services for low-income families, children, and pregnant women.

(94) [~~(91)~~] STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in DFPS conservatorship;

(B) young adults who voluntarily agree to continue in a foster care placement (if the state as conservator elects to place the child in managed care); and

(C) young adults who are eligible for Medicaid as a result of their former foster care status through the month of their 21st birthday.

(95) [~~(92)~~] STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preventative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(96) [~~(93)~~] STAR+PLUS--The managed care program that operates under a federal waiver and primarily provides, arranges, and coordinates preventive, primary, acute care, and long-term services and supports to persons with disabilities and elderly persons age 65 and over who qualify for Medicaid by virtue of their SSI or MAO status.

(97) [~~(94)~~] STAR+PLUS Home and Community-Based Services Program--The program that provides person-centered care services that are delivered in the home or in a community setting, as authorized through a federal waiver under §1115 of the Social Security Act, to qualified Medicaid-eligible clients who are age 21 or older, as cost-effective alternatives to institutional care in nursing facilities.

(98) [~~(95)~~] State plan--The agreement between the CMS and HHSC regarding the operation of the Texas Medicaid program, in accordance with the requirements of Title XIX of the Social Security Act.

(99) [~~(96)~~] Supplemental Security Income (SSI)--The federal cash assistance program of direct financial payments to people who are 65 years of age or older, are blind, or have a disability administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. All persons who are certified as eligible for SSI in Texas are eligible for Medicaid. Local SSA claims representatives make SSI eligibility determinations. The transactions are forwarded to

the SSA in Baltimore, which then notifies the states through the State Data Exchange (SDX).

(100) [~~(97)~~] Texas Health Steps (THSteps)--The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, described at 42 U.S.C. §1396d(r) and 42 CFR §440.40 and §§441.40 - 441.62.

(101) [~~(98)~~] Value-added service--A service provided by an MCO that is not "medical assistance," as defined by §32.003 of the Texas Human Resources Code.

§353.4. Managed Care Organization Requirements Concerning Out-of-Network Providers.

(a) Network adequacy. HHSC is the state agency responsible for overseeing and monitoring the Medicaid managed care program. Each managed care organization (MCO) participating in the Medicaid managed care program must offer a network of providers that is sufficient to meet the needs of the Medicaid population who are MCO members. HHSC monitors MCO members' access to an adequate provider network through reports from the MCOs and complaints received from providers and members. Certain reporting requirements are discussed in subsection (g) of this section.

(b) MCO requirements concerning coverage for treatment of members by out-of-network providers for non-emergency services.

(1) Nursing facility services. A health care MCO must reimburse an out-of-network nursing facility for medically necessary services authorized by HHSC, using the reasonable reimbursement methodology in subsection (f) of this section. Nursing facility add-on services are considered "other authorized services" under paragraph (2) of this subsection, and are authorized by STAR+PLUS MCOs.

(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:

(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;

(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and

(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.

(3) School-based telemedicine medical services. If a telemedicine medical service provided by an out-of-network physician to a member in a primary or secondary school-based setting meets the conditions for reimbursement in §354.1432 of this title (relating to Telemedicine and Telehealth Benefits and Limitations), a health care MCO must reimburse the out-of-network physician without prior authorization, even if the physician is not the member's primary care provider. The MCO must use the reasonable reimbursement methodology described in subsection (f)(2) of this section to reimburse an out-of-network physician.

(c) MCO requirements concerning coverage for treatment of members by out-of-network providers for emergency services.

(1) An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services.

(2) Health care MCO requirements concerning emergency services.

(A) A health care MCO may not refuse to reimburse an out-of-network provider for post-stabilization care services provided as a result of the MCO's failure to authorize a timely transfer of a member.

(B) A health care MCO must allow its members to be treated by any emergency services provider for emergency services, and services to determine if an emergency condition exists. The health care MCO must pay for such services.

(C) A health care MCO must reimburse for transport provided by an ambulance provider for a Medicaid recipient whose condition meets the definition of an emergency medical condition. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in §353.2 of this subchapter (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

(D) A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

(3) Dental MCO requirements concerning emergency services.

(A) A dental MCO must allow its members to be treated for covered emergency services that are provided outside of a hospital or ambulatory surgical center setting, and for covered services provided outside of such settings to determine if an emergency condition exists. The dental MCO must pay for such services.

(B) A dental MCO is prohibited from requiring an authorization for the services described in subparagraph (A) of this paragraph.

(C) A dental MCO is not responsible for payment of non-capitated emergency services and post-stabilization care provided in a hospital or ambulatory surgical center setting, or devices for craniofacial anomalies. A dental MCO is not responsible for hospital and physician services, anesthesia, drugs related to treatment, and post-stabilization care for:

(i) a dislocated jaw, traumatic damage to a tooth, and removal of a cyst;

(ii) an oral abscess of tooth or gum origin; and

(iii) craniofacial anomalies.

(D) The services and benefits described in subparagraph (C) of this paragraph are reimbursed:

(i) by a health care MCO, if the member is enrolled in a managed care program; or

(ii) by HHSC's claims administrator, if the member is not enrolled in a managed care program.

(d) Health care MCO requirements concerning coverage for services provided to certain members by an out-of-network "specialty provider" as that term is defined in §353.7(c) of this subchapter (relating to Continuity of Care with Out-Of-Network Specialty Providers).

(1) A health care MCO may not refuse to reimburse an out-of-network "specialty provider" enrolled as a provider in the Texas Medicaid program for services provided to a member under the circumstances set forth in §353.7 of this subchapter.

(2) In reimbursing a provider for the services described in paragraph (1) of this subsection, a health care MCO must use the reasonable reimbursement methodology in subsection (f)(2) of this section.

(e) An MCO may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described in subsections (b) - (d) of this section.

(f) Reasonable reimbursement methodology.

(1) Out-of-network nursing facilities.

(A) Out-of-network nursing facilities must be reimbursed[:]

[(i)] at or above 95 [~~ninety-five~~] percent of the nursing facility unit rate established by HHSC for the dates of service for services provided inside of the MCO's service area. [~~; and~~]

(B) Out-of-network nursing facilities must be reimbursed

[(ii)] at or above 100 [~~one hundred~~] percent of the nursing facility unit rate for the dates [~~date~~] of services for services provided outside of the MCO's service area.

[~~(B) The nursing facility unit rate refers to the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as determined by HHSC. The rate includes items such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes professional and general liability insurance and applicable nursing facility rate enhancements. The nursing facility unit rate excludes nursing facility add-on services.~~]

(2) Emergency and authorized services performed by out-of-network providers.

(A) Except as provided in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (j)(2) of this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.

(B) Except as provided in §353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service, unless the parties agree to a different reimbursement amount, until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

(3) For purposes of this subsection, the Medicaid FFS rates are defined as those rates for providers of services in the Texas Medicaid program for which reimbursement methodologies are specified in Chapter 355 of this title (relating to Reimbursement Rates), exclusive of the rates and payment structures in Medicaid managed care.

(g) Reporting requirements.

(1) Each MCO that contracts with HHSC to provide health care services or dental services to members in a service area must submit quarterly information in its Out-of-Network quarterly report to HHSC.

(2) Each report submitted by an MCO must contain information about members enrolled in each HHSC Medicaid managed care program provided by the MCO. The report must include the following information:

(A) the types of services provided by out-of-network providers for the MCO's members;

(B) the scope of services provided by out-of-network providers to the MCO's members;

(C) for a health care MCO, the total number of hospital admissions, as well as the number of admissions that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(D) for a health care MCO, the total number of emergency room visits, as well as the total number of emergency room visits that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(E) total dollars for paid claims by MCOs, other than those described in subparagraphs (C) and (D) of this paragraph, as well as total dollars billed by out-of-network providers for other services; and

(F) any additional information required by HHSC.

(3) HHSC determines the specific form of the report described in this subsection and includes the report form as part of the Medicaid managed care contract between HHSC and the MCOs.

(h) Utilization.

(1) Upon review of the reports described in subsection (g) of this section that are submitted to HHSC by the MCOs, HHSC may determine that an MCO exceeded maximum out-of-network usage standards set by HHSC for out-of-network access to health care services and dental services during the reporting period.

(2) Out-of-network usage standards.

(A) Inpatient admissions: No more than 15 percent of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.

(B) Emergency room visits: No more than 20 percent of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.

(C) Other services: For services that are not included in subparagraph (A) or (B) of this paragraph, no more than 20 percent of total dollars for paid claims by the MCO for services provided may be provided by out-of-network providers.

(3) Special considerations in calculating a health care MCO's out-of-network usage of inpatient admissions and emergency room visits.

(A) In the event that a health care MCO exceeds the maximum out-of-network usage standard set by HHSC for inpatient admissions or emergency room visits, HHSC may modify the calculation of that health care MCO's out-of-network usage for that standard if:

(i) the admissions or visits to a single out-of-network facility account for 25 percent or more of the health care MCO's admissions or visits in a reporting period; and

(ii) HHSC determines that the health care MCO has made all reasonable efforts to contract with that out-of-network facility as a network provider without success.

(B) In determining whether the health care MCO has made all reasonable efforts to contract with the single out-of-network facility described in subparagraph (A) of this paragraph, HHSC considers at least the following information:

(i) how long the health care MCO has been trying to negotiate a contract with the out-of-network facility;

(ii) the in-network payment rates the health care MCO has offered to the out-of-network facility;

(iii) the other, non-financial contractual terms the health care MCO has offered to the out-of-network facility, particularly those relating to prior authorization and other utilization management policies and procedures;

(iv) the health care MCO's history with respect to claims payment timeliness, overturned claims denials, and provider complaints;

(v) the health care MCO's solvency status; and

(vi) the out-of-network facility's reasons for not contracting with the health care MCO.

(C) If the conditions described in subparagraph (A) of this paragraph are met, HHSC may modify the calculation of the health care MCO's out-of-network usage for the relevant reporting period and standard by excluding from the calculation the inpatient admissions or emergency room visits to that single out-of-network facility.

(i) Provider complaints.

(1) HHSC accepts provider complaints regarding reimbursement for or overuse of out-of-network providers and conducts investigations into any such complaints.

(2) When a provider files a complaint regarding out-of-network payment, HHSC requires the relevant MCO to submit data to support its position on the adequacy of the payment to the provider. The data includes a copy of the claim for services rendered and an explanation of the amount paid and of any amounts denied.

(3) Not later than the 60th day after HHSC receives a provider complaint, HHSC notifies the provider who initiated the complaint of the conclusions of HHSC's investigation regarding the complaint. The notification to the complaining provider includes:

(A) a description of the corrective actions, if any, required of the MCO in order to resolve the complaint; and

(B) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

(4) If HHSC determines through investigation that an MCO did not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) of this section, HHSC initiates a corrective action plan. Refer to subsection (j) of this section for information about the contents of the corrective action plan.

(5) If, after an investigation, HHSC determines that additional reimbursement is owed to an out-of-network provider, the MCO must:

(A) pay the additional reimbursement owed to the out-of-network provider within 90 days from the date the complaint was received by HHSC or 30 days from the date the clean claim, or information required that makes the claim clean, is received by the MCO, whichever comes first; or

(B) submit a reimbursement payment plan to the out-of-network provider within 90 days from the date the complaint was received by HHSC. The reimbursement payment plan provided by the MCO must provide for the entire amount of the additional reimbursement to be paid within 120 days from the date the complaint was received by HHSC.

(6) If the MCO does not pay the entire amount of the additional reimbursement within 90 days from the date the complaint was received by HHSC, HHSC may require the MCO to pay interest on the unpaid amount. If required by HHSC, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the complaint was received by HHSC, until the date the entire amount of the additional reimbursement is paid.

(7) HHSC pursues any appropriate remedy authorized in the contract between the MCO and HHSC if the MCO fails to comply with a corrective action plan under subsection (j) of this section.

(j) Corrective action plan.

(1) HHSC requires a corrective action plan in the following situations:

(A) the MCO exceeds a maximum standard established by HHSC for out-of-network access to health care services and dental services described in subsection (h) of this section; or

(B) the MCO does not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) of this section.

(2) A corrective action plan imposed by HHSC requires one of the following:

(A) reimbursements by the MCO to out-of-network providers at rates that equal the allowable rates for the health care services as determined under §32.028 and §32.0281, Texas Human Resources Code, for all health care services provided during the period:

(i) the MCO is not in compliance with a utilization standard established by HHSC; or

(ii) the MCO is not reimbursing out-of-network providers based on a reasonable reimbursement methodology, as described in subsection (f) of this section;

(B) initiation of an immediate freeze by HHSC on the enrollment of additional recipients in the MCO's managed care plan until HHSC determines that the provider network under the managed care plan can adequately meet the needs of the additional recipients;

(C) education by the MCO of members enrolled in the MCO regarding the proper use of the MCO's provider network; or

(D) any other actions HHSC determines are necessary to ensure that Medicaid recipients enrolled in managed care plans provided by the MCO have access to appropriate health care services or dental services, and that providers are properly reimbursed by the MCO for providing medically necessary health care services or dental services to those recipients.

(k) Application to Pharmacy Providers. The requirements of this section do not apply to providers of outpatient pharmacy benefits, except as noted in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services).

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304327

Karen Ray
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 221-6857

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 417. AGENCY AND FACILITY RESPONSIBILITIES

SUBCHAPTER A. STANDARD OPERATING PROCEDURES

25 TAC §§417.47, 417.49, 417.50

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes the repeal of §417.47, concerning Training Requirements for State Mental Health Facilities; §417.49, concerning References; and concerning §417.50, Distribution.

BACKGROUND AND PURPOSE

The purpose of the proposed repeals is to reflect the move of the state hospitals from the Department of State Health Services (DSHS) to HHSC by moving HHSC rules from Texas Administrative Code (TAC) Title 25, Chapter 417, Subchapter A to 26 TAC Chapter 926 and consolidate HHSC rules. These rules will be repealed, updated, and placed in 26 TAC Chapter 926. The new rules are proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

The repeal of the rules in 25 TAC Chapter 417, Subchapter A will delete the rules from 25 TAC and place updated rules in 26 TAC to reflect the transfer of functions from DSHS to HHSC.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the repeals will be in effect, enforcing or administering the repeals does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed repeals will repeal existing rules;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities because the repeals do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed repeals will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these repeals because the repeals do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the repeals are in effect, the public benefit will be the removal of rules no longer associated with DSHS from 25 TAC.

Trey Wood has also determined that for the first five years the repeals are in effect, there are no anticipated economic costs to persons who are required to comply with the repeals because the repeals do not impose a cost.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Health and Safety Code §552.052, which requires HHSC to provide certain training for employees of State Hospitals and requires the Executive Commissioner to adopt rules to require State Hospitals to provide refresher training courses to employees.

The repeals affect Texas Government Code §531.0055 and Texas Health and Safety Code §552.052.

§417.47. Training Requirements for State Mental Health Facilities.
§417.49. References.
§417.50. Distribution.

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

Filed with the Office of the Secretary of State on November 20, 2023.

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Karen Ray
Chief Counsel
Department of State Health Services
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For further information, please call: (512) 438-3049

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 338. DISASTER RULE FLEXIBILITIES FOR LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES (LIDDAs)

26 TAC §338.1

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes in Title 26, Texas Administrative Code (TAC), new Chapter 338, Disaster Rule Flexibilities for Local Intellectual and Developmental Disability Authorities (LIDDAs), comprising of §338.1, concerning Disaster Flexibilities.

BACKGROUND AND PURPOSE

The purpose of the proposal is to add a new chapter and rule to allow LIDDAs to use certain flexibilities to certain rules when providing services during a declared disaster under Texas Government Code §418.014.

LIDDAs provide essential services to individuals with intellectual or developmental disabilities (IDD). This vulnerable population relies on LIDDA staff to assist them in securing the services they need, achieving their desired outcomes and best quality of life. Disaster rule flexibilities for LIDDAs ensure that when a disaster declaration is in effect, HHSC may issue timely guidance and authorize flexibilities for LIDDAs to provide services.

The proposal creates a standing rule allowing HHSC to notify LIDDAs of certain flexibilities immediately upon a disaster declaration. These flexibilities include allowing service coordination to be delivered via audio-only or audio-visual communication to ensure continuity of services, as well as extending some timeframes for LIDDAs. In addition, the proposal requires that LIDDAs follow HHSC guidance related to the rules, comply with all applicable requirements related to security and privacy of information, and notify persons impacted by the flexibilities, if applicable.

SECTION-BY-SECTION SUMMARY

Proposed new §338.1(a) establishes definitions for terminology used in this chapter, including "audio-only," "audio-visual," "face-to-face," and "in-person (or in person)."

Proposed new §338.1(b) establishes that in the event of a declared state of disaster, HHSC may allow flexibilities described in subsection (c). HHSC will notify LIDDAs of the beginning and end dates for rule flexibilities.

Proposed new §338.1(c) identifies the rules for which HHSC will allow flexibilities to the extent authorized under federal and state law, including a flexibility to 26 TAC §331.11(d) that allows LIDDAs to provide service coordination using audio-visual or audio-only communication instead of in person. Additionally, HHSC may allow flexibilities to certain rules that set forth timeframes applicable to the LIDDAs by extending the timeframes.

Proposed new §338.1(d) requires LIDDAs that use the flexibilities to comply with all guidance on the application of the rules identified in subsection (c) published by HHSC, including policy guidance issued by HHSC's Community Services Division and Medicaid and CHIP Services.

Proposed new §338.1(e) requires that LIDDAs ensure audio-only or audio-visual communication complies with all applicable requirements related to security and privacy of information.

Proposed new §338.1(f) requires LIDDAs to notify persons receiving services, or other individuals, as applicable, of the extensions to the timeframes permitted under subsection (c)(2).

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rule will be in effect, enforcing or administering the rule does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

Trey Wood has also determined that there is no adverse economic effect on small businesses, micro-businesses, or rural communities. The proposed rule provides certain flexibilities for LIDDAs during a declared disaster, but there is no requirement to alter current business practices. No rural communities contract

with HHSC in any program or service affected by the proposed rule.

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect the local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to this rule because the rule is necessary to protect the health, safety, and welfare of the residents of Texas; does not impose a cost on regulated persons; and is proposed to reduce the burden or responsibilities imposed on regulated persons by the rule.

PUBLIC BENEFIT AND COSTS

Haley Turner, Deputy Executive Commissioner for Community Services, has determined that for each year of the first five years the rule is in effect, the public benefit will be the continuity of services to vulnerable Texans during declared disasters.

Trey Wood has also determined that for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because there is no requirement to alter current business practices. LIDDAs are not required to utilize HHSC-authorized flexibilities during declared disasters.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 701 W. 51st Street, Austin, Texas 78751 or by email to Brandi Lambert at IDDServicesPolicyandRules@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R019" in the subject line.

STATUTORY AUTHORITY

The new section is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; Texas Human Resources Code §32.021, which provides that HHSC will adopt necessary rules for the proper and efficient administration of the Medicaid program; and Texas Health & Safety Code §533A.0355(a), which provides that the Executive Commissioner of HHSC shall adopt rules establishing the roles and responsibilities of LIDDAs.

The new section affects Texas Government Code §§531.0055 and 531.021, Texas Human Resources Code §32.021, and Texas Health & Safety Code §533A.0355(a).

§338.1. Disaster Flexibilities.

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

(1) Audio-only--An interactive, two-way audio communication that uses only sound and that meets the privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include face-to-face communication.

(2) Audio-visual--An interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audio-visual does not include audio-only or in-person communication.

(3) Face-to-face--In-person or audio-visual communication that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include audio-only communication.

(4) In-person (or in person)--Within the physical presence of another person. In-person or in person does not include audio-visual or audio-only communication.

(b) The Texas Health and Human Services Commission (HHSC) may allow local intellectual and developmental disability authorities (LIDDAs) to use the flexibilities described in subsection (c) of this section while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. HHSC will notify LIDDAs when a flexibility is permitted and the date the flexibility must no longer be used, which may be before the declaration of a state of disaster expires.

(c) Subject to the notification by HHSC, the following flexibilities may be available to LIDDAs to the extent the flexibility is permitted by and does not conflict with other laws or obligations of the LIDDA and is allowed by federal and state law.

(1) Service coordination required to be provided in person under 26 TAC §331.11(d) of this title (relating to LIDDA's Responsibilities) may be provided using audio-visual or audio-only communication.

(2) HHSC may extend the timeframes for LIDDAs in the following rules:

(A) the timeframe to request an administrative hearing in 40 TAC §4.156 (relating to Request for an Administrative Hearing);

(B) the timeframe for a person and legally authorized representative (LAR) to request a review of a decision to deny or terminate services in 40 TAC §2.46(e)(3) (relating to Notification and Appeals Process);

(C) the timeframe for a person or the person's parent to comply with the applicable accountability requirement in 40 TAC §2.105(f)(1) (relating to Accountability)in order for the LIDDA to retroactively adjust the person's account; and

(D) the timeframe for a person or parent to submit a request to review a LIDDA's appeal decision to HHSC in 40 TAC §2.109(e)(3) (relating to Payments, Collections, and Non-payment).

(d) LIDDAs that use one or more of the flexibilities allowed under subsection (c) of this section must comply with:

(1) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Community Services Division during the declaration of disaster that is published by HHSC on its LIDDA website or in another communication format HHSC determines appropriate; and

(2) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Medicaid and CHIP Services.

(e) LIDDAs must ensure audio-only or audio-visual communication complies with all applicable requirements related to security and privacy of information.

(f) LIDDAs must notify the person, the LAR, or the person's parent if the person is younger than 18 years of age, of the extension of timeframes permitted under subsection (c)(2) of this section that apply to the person receiving services.

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

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 438-5609

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CHAPTER 745. LICENSING
SUBCHAPTER G. CONTROLLING PERSONS

26 TAC §§745.901, 745.903 - 745.905

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §745.901, concerning Who is a controlling person at a child-care operation, §745.903, concerning When and how must an operation submit controlling-person information to Licensing, and §745.905, concerning When will Licensing designate someone at my child-care operation as a controlling person; and new §745.904, concerning What must I do to verify the accuracy of the list of controlling persons associated with my operation, in Texas Administrative Code, Title 26, Chapter 745, Licensing, Subchapter G, Controlling Persons.

BACKGROUND AND PURPOSE

The purpose of this proposal is to adopt rules in Chapter 745 to implement HHSC Child Care Regulation's (CCR) Performance Management Unit (PMU) recommendations from the Fiscal Year (FY) 2019 and FY 2021 reports: Annual Casereading, Read-Behind, and Field Assessment. In these reports, PMU recommended IT enhancements to support a change in current business practice related to verifying an operation's controlling persons list. The current practice requires CCR inspectors to verify an operation's controlling persons list during all monitoring inspections. PMU recommended CCR change to a new practice that would require an operation to validate the controlling persons list on a scheduled basis using the operation's online Child Care Regulation Account.

The IT enhancements, and consequently the rules, also support implementation of Texas Human Resources Code (HRC) §42.025(b)(4) and (c), which were added by Senate Bill 225, 87th Legislature, Regular Session, 2021. HRC §42.025(b)(4) and (c) require CCR to list certain information for child-care homes and listed family homes on the Search Texas Child Care website regarding involuntary suspensions, revocations, and refusals to renew permits.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §745.901 (1) reorganizes a subdivision of the rule to improve readability; (2) adds language to clarify that a child-care home includes a licensed or registered child-care home; and (3) adds the primary caregiver of a listed family home and the caregiver's spouse to the definition of a controlling person.

The proposed amendment to §745.903 (1) updates language and punctuation to improve readability; (2) updates a reference; and (3) updates language to reflect that a child-care operation may submit controlling person information online through the operation's Child Care Regulation Account, not the DFPS website.

Proposed new §745.904 outlines what a child-care operation must do to verify the accuracy of the operation's controlling persons list by requiring a child-care operation to validate the controlling persons list, including each person's role at the operation, on a scheduled basis and prescribing the way the operation must complete the validation. The rule requires (1) a School-Age and Before or After-School Program, Licensed Child-Care Center, General Residential Operation, and Child-Placing Agency to validate the accuracy of the list quarterly and make necessary corrections via the child-care operation's online Child Care Regulation Account; (2) a Licensed Child-Care Home and Registered Child-Care Home to validate the accuracy of the list annually and make necessary corrections via the child-care home's online Child Care Regulation Account; and (3) a Listed Family Home to validate the accuracy of the list annually and make necessary corrections via the home's online Child Care Regulation Account or by contacting the local Child Care Regulation office.

The proposed amendment to §745.905 (1) updates a reference; (2) updates language to improve readability; (3) corrects an inaccurate pronoun usage; and (4) removes language that implies a Controlling Person Form is the only way an operation may submit controlling person information.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments. All costs related to IT enhancements will be absorbed with existing resources.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Associate Commissioner for Child Care Regulation, has determined that for each year of the first five years the rules are in effect, the public will benefit through improved safety of children in out of home care as a result of more timely and accurate accounting of the controlling persons associated with a child-care operation and rules that support a change to business practice.

Trey Wood has also determined that for the first five years the rules are in effect there are no anticipated economic costs to persons who are required to comply with the proposed rules. The controlling persons validation requirements can be implemented by each child-care operation's existing administrative processes and do not require additional staff.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Questions about the content of this proposal may be directed to Aimee Belden by email at Aimee.Belden@hhs.texas.gov.

Written comments on the proposal may be submitted to Aimee Belden, Rules Writer, Child Care Regulation, Texas Health and Human Services Commission, E-550, P.O. Box 149030, Austin, Texas 78714-9030; or by email to CCRRules@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R016" in the subject line.

STATUTORY AUTHORITY

The amendments and new section are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.02011, which transferred the regulatory functions of the Department of Family and Protective Services to HHSC. In addition, HRC §42.042(a) requires HHSC to adopt rules to carry out the requirements of Chapter 42 of HRC.

The amendments and new section affect Texas Government Code §531.0055 and HRC §42.042.

§745.901. Who is a controlling person at a child-care operation?

(a) A controlling person of a child-care operation is any:

(1) Owner of the operation or member of the governing body of the operation, including, as applicable: [~~,~~]

(A) An [~~an~~] executive, an officer, or a board member; [~~,~~]

(B) A [~~a~~] partner;[~~,~~]

(C) A [~~a~~] sole proprietor and the sole proprietor's spouse; [~~,~~] or

(D) The [~~the~~] primary caregiver at a licensed child-care home, registered child-care home, or listed family home and the primary caregiver's spouse;

(2) Person who manages, administrates, or directs the operation or its governing body, including a day care director or a licensed administrator; or

(3) Person who either alone or in connection with others has the ability to influence or direct the management, expenditures, or policies of the operation. For example, a person may have influence over the operation because of a personal, familial, or other relationship with the governing body, manager, or other controlling person of the operation.

(b) A person does not have to be present at the operation or hold an official title at the operation or governing body in order to be a controlling person.

(c) An employee, lender, secured creditor, or landlord of the operation is not a controlling person unless the person meets a definition in subsection (a) of this section.

§745.903. When and how must I [~~an operation~~] submit controlling person [~~controlling person~~] information to Licensing?

(a) You must provide information about each person that is a controlling person at your operation as defined in §745.901(a) of this subchapter [~~title~~] (relating to Who is a controlling person at a child-care operation?) when you apply for your permit.

(b) After you receive a permit from us, you must provide us information about someone who is a controlling person at your operation within two days after a person becomes a controlling person.

(c) To provide the information to us, you must either:

(1) Enter the information online [~~on-line~~] through your Child Care Regulation Account [~~the DFPS website~~]; or

(2) Submit a completed Controlling Person Form to your local Child Care Regulation [~~Licensing~~] office.

§745.904. What must I do to verify the accuracy of the list of controlling persons associated with my operation?

You must validate the accuracy of your controlling persons list, including each person's role at your operation, and make any necessary corrections:

(1) Every three months through your online Child Care Regulation Account for:

(A) School-Age or Before or After-School Programs;

(B) Licensed Child-Care Centers;

(C) General Residential Operations; and

(D) Child-Placing Agencies;

(2) Once a year through your online Child Care Regulation Account for:

(A) Licensed Child-Care Homes; and

(B) Registered Child-Care Homes; and

(3) Once a year for Listed Family Homes:

(A) Through your online Child Care Regulation Account; or

(B) By contacting the local Child Care Regulation office.

§745.905. When will Licensing designate someone at my child-care operation as a controlling person?

(a) We will designate each person who meets the definition of a controlling person in §745.901(a) of this subchapter [~~title~~] (relating to Who is a controlling person at a child-care operation?) as a controlling person at your operation when:

(1) We revoke your permit; or

(2) You voluntarily close your operation or relinquish your permit after you receive notice of our intent to revoke your permit or that we are revoking your permit.

(b) We may designate a person at your operation as a controlling person, regardless of whether you submitted the person's [~~their~~] name as a controlling person at your child-care operation [~~on a Controlling Person Form~~].

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

Filed with the Office of the Secretary of State on November 21, 2023.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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CHAPTER 926. TRAINING FOR FACILITY STAFF

26 TAC §§926.1 - 926.6

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §926.1, concerning Application; §926.2, concerning Definitions; concerning §926.3, concerning Training for New Employees; §926.4, concerning Additional Training for Employees who Provide Direct Care to Individuals; §926.5, concerning State Hospital Refresher Training; and §926.6, concerning State Supported Living Center (SSLC) Refresher Training.

BACKGROUND AND PURPOSE

The purpose of the proposed new rules is to reflect the move of the state hospitals from the Department of State Health Services and the state supported living centers from the Department of Aging and Disability Services to HHSC. HHSC is moving several rules from Title 25 of the Texas Administrative Code (TAC), Chapter 417, Subchapter A and 40 TAC Chapter 3, Subchapter D, Training, and consolidating rules under 26 TAC Chapter 926. The proposed rules update agency information, provide uniform training topics and timeframes, and remove text regarding expedited training due to the COVID-19 disaster declaration. The repeal of certain rules from 25 TAC Chapter 417, Subchapter A and 40 TAC Chapter 3, Subchapter D is proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

Proposed new §926.1 establishes that the chapter applies to state hospitals in accordance with Texas Health and Safety Code §552.052 and state supported living centers in accordance with Texas Health and Safety Code §555.024.

Proposed new §926.2 provides the definition of certain terms used within the chapter.

Proposed new §926.3 outlines training provided to all new facility employees.

Proposed new §926.4 outlines additional training provided to facility employees who provide direct care.

Proposed new §926.5 outlines refresher training provided to state hospital employees.

Proposed new §926.6 outlines refresher training provided to SSLC employees.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new rules;

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

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The proposed rules do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas and do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the rules are in effect, the public benefit will be consolidation of HHSC rules in 26 TAC, and improved general public access to requirements.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the rules because the rule applies only to HHSC.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The new rules are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, Health and Safety Code §552.052, which requires HHSC to provide certain training to state hospital employees, and for the Executive Commissioner to adopt rules regarding refresher trainings for employees, and Texas Health and Safety Code §555.024, which requires HHSC to provide certain training to SSLC employees, and for the Executive Commissioner to adopt rules regarding refresher trainings for employees.

The new rules affect Texas Government Code §531.0055, and Texas Health and Safety Code §§552.052 and 555.024.

§926.1. Application.

This chapter applies to state hospitals in accordance with Texas Health and Safety Code (HSC) §552.052 and state supported living centers in accordance with Texas HSC §555.024.

§926.2. Definitions.

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

(1) Direct care employee--A facility employee who provides direct delivery of services to an individual.

(2) Facility--A state hospital or state supported living center.

(3) Individual--A person who is receiving services at a facility.

(4) State hospital--A hospital as defined under Texas Health and Safety Code (HSC) §552.0011 operated by the Texas Health and Human Services Commission (HHSC) primarily to provide inpatient care and treatment for individuals with mental illness.

(5) State supported living center (SSLC)--An SSLC as defined by Texas HSC §531.002 and the intermediate care facility for individuals with intellectual disabilities component of the Rio Grande State Center operated by HHSC.

§926.3. Training for New Employees.

Before an employee performs employment duties without direct supervision, the employee must receive competency-based training and instruction on general duties.

(1) The focus of training must be on:

(A) the uniqueness of the individuals with whom the employee works;

(B) techniques for improving quality of life for and promoting the health and safety of individuals; and

(C) the conduct expected of employees.

(2) The training must include instruction and information on:

(A) the general operation and layout of the facility at which the person is employed;

(B) armed intruder lockdown procedures;

(C) respecting personal choices made by individuals;

(D) the safe and proper use of restraints;

(E) recognizing and reporting:

(i) abuse, neglect, and exploitation of individuals;

(ii) unusual or reportable incidents;

(iii) reasonable suspicion of illegal drug use in the workplace;

(iv) workplace violence; and

(v) sexual harassment in the workplace;

(F) preventing and treating infection;

(G) responding to emergencies, including information about first aid and cardiopulmonary resuscitation procedures;

(H) the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191);

(I) the rights of employees;

(J) additional topics for state hospital employees, which include:

(i) an introduction to mental illness;

(ii) an introduction to substance use;

(iii) an introduction to dual diagnosis; and

(iv) the rights of individuals with mental illness;

(K) additional topics for state supported living center employees, which include:

(i) an introduction to intellectual disabilities;

(ii) an introduction to autism; and

(iii) an introduction to mental illness and dual diagnosis; and

(L) the rights of individuals with an intellectual or developmental disability, including the right to live in the least restrictive setting appropriate to the individual's needs and abilities.

§926.4. Additional Training for Employees who Provide Direct Care to Individuals.

(a) Before an employee who provides direct delivery of services begins to perform direct care duties without direct supervision, the facility must provide the employee relevant training essential to perform the employee's duties regarding implementation of the interdisciplinary treatment program for each individual for whom the employee will provide direct care, including the following topics:

(1) prevention and management of aggressive or violent behavior;

(2) observing and reporting changes in behavior, appearance, or health of an individual;

(3) positive behavior support;

(4) emergency response;

(5) person-directed plans;

(6) self-determination; and

(7) trauma-informed care.

(b) Facilities must provide training on the following topics relevant to the individuals the direct care employee will serve:

(1) techniques for lifting, positioning, moving and increasing mobility;

(2) specialized needs of geriatric individuals;

(3) assisting individuals with visual, hearing, or communication impairments or who require adaptive devices and specialized equipment;

(4) recognizing appropriate food textures;

(5) using proper feeding techniques to assist individuals with meals;

(6) specific to state supported living center direct care employees:

(A) seizure safety;

(B) working with aging individuals;

(C) assisting individuals with personal hygiene;

(D) physical and nutritional management plans;

(E) home and community-based services, including the principles of community inclusion and participation and the community living options information process; and

(F) procedures for securing evidence following an incident of suspected abuse, neglect, or exploitation; and

(7) specific to state hospital direct care employees:

(A) seizure safety;

(B) assisting patients with personal hygiene; and

(C) physical and nutritional management plans.

§926.5. State Hospital Refresher Training.

State hospitals must provide all employees annual training relevant to their position on the topics outlined in §926.3 of this chapter (relating to Training for New Employees) and §926.4 of this chapter (relating to Additional Training for Employees who Provide Direct Care to Individuals), as the topics pertain to state hospital employees. State hospitals must provide this training throughout an employee's employment or association with the state hospital, unless the agency determines in good faith and with good reason a particular employee's performance will not be adversely affected in the absence of such refresher training.

§926.6. State Supported Living Center (SSLC) Refresher Training.

(a) An SSLC must provide employees annual training on:

(1) abuse, neglect, and exploitation; and

(2) unusual incidents.

(b) An SSLC must provide training to employees who are not direct care employees on the rights of individuals every two years.

(c) An SSLC must provide all direct care employees annual training relevant to their position on the topics outlined in §926.3 of this chapter (relating to Training for New Employees) and §926.4 of this chapter (relating to Additional Training for Employees who Provide Direct Care to Individuals), unless otherwise addressed in this section, as the topics pertain to SSLC employees.

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

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Karen Ray
Chief Counsel
Health and Human Services Commission
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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT, AND HEALTH INSURANCE AND ANNUITIES

The Texas Department of Insurance (TDI) proposes to amend §3.3038 in Subchapter S of 28 TAC Chapter 3; §§3.3702 - 3.3705 and 3.3707 - 3.3711 in Subchapter X, Division 1, of 28 TAC Chapter 3; and §§3.3720, 3,3722, and 3.3723 in Subchapter X, Division 2, of 28 TAC Chapter 3. TDI also proposes new §3.3712 and §3.3713 in Subchapter X, Division 1; proposes to repeal §3.3725 in Subchapter X, Division 2; and proposes to amend the title of Subchapter X, Division 2. These sections concern preferred and exclusive provider benefit plans. Among other changes, the repeal, amendments, and new sections implement House Bills 711, 1647, 1696, 2002, and 3359, 88th Legislature, 2023; Senate Bill 1264, 86th Legislature, 2019; and Senate Bills 1003 and 2476, 88th Legislature, 2023, and address the 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) (TAHP Order), which invalidated 28 TAC §§3.3708(a), 3.3708(b)(1), 3.3708(b)(3), 3.3725(d), and 11.1611(d).

EXPLANATION. This proposal implements HB 711, which prohibits anticompetitive contract provisions; HB 1647, which provides protections for certain clinician-administered drugs; HB 1696, which expands protections for optometrists and therapeutic optometrists in contracts with managed care plans; HB 2002, which requires insurers to credit certain out-of-network payments to the enrollee's deductible and maximum out-of-pocket amounts; HB 3359, which provides extensive network adequacy standards and requirements; SB 1003, which expands facility-based provider types that must be listed in provider directories; and SB 2476, which creates new payment standards and balance billing protections for emergency medical services.

The proposal makes additional amendments in Subchapter S and throughout Subchapter X. The proposed amendments remove payment rules that were invalidated by court order, provide new payment requirements and protections for preferred and exclusive provider plans consistent with SB 1264, expand exceptions to guaranteed renewability requirements, affirm TDI's prohibition on referral requirements, prohibit penalties on insureds for failure to obtain a preauthorization, restrict misrepresentation of cost-sharing incentives in advertisements, streamline disclosure requirements for policy terms, require that certain filings be submitted to TDI via the National Association of Insurance Commissioners' System for Electronic Rate and Form Filings (SERFF) instead of email, remove references to a repealed section, and revise sections as necessary to conform to changes in other sections. A proposed amendment revises the title of Subchapter X, Division 2, to reflect that the division addresses application, examination, and plan requirements and applies to both preferred and exclusive provider benefit plans.

HB 3359 applies to policies delivered, issued for delivery, or renewed on or after September 1, 2024. Insurance Code §1301.0056 requires TDI to examine network adequacy before a plan is offered, and Insurance Code §1301.00565 requires TDI to hold a public hearing before approving a waiver request. To ensure adequate time for network adequacy reviews and waiver hearings, TDI will begin reviewing networks according to the new standards in advance of September 1, 2024. The proposed rules will apply to annual network adequacy reports due by April 1, 2024, and any network configuration filings made after that date. A network that will not be used with any plan issued or renewed on or after September 1, 2024, will continue to be subject to the rules in effect at the time the plan was issued or renewed.

The proposed repeal, amendments, and new sections are described in the following paragraphs.

Section 3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical or Surgical Coverage; Exceptions. The proposed amendments to §3.3038 expand the exceptions related to guaranteed renewability to permit coverage under a preferred or exclusive provider benefit plan to be discontinued or nonrenewed if the insured no longer resides, lives, or works in the service area of the issuer by removing a reference to subsection (c) of the section in subsection (a) and amending subsection (c)(4) to include Insurance Code Chapter 1301 and adding references to the insurer's service area to subsections (c), (e), and (f). These changes implement Insurance Code §1202.051, which addresses guaranteed renewability, and §1301.0056, which addresses qualifying examinations for preferred and exclusive provider benefit plans. As amended by HB 3359, §1301.0056 provides that an insurer may not offer a preferred or exclusive provider benefit plan before the commissioner determines that the network meets the quality of care and network adequacy standards in Insurance Code Chapter 1301 or the insurer receives a waiver.

The proposal amends subsection (d) to require insurers to notify the commissioner of a discontinuance and amend subsection (h) to clarify requirements for uniform modifications. They also add a definition of a uniform modification in new subsection (i), clarify notice requirements by adding new subsection (j), which states that a notice provided to the commissioner under §3.3038 must be submitted as an informational filing consistent with the procedures specified in 28 TAC Chapter 3, Subchapter A, and clarify network filing requirements by adding new subsection (k).

In addition, a proposed amendment to the section title adds a comma, and another proposed amendment adds a reference to the title of Insurance Code Chapter 842 in a citation to the chapter in subsection (c)(4).

Subchapter X. Preferred and Exclusive Provider Plans

Division 1. General Requirements

28 TAC §§3.3702 - 3.2705, 3.3707 - 3.3711, and new 3.3712 and 3.3713

Section 3.3702. Definitions. The proposed amendments to §3.3702 expand the definition of "facility-based physician" in subsection (b)(8) by changing the defined term to "facility-based physician or provider," thereby including non-physician providers, and by deleting the reference to specific specialists listed in the current definition, consistent with SB 1003.

An amendment also revises subsection (b)(17) to remove the definition of "rural area," which is no longer needed with the addition of new §3.3713, and replace it with a definition for SERFF.

Amendments also add the titles of a cited Insurance Code chapter and cited Insurance Code sections in subsections (a) and (b)(1), (7), and (10).

Section 3.3703. Contracting Requirements. Proposed amendments to §3.3703 implement HB 711 and HB 1696, respectively, by adding requirements in new paragraphs (29) and (30) of subsection (a) that a contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning contract requirements, including the prohibitions on contractual anti-steering, anti-tiering, most favored nation, and

gag clauses, and Insurance Code Chapter 1451, Subchapter D, concerning access to optometrists used under managed care plan, including protections for optometrists and therapeutic optometrists in managed care plans that cover vision or medical eye care. Amendments also update a reference to "facility-based physician group" in subsection (a)(26) by adding the words "or provider" to conform with an amended definition in §3.3702.

Amendments also clarify language in the section by changing "assure" to "ensure" in subsection (a); "shall" to "must" in subsection (a)(4); "x-ray" to "X-ray" in subsection (a)(5); "therein" to "in the contract" in subsection (a)(13); "such immunizations or vaccinations" to "they" and "rules promulgated thereunder" to "implementing rules" in subsection (a)(17); "e-mail" to "email," "pursuant to" to "in accordance with," and "in accordance with" to "under" in subsection (a)(20); "methodologies" to "methods" in subsection (a)(20)(A); "pursuant to" to "in accordance with" in (a)(20)(G)(iii); and "utilized insofar as" to "employed to the extent" in subsection (b). In addition, proposed amendments add an apostrophe following the word "days" in subsection (a)(20)(D) and quotation marks around the words "batch submission" in subsection (a)(20)(D), remove parenthetical information following a citation to Insurance Code §1661.005, add the titles of cited Insurance Code sections in paragraphs (13), (14), (15), (18), (25), and (27) of subsection (a) and subsections (b) and (c), and delete an unnecessary use of the word "the" in a citation to Insurance Code §1661.005 in subsection (a)(25). Also, a citation to Insurance Code §1301.0053 is added to subsection (a)(28).

Section 3.3704. Freedom of Choice; Availability of Preferred Providers. The proposed amendments to §3.3704 remove references to §3.3725, which this proposal repeals, and add the titles of cited Insurance Code sections in subsection (a), including in paragraphs (1), (4), (5), (9), and (12). Citations in subsections (a) and (b) to specific Insurance Code sections are replaced with broader chapter and subchapter citations. The citation in subsection (a)(5) to §3.3708 is changed to reflect the proposed amendment to the section title, and the citation to 28 TAC Chapter 19, Subchapter R in subsection (a)(9) is updated to reflect the current name of that subchapter. References in subsection (a) to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Amendments in subsection (a)(7) affirm TDI's prohibition on insurers requiring an insured to select a primary care provider or obtain a referral before seeking care, and amendments in subsection (a)(9) prohibit an insurer from penalizing an insured based solely on a failure to obtain a preauthorization, as TDI views such practices as unjust under Insurance Code §1701.055(a)(2). TDI invites comments on amended subsection (a)(9) as proposed. Also, an amendment in subsection (a)(12) removes a citation to 28 TAC §3.3725 to reflect the repeal of that section.

The proposal implements Insurance Code §1458.101(i), as added by HB 711, by replacing the current subsection (e) with a new subsection (e) containing provisions that restrict the use of steering or a tiered network to encourage an insured to obtain services from a particular provider only to situations in which the insurer engages in such conduct for the primary benefit of the insured.

The proposal implements HB 3359 by amending subsection (f) to add requirements that preferred provider plans comply with new network adequacy standards, provide sufficient choice and number of providers, monitor compliance, report material deviations to TDI, and promptly take corrective action. Subsection (f) is also amended to delete the previous network adequacy standards and reference to local market adequacy requirements, consistent with the statutory changes in HB 3359. Subsection (g) is amended to address requirements if a material deviation from network adequacy standards occurs. Amendments to subsection (h) also implement Insurance Code §1301.005(d), as added by HB 3359, by requiring a service area to be defined in terms of one or more Texas counties, removing options to define a service area by ZIP codes or 11 Texas geographic regions, and specifying that a plan may not divide a county into multiple service areas.

In addition, amendments clarify language in the section by changing "pursuant to" to "in accordance with" in subsection (a)(1), "50 percent" to "50%" in subsection (a)(5), "is taken pursuant to the" to "are taken under" in subsection(a)(9), and "accord" to "accordance" in subsection (a)(12).

Section 3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations. The proposed amendments to subsections (l) and (n) in §3.3705 implement SB 1003 by updating references to "facility-based physician" and by deleting the related listing of included specialist categories. Amendments to subsection (l) also clarify that the applicability of paragraphs (10) and (11) is consistent with Insurance Code Chapter 1451, Subchapter K.

The amendments modernize and streamline the disclosure requirements, including by shortening the name of the written description to plan disclosure in subsections (b), (c), and (f); requiring insurers to provide the plan disclosure in any plan promotion and link to the plan disclosure from the federally required summary of benefits and coverage in subsection (b); removing the requirement that a plan disclosure follow a specified order and permitting the insurer to use its policy or certificate to provide the disclosure in subsection (b); requiring availability via a website address instead of a mailing address in subsection (b)(2); requiring an explanation relating to preauthorization requirements in subsection (b)(9); conforming to the waiver disclosure requirements in HB 3359 in subsections (b)(14) and (m)(1); conforming prescription drug coverage disclosures requirements to §21.3030 in subsection (b)(4); streamlining network disclosure requirements in in subsection (b)(12); replacing service area disclosures with county disclosure to conform with HB 3359 in subsections (b)(13) and (e)(2); and conforming disclosure requirements concerning reimbursements of out-of-network claims to proposed changes in other sections, such as removing disclosure requirements for preauthorization penalties, consistent with the proposed amendment in §3.3704(a)(9).

Amendments to subsection (c) remove filing requirements for listings of preferred providers, consistent with the changes in subsection (b). A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage.

Amendments to subsection (f) replace the preferred and exclusive provider benefit plan notices to reflect balance billing protections contained in SB 1264 from 2019, to remove outdated references, and to limit the notice requirements to apply only to major medical insurance plans.

In recognition of the robust network adequacy requirements contained in HB 3359, amendments remove requirements in subsection (n) to notify TDI of provider terminations that do not impact network compliance and requirements in subsections (p)

and (q) to designate a plan network as an approved or limited hospital care network.

Amendments to subsection (o) update disclosure of payment standards for out-of-network services, consistent with the proposed changes in §3.3708. A reference in subsection (d) to "basic benefits" is updated to clarify that the term refers to out-of-network coverage. Amendments also add the titles of cited Insurance Code sections and update citations in subsection (k) to §3.3708 and §3.3725 to conform with the amendments and repeal in this proposal.

In addition, amendments clarify language in the section by changing "chapter" to "title" in subsection (a), "address" to "website address" in subsection (b)(2), and "pursuant to" to "under" in subsections (b)(14)(B) and (m)(1), Also amendments to subsections (e), (i), (j), (l), and (n)(5) make changes to simplify the text addressing information on an insurer's website by removing the words "internet" and "internet-based" and adding language using the term "website."

Section 3.3707. Waiver Due to Failure to Contract in Local Markets. The proposed amendments to §3.3707 implement HB 3359 by updating the requirements for a finding of good cause for granting a waiver from network adequacy standards, subject to statutory limits in subsection (a); requiring that a waiver request include certain information including information demonstrating a good faith effort to contract (if providers are available) and describing any exclusivity arrangements or other external factors impacting the ability of the parties to contract in subsections (b) and (c); and clarifying the commissioner's consideration of an access plan for waiver requests in subsection (c). The proposal specifies in subsections (b) and (c) that an insurer must use the process and electronic form specified in §3.3712 to file a waiver request and access plan, which will enable TDI to publish data on waivers as required by statute.

Additional amendments in subsections (b) and (d) require an insurer to use TDI's electronic form to submit the evidence supporting the waiver request and mark the document as confidential if it contains proprietary information. Required documents must be submitted in SERFF, which makes filed information publicly available, unless the insurer marks a document as confidential. Proposed amendments in subsection (d) also remove the requirement for insurers to send notices of waiver requests to physicians and providers; instead, TDI will send notices to those providers in advance of a waiver hearing. Amendments to subsection (e) clarify the process for providers to respond to a waiver request.

An amendment to subsection (h) clarifies that TDI will specify the one-year period for which the waiver will apply and will post information relating to the waiver on its website, and an amendment to subsection (g) clarifies that an insurer may request to renew a waiver in conjunction with filing the annual report as required in §3.3709.

Existing subsections (i)(1) and (2) and (j) are deleted to conform with the proposed access plan requirements of this section and filing requirements in §3.3712; references in this section to "local market access plan" are changed to remove references to local markets to conform with the changes in HB 3359.

Amendments in the text of existing subsection (k) (which is redesignated as subsection (j)) and the text of new subsection (k) update the required processes that an insurer must develop to facilitate access to covered services, provide insureds with an option to obtain care without being subject to balance billing, and ensure that insureds understand what options they have when no in-network provider is reasonably available.

New subsection (m) replaces previous access plan requirements with the requirement that insurers submit a general access plan that will apply in any unforeseen circumstance where an insured is unable to access in-network care within the network adequacy standards.

Subsection (n) is deleted, as it is outdated in view of the proposed changes relating to network waivers in this section.

Also, an amendment to subsection (a) corrects an Insurance Code citation and adds the name of the cited section. In addition, amendments clarify language in the section by changing "in accord with" to "consistent with" in subsection (a) and "pursuant to" to "in accordance with" in subsections (g)(2) and (i).

Section 3.3708. Payment of Certain Basic Benefit Claims and Related Disclosures. Proposed amendments to §3.3708 remove existing subsections (a) and (b), which contain provisions invalidated by the TAHP Order and change the section title to replace "Basic Benefit" with "Out-of-Network" and to delete "and Related Disclosures." This text is replaced by a new subsection (a) and (b). New subsection (a) provides payment standards for certain out-of-network claims and reflect balance billing protections, consistent with SB 2476 and SB 1264. New subsection (b) provides consumer protections for network gaps.

The proposal consolidates requirements for preferred and exclusive provider benefit plans by moving some provisions from §3.3725, which is proposed for repeal, to §3.3708. Subsection (d) is amended to clarify that exclusive provider benefit plans are exempt from certain payment requirements for out-of-network services, and references to "basic level of coverage" are updated to clarify that the term refers to out-of-network coverage.

Current subsection (e) is deleted, as it is no longer in effect. It is replaced by a new subsection (e), which implements HB 2002 by clarifying that an insurer must credit certain direct payments to nonpreferred providers towards the insured's in-network cost-sharing maximums.

Existing subsection (f) is deleted because, with the other proposed changes, application of the section should no longer be limited to exclusive provider plans. The subsection is replaced by a new subsection (f), which implements HB 1647 by clarifying that insurers must cover certain clinician-administered drugs at the in-network benefit level.

Section 3.3709. Annual Network Adequacy Report. Proposed amendments to subsections (b) and (c) revise the text of the subsections to expand the content to be included in the annual network adequacy report, including requirements for insurer identifying information and information relating to network configuration, facility access, waiver requests and access plans, enrollee demographics, complaints, and actuarial data. An amendment to subsection (c)(4) also updates a reference to "basic benefits" to clarify that the term refers to out-of-network benefits.

Amendments to subsection (d) require that annual network adequacy reports be submitted to TDI via the SERFF system using the electronic form provided by TDI and remove the option to file the report via email.

Proposed amendments to subsection (a) restructure the language of the section for clarification.

Section 3.3710. Failure to Provide an Adequate Network. Proposed amendments to subsection (a) clarify the scope of the commissioner's sanction authority. Additional amendments to subsection (a) add the titles of cited Insurance Code sections, remove references to the term "local market," and change "and/or" to "and," and amendments to subsections (a) and (b) change "pursuant to" to "under."

Section 3.3711. Geographic Regions. Proposed amendments to §3.3711 replace the ZIP code listing with a county listing, based on the regional map available at www.hhs.texas.gov, consistent with the requirement in HB 3359 that service areas may not divide a county.

Section 3.3712. Network Configuration Filings. New §3.3712 implements HB 3359 by requiring submission of network configuration information. This information is currently addressed in §3.3722. Subsections (a) and (b) clarify that network configuration filings must be submitted in SERFF and are required in connection with a waiver request under §3.3707, an annual report under §3.3709, or an application or modification under §3.3722. Subsection (c) specifies that insurers must use TDI's electronic forms when making network configuration filings and lists the information that must be included within the forms. The purposes of these electronic forms are to assist the insurer in demonstrating compliance with the network adequacy requirements contained in HB 3359 and to allow TDI to aggregate and publish information concerning networks and waivers consistent with Insurance Code §§1301.0055(a)(3), 1301.00565(g), and 1301.009. Subsection (d) clarifies that the submitted information is considered public information subject to publication by TDI.

Section 3.3713. County Classifications for Maximum Time and Distance Standards. New §3.3713 implements Insurance Code §1301.00553 as added by HB 3359, which specifies that counties are classified based on determinations made by the federal Centers for Medicare and Medicaid Services as of March 1, 2023. The new section lists each Texas county according to its classification as a large metro, metro, micro, or rural county, or a county with extreme access considerations.

Division 2. Application, Examination, and Plan Requirements

28 TAC §§3.3720, 3.3722, 3.3723, and 3.3725

Section 3.3720. Preferred and Exclusive Provider Benefit Plan Requirements. The proposed amendments to §3.3720 update the titles of administrative code sections referenced in the section; revise an incorrect citation in the section; remove a reference to §3.3725, which is repealed by this proposal; add the title to a citation to the Insurance Code; and change "pursuant to" to "under."

Section 3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications. The proposed amendments to §3.3722 implement HB 3359 by updating network configuration filing requirements and cross-references to conform to changes made in §§3.3038, 3.3707, 3.3708, and 3.3712, and the repeal of §3.3725. Requirements for network modifications are clarified to align with current practices.

Amendments to subsection (a) clarify that insurers must use the specified form to file an application for approval of a plan.

An amendment to subsection (b)(4) clarifies the rule text by changing passive voice to active voice.

Amendments to subsection (c) update references to service areas to refer to counties, consistent with HB 3359; update a reference to "medical peer review" to conform to statute; replace the listing of required network configuration information with a reference to proposed new §3.3712; replace citations to §3.3725, which is proposed for repeal; change "pursuant to" to "under"; and add titles to citations to the Insurance Code.

Amendments to subsection (d) clarify that the documents required for a qualifying examination must include network configuration information described in new §3.3712 that demonstrates network adequacy compliance. Amendments to subsection (d) also change "pursuant to" to "in accordance with" and "under."

Amendments to subsection (e) add a reference to new §3.3712; require that for nonrenewals resulting from a service area reduction, insurers must comply with §3.3038, as amended in this proposal; and remove the requirement that insurers must comply with §3.3724 to receive approval of a service area expansion or reduction application for certain exclusive provider benefit plans.

Section 3.3723. Examinations. Proposed amendments to §3.3723 change "pursuant to" to "under" and "in accordance with" and "in accord with" to "in accordance with"; add the titles of cited Insurance Code, Administrative Code, and Occupations Code provisions; and add a citation to new §3.3712.

Section 3.3725. Payment of Certain Out-of-Network Claims. The proposal repeals §3.3725 to conform with the proposed amendments to §3.3708 and to remove sections invalidated by the TAHP Order.

In addition, the proposed amendments include nonsubstantive editorial and formatting changes to conform the sections to the agency's current style and to improve the rule's clarity. These changes appear throughout the amended sections and include adding headings to cited statutes and rules; removing references to §3.3725, which is repealed by this proposal; updating cross-references to other rules; updating terminology, including references to access plans, out-of-network level of coverage, and service areas; nonsubstantive text edits, including removing extraneous words such as "the" from statutory citations; and grammatical, punctuational, and format changes to reflect TDI's current drafting style and plain language preferences.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Rachel Bowden, director of Regulatory Initiatives in the Life and Health Division, has determined that during each year of the first five years the sections as proposed are in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the proposed sections, other than that imposed by statute. Ms. Bowden made this determination because the sections as proposed do not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed sections.

Ms. Bowden does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the sections as proposed are in effect, Ms. Bowden expects that enforcing and administering them will have the public benefits of ensuring that TDI's rules properly implement House Bills 711, 1647, 1696, 2002, and 3359, and Senate Bills 1003, 2476, and 1264, and the TAHP Order. The proposed amendments to §3.3704 will have the public benefit of ensuring that health plan requirements are fair to insureds and that

the plan provides benefits consistent with how the plan is advertised. The proposed amendments to §3.3705 will have the public benefit of making it easier for insureds to find information about the policy terms and conditions, network breadth, and network waivers. The proposed amendments to §3.3708 will have the public benefit of ensuring that insureds are protected in any case where they obtain out-of-network care because they are unable to reasonably access in-network care. The proposed amendments to §§3.3707, 3.3709, and 3.3711 and new §3.3712 and §3.3713 will benefit the public by ensuring that TDI collects the information necessary to thoroughly evaluate network adequacy and requests for waivers, consistent with new statutory requirements. This proposal will ensure that insureds who purchase preferred and exclusive provider benefit plans are able to access medically necessary covered services from preferred providers or through an access plan facilitated by the insurer, without being subject to extra costs.

Ms. Bowden expects that the sections as proposed will impose an economic cost on persons required to comply with them. However, some of those costs may be offset by cost savings created by amendments to existing rules.

Costs

The proposed amendments to §3.3707 and §3.3709 and new §3.3712 require insurers to make network filings, including waiver requests, using SERFF. Since the use of SERFF is not currently required, the proposed amendments could have a cost impact on any insurer that currently submits network filings outside of SERFF. In 2023, SERFF charges a fee of $17.61 for each filing. TDI is not able to predict how many network filings will be required when the proposed new and amended sections become effective, but past experience may be helpful in estimating the potential cost impact. In the past five years, TDI has not received any network filings for a licensed insurer outside of SERFF. Therefore, Ms. Bowden estimates that this change in practice will not have a cost impact on insurers subject to the proposal. Insurers voluntarily use SERFF because it provides a cost-effective option for insurers to transmit filings, store information, communicate with TDI staff, make information publicly available, and designate any information that is proprietary or confidential. Continued acceptance of filings through email would be less efficient and less technically secure for both TDI and insurers. The use of SERFF filings helps TDI comply with Government Code Chapter 552 by facilitating the appropriate release of information while including the necessary technical safeguards to protect confidential information.

The proposed amendments to §3.3707 and §3.3709 and new §3.3712 require insurers to use electronic forms published on TDI's website to provide the information specified in the proposed rules. Currently, TDI publishes example forms for network filings, which insurers can use if they choose. TDI forms help insurers make filings that meet all requirements. In implementing HB 3359, the required use of TDI's provider listings form is necessary to enable TDI to use software that can validate an insurer's compliance with time and distance standards specified in Insurance Code §1301.00553. The required use of TDI's network compliance and waiver request form to document network compliance and summarize network waiver requests and associated access plans is necessary to enable TDI to confirm compliance with network adequacy standards, compile information on provider networks and waivers, and publish that information in a comparable format as required in Insurance Code §1301.0055 and §1301.009. The required use of TDI's attempt to contract form to document good faith efforts to contract is needed for TDI to consider waiver requests and evaluate whether good cause for a waiver is shown. The required use of TDI's annual network adequacy report form to collect annual report information is needed to help TDI evaluate the impact that any network gaps and waivers have on insureds and providers. Insurers may face administrative costs associated with updating internal data systems to submit network information using TDI's electronic forms. Some of these costs will be offset by savings. For example, TDI proposes to remove the requirement for insurers to submit extensive maps to illustrate distance standards compliance. The proposed submission requirements may also be less costly to the extent that they align more closely with federal requirements for insurers that offer qualified health plans in the individual market. While it is not feasible to determine the actual cost of any employees needed, Ms. Bowden estimates that making the required filings to comply with HB 3359 using TDI's new required electronic forms may necessitate:

- between 20 and 80 hours for a computer programmer on a one-time basis; and

- between 10 and 40 hours for a compliance officer to populate the forms each time a network filing is made.

Some of these costs are attributable to statute and would be incurred even if TDI did not require the use of specific forms. Staff costs may vary depending on the skill level required and the geographic location where work is done. According to the Texas Wages and Employment Projections database, which is developed and maintained by the Texas Workforce Commission and located at www.texaswages.com/WDAWages, the average hourly wage in Texas is $44.98 for a computer programmer and $35.31 for a compliance officer.

The proposed amendment to §3.3704(a)(9) prohibits insurers from penalizing an insured for failure to obtain preauthorization before accessing medically necessary care. This does not impact contractual requirements with preferred providers related to preauthorization requirements and does prevent an insurer from retrospectively reviewing a claim for a service that was not preauthorized and denying a claim if it fails to meet medical necessity standards. To the extent that an insurer is currently imposing and collecting such penalties, this provision could decrease the portion of claims paid by insureds and increase the portion of claims paid by the insurer. TDI does not have data available that allows it to estimate how often such penalties are imposed and invites comment on this issue.

The proposed amendments to §3.3705(b) modify when and how insurers are required to provide the written description of policy terms and conditions (plan disclosure) and simplify the information that must be included. The proposed amendments allow insurers to use the federally required summary of benefits and coverage (SBC) as a method to deliver access to the disclosure. They also remove the requirement that the plan disclosure be listed in a particular order and allow insurers to use its policy or certificate to satisfy the disclosure requirements. Collectively, this provides significant flexibility for insurers and reduces the number of separate documents the insurer must produce that reflect plan-specific information. Ms. Bowden estimates that the flexibility added in the proposed amendments will save insurers between eight and 24 hours of time for a compliance officer (earning an average wage of $35.41 per hour in Texas, as cited previously) for each plan offered.

The proposed amendments to §3.3707(d) remove the requirement for insurers to send a notice to each provider they attempt to contract with, concurrent with filing a waiver request to TDI. Ms. Bowden estimates that removing this requirement will save insurers between eight and 16 hours of time that otherwise would be needed to send those notices for each network for which a waiver request is filed. According to the Texas Wages and Employment Projections database, an Office and Administrative Support worker in Texas earns an average hourly wage of $20.59.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the sections as proposed will not have an adverse economic impact on rural communities, but they may have an adverse economic effect on small or micro businesses. Rural communities will not be adversely impacted because the rule applies only to insurers. The cost analysis in the Public Benefit and Cost Note section also applies to these small or micro businesses. TDI estimates that the sections as proposed may affect between zero and three small or micro businesses. This proposal's primary objective is to ensure that preferred and exclusive provider benefit plans contract with a sufficient number and type of providers to provide sufficient access to all types of covered health care services to all insureds across the plans' service areas. The proposal also aims to ensure that consumers are adequately informed about their rights and protected from balance billing that may occur if they are unable to reasonably access covered health care services within the network adequacy standards. TDI considered the following alternatives to minimize any adverse impact on small or micro businesses while accomplishing the proposal's objectives:

(1) exempting small or micro businesses from the sections as proposed;

(2) providing additional time for small or micro businesses to comply; and

(3) exempting small or micro businesses from the proposed requirement to submit network filings in SERFF using TDI's electronic forms.

After considering Option 1, TDI declined to exempt small or micro businesses from the sections as proposed because TDI does not have authority to exempt these businesses from compliance with the new laws, and the rules as proposed work together to implement the new laws. Without the guidance and clarification provided by the proposal, small or micro businesses would have more difficulty complying with the new statutory requirements.

In regard to Option 2, TDI determined that extending the compliance deadline for small or micro businesses was not supported by statute. Providing additional time for some businesses and not others would create an unlevel playing field and provide inequitable protections for consumers depending on whether they enrolled in a plan offered by a small or micro business.

In considering Option 3, TDI determined that exempting small or micro businesses from requirements to submit network filings in SERFF and to use TDI forms would create a significant burden on agency staff to review information submitted in a nonstandard format. Without the standardized format in the TDI forms, TDI would be unable to publish uniform information on waivers or would need to do significant manual data entry or manual compliance analysis. In addition, exempting a small or micro business from the requirements to submit network filings via SERFF would require agency staff to maintain a separate process for handling such filings. To maintain agency records, staff would have to manually upload multiple types of filings, and all communications related to those filings, into SERFF throughout the year. These manual processes would strain agency resources and create opportunities for errors.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does impose a possible cost on regulated persons. However, no additional rule amendments are required under Government Code §2001.0045 because the proposed rule is necessary to implement legislation. The proposed rule implements SB 1264 from the 86th legislative session and the following bills from the 88th legislative session: House Bills 711, 1647, 1696, 2002, and 3359, and Senate Bills 1003 and 2476. The proposed rule also includes amendments to reduce the burden or responsibilities imposed on regulated persons by the rule or decrease their costs of compliance. TDI has solicited input from regulated entities and the Centers for Medicare and Medicaid Services to determine cost-effective methods of compliance that align with current state and federal regulatory standards and compliance practices, and TDI has considered such input when drafting this proposal.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the sections as proposed are in effect, the proposed rule:

- will not create or eliminate a government program;

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

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

- will not require an increase or decrease in fees paid to the agency;

- will create new regulations;

- will expand, limit, and repeal existing regulations;

- will increase the number of individuals subject to the rule's applicability; and

- will not positively or adversely affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on January 10, 2024. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

The commissioner of insurance will also consider written and oral comments on the proposal in a public hearing under Docket No. 2842 at 2:30 p.m., central time, on January 9, 2024, in Room 2.029 of the Barbara Jordan State Office Building, 1601 Congress Avenue, Austin, Texas 78701.

SUBCHAPTER S. MINIMUM STANDARDS AND BENEFITS AND READABILITY FOR

INDIVIDUAL ACCIDENT AND HEALTH INSURANCE POLICIES

28 TAC §3.3038

STATUTORY AUTHORITY. TDI proposes amendments to §3.3038 under Insurance Code §§1202.051, 1301.0056, and 36.001.

Insurance Code §1202.051 requires the commissioner to adopt rules necessary to implement the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

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

CROSS-REFERENCE TO STATUTE. The proposed amendments to §3.3038 implement Insurance Code Chapters 1202 and 1301.

§3.3038. Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions.

(a) Except as provided by [~~subsection (c) of~~] this section, all individual hospital, medical, or surgical coverage (as defined in §3.3002(b)(12) of this title (relating to Definitions)) must be renewed or continued in force at the option of the insured.

(b) Medicare eligibility or entitlement is not a basis for nonrenewal or termination of individual hospital, medical, or surgical coverage; however, such coverage sold to an insured before the insured attains Medicare eligibility may contain a clause that excludes payments for benefits under the policy to the extent that Medicare pays for such benefits.

(c) Individual hospital, medical, or surgical coverage may only be discontinued or nonrenewed based on one or more of the following circumstances:

(1) the policyholder has failed to pay premiums or contributions in accordance with the terms of the policy, including any timeliness requirements;

(2) the policyholder has performed an act or practice that constitutes fraud, or has made an intentional misrepresentation of material fact, relating in any way to the policy, including claims for benefits under the policy;

(3) the insurer is ceasing to offer individual hospital, medical, or surgical coverage under the particular type of policy, or is ceasing to offer any form of individual hospital, medical, or surgical coverage in this state or in the insurer's service area, in accordance with subsections (d) and (e) of this section;

(4) in regard [~~regards~~] only to coverage offered by an issuer under Insurance Code Chapter 842, concerning Group Hospital Service Corporations, or Chapter 1301, concerning Preferred Provider Benefit Plans, the insured no longer resides, lives, or works in the service area of the issuer, or area for which the issuer is authorized to do business, but only if coverage is terminated uniformly without regard to any health-status-related factor of covered individuals.

(d) An insurer may elect to discontinue offering a particular type of individual hospital, medical, or surgical coverage plan in the individual market only if the insurer:

(1) provides written notice to the commissioner and each covered individual of the discontinuation before the 90th day preceding the date of the discontinuation of the coverage;

(2) offers to each covered individual on a guaranteed issue basis the option to purchase any other individual hospital, medical, or surgical insurance coverage offered by the insurer at the time of the discontinuation; and

(3) acts uniformly without regard to any health-status related factors of a covered individual or dependents of a covered individual who may become eligible for the coverage.

(e) An insurer may elect to refuse to renew all individual hospital, medical, or surgical coverage plans delivered or issued for delivery by the insurer in this state or in the insurer's service area, only if the insurer:

(1) notifies the commissioner of the election not later than the 180th day before the date coverage under the first individual hospital, medical, or surgical health benefit plan terminates;

(2) notifies each affected covered individual not later than the 180th day before the date on which coverage terminates for that individual; and

(3) acts uniformly without regard to any health-status related factor of covered individuals or dependents of covered individuals who may become eligible for coverage.

(f) An insurer that elects not to renew all individual hospital, medical, or surgical coverage in Texas or in the insurer's service area in accordance with subsection (e) of this section may not issue any such coverage in Texas or in the insurer's service area during the five-year period beginning on the date of discontinuation of the last such coverage not renewed.

(g) Nothing in this section prohibits or restricts an insurer's ability to make changes in premium rates by classes in accordance with applicable laws and regulations.

(h) Nothing in this section may be interpreted as prohibiting an insurer from making policy modifications mandated by state law, or, acting consistently with §3.3040(b) of this title (relating to Prohibited Policy Provisions), from honoring requests from a policyholder for modifications to an individual policy or offering policy modifications uniformly to all insureds under a particular policy form, if:[.]

(1) the modification meets the definition of a uniform modification under subsection (i) of this section; and

(2) the notice describes the uniform modifications and includes any rate change notice required under Insurance Code §1201.109, concerning Notice of Rate Increase for Major Medical Expense Insurance Policy.

(i) For the purposes of this section, a "uniform modification" is a change to coverage that is made at the time of coverage renewal, applies uniformly for all insureds covered under the policy form, and complies with the requirements of 45 CFR §147.106(e) and (f), concerning Guaranteed Renewability of Coverage.

(j) A notice that is required to be provided to the commissioner under this section must be submitted as an informational filing consistent with the procedures specified in Chapter 3, Subchapter A, of this title (relating to Submission Requirements for Filings and Departmental Actions Related to Such Filings).

(k) If a nonrenewal addressed under this section occurs in connection with a change to the insurer's service area, the insurer must make network configuration filings consistent with requirements

in Chapter 3, Subchapter X, of this title (relating to Preferred and Exclusive Provider Plans).

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

Filed with the Office of the Secretary of State on November 21, 2023.

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Jessica Barta
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Texas Department of Insurance
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For further information, please call: (512) 676-6555

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SUBCHAPTER X. PREFERRED AND EXCLUSIVE PROVIDER PLANS
DIVISION 1. GENERAL REQUIREMENTS

28 TAC §§3.3702 - 3.3705, 3.3707 - 3.3713

STATUTORY AUTHORITY. TDI proposes amendments to §§3.3702 - 3.3705 and 3.3707 - 3.3711 and new §3.3712 and §3.3713 under Insurance Code §§541.401, 1301.0055, 1301.0056, 1301.007, 1369.057, 1458.004, 1701.060, and 36.001.

Insurance Code §541.401 authorizes the commissioner to adopt reasonable rules necessary to accomplish the purposes of Chapter 541.

Insurance Code §1301.0055 requires the commissioner to adopt network adequacy standards that include requirements set out in the section.

Insurance Code §1301.0056 requires the commissioner to adopt rules establishing a process for examining a preferred provider benefit plan before an insurer offers the plan for delivery.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider services.

Insurance Code §1369.057 authorizes the commissioner to adopt rules to implement Chapter 1369, Subchapter B.

Insurance Code §1458.004 authorizes the commissioner to adopt rules to implement Chapter 1458.

Insurance Code §1701.060 authorizes the commissioner to adopt reasonable rules necessary to implement the purposes of Chapter 1701.

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

CROSS-REFERENCE TO STATUTE. The proposed amendments to §§3.3702 - 3.3705, 3.3707 - 3.3711, and new §3.3712 and §3.3713 implement Insurance Code Chapters 1301, 1369, 1451, and 1458.

§3.3702. Definitions.

(a) Words and terms defined in Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, have the same meaning when used in this subchapter, unless the context clearly indicates otherwise.

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

(1) Adverse determination--As defined in Insurance Code §4201.002(1), concerning Definitions.

(2) Allowed amount--The amount of a billed charge that an insurer determines to be covered for services provided by a nonpreferred provider. The allowed amount includes both the insurer's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

(3) Billed charges--The charges for medical care or health care services included on a claim submitted by a physician or provider.

(4) Complainant--As defined in §21.2502 of this title (relating to Definitions).

(5) Complaint--As defined in §21.2502 of this title.

(6) Contract holder--An individual who holds an individual health insurance policy, or an organization that holds a group health insurance policy.

(7) Facility--As defined in Health and Safety Code §324.001(7), concerning Definitions.

(8) Facility-based physician or provider--A physician or health care provider [~~radiologist, an anesthesiologist, a pathologist, an emergency department physician, a neonatologist, or an assistant surgeon~~]:

(A) to whom a facility has granted clinical privileges; and

(B) who provides services to patients of the facility under those clinical privileges.

(9) Health care provider or provider--As defined in Insurance Code §1301.001(1-a).

(10) Health maintenance organization (HMO)--As defined in Insurance Code §843.002(14), concerning Definitions.

(11) In-network--Medical or health care treatment, services, or supplies furnished by a preferred provider, or a claim filed by a preferred provider for the treatment, services, or supplies.

(12) NCQA--The National Committee for Quality Assurance, which reviews and accredits managed care plans.

(13) Nonpreferred provider--A physician or health care provider, or an organization of physicians or health care providers, that does not have a contract with the insurer to provide medical care or health care on a preferred benefit basis to insureds covered by a health insurance policy issued by the insurer.

(14) Out-of-network--Medical or health care treatment services, or supplies furnished by a nonpreferred provider, or a claim filed by a nonpreferred provider for the treatment, services, or supplies.

(15) Pediatric practitioner--A physician or provider with appropriate education, training, and experience whose practice is limited to providing medical and health care services to children and young adults.

(16) Provider network--The collective group of physicians and health care providers available to an insured under a preferred or

exclusive provider benefit plan and directly or indirectly contracted with the insurer of a preferred or exclusive provider benefit plan to provide medical or health care services to individuals insured under the plan.

(17) SERFF--The National Association of Insurance Commissioners (NAIC) System for Electronic Rate and Form Filings. [~~Rural area--~~]

[~~(A) a county with a population of 50,000 or less as determined by the United States Census Bureau in the most recent decennial census report;~~]

[~~(B) an area that is not designated as an urbanized area by the United States Census Bureau in the most recent decennial census report; or~~]

[~~(C) any other area designated as rural under rules adopted by the , notwithstanding subparagraphs (A) and (B) of this paragraph.~~]

(18) Urgent care--Medical or health care services provided in a situation other than an emergency that are typically provided in a setting such as a physician or individual provider's office or urgent care center, as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, illness, or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of the person's health.

(19) Utilization review--As defined in Insurance Code §4201.002(13).

§3.3703. Contracting Requirements.

(a) An insurer marketing a preferred provider benefit plan must contract with physicians and health care providers to ensure [~~assure~~] that all medical and health care services and items contained in the package of benefits for which coverage is provided, including treatment of illnesses and injuries, will be provided under the plan in a manner that assures both availability and accessibility of adequate personnel, specialty care, and facilities. Each contract must meet the following requirements:

(1) A contract between a preferred provider and an insurer may not restrict a physician or health care provider from contracting with other insurers, preferred provider plans, preferred provider networks or organizations, exclusive provider benefit plans, exclusive provider networks or organizations, health care collaboratives, or HMOs.

(2) Any term or condition limiting participation on the basis of quality that is contained in a contract between a preferred provider and an insurer is required to be consistent with established standards of care for the profession.

(3) In the case of physicians or practitioners with hospital or institutional provider privileges who provide a significant portion of care in a hospital or institutional provider setting, a contract between a preferred provider and an insurer may contain terms and conditions that include the possession of practice privileges at preferred hospitals or institutions, except that if no preferred hospital or institution offers privileges to members of a class of physicians or practitioners, the contract may not provide that the lack of hospital or institutional provider privileges may be a basis for denial of participation as a preferred provider to such physicians or practitioners of that class.

(4) A contract between an insurer and a hospital or institutional provider must [~~shall~~] not, as a condition of staff membership or privileges, require a physician or practitioner to enter into a preferred provider contract. This prohibition does not apply to requirements concerning practice conditions other than conditions of membership or privileges.

(5) A contract between a preferred provider and an insurer may provide that the preferred provider will not bill the insured for unnecessary care, if a physician or practitioner panel has determined the care was unnecessary, but the contract may not require the preferred provider to pay hospital, institutional, laboratory, X-ray [~~x-ray~~], or like charges resulting from the provision of services lawfully ordered by a physician or health care provider, even though such service may be determined to be unnecessary.

(6) A contract between a preferred provider and an insurer may not:

(A) contain restrictions on the classes of physicians and practitioners who may refer an insured to another physician or practitioner; or

(B) require a referring physician or practitioner to bear the expenses of a referral for specialty care in or out of the preferred provider panel. Savings from cost-effective utilization of health services by contracting physicians or health care providers may be shared with physicians or health care providers in the aggregate.

(7) A contract between a preferred provider and an insurer may not contain any financial incentives to a physician or a health care provider which act directly or indirectly as an inducement to limit medically necessary services. This subsection does not prohibit the savings from cost-effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) An insurer's contract with a physician, physician group, or practitioner must have a mechanism for the resolution of complaints initiated by an insured, a physician, physician group, or practitioner. The mechanism must provide for reasonable due process, including, in an advisory role only, a review panel selected as specified in §3.3706(b)(2) of this title (relating to Designation as a Preferred Provider, Decision to Withhold Designation, Termination of a Preferred Provider, Review of Process).

(9) A contract between a preferred provider and an insurer may not require any health care provider, physician, or physician group to execute hold harmless clauses that shift an insurer's tort liability resulting from acts or omissions of the insurer to the preferred provider.

(10) A contract between a preferred provider and an insurer must require a preferred provider who is compensated by the insurer on a discounted fee basis to agree to bill the insured only on the discounted fee and not the full charge.

(11) A contract between a preferred provider and an insurer must require the insurer to comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

(12) A contract between a preferred provider and an insurer must require the provider to comply with the Insurance Code §§1301.152 - 1301.154, which relates to Continuity of Care.

(13) A contract between a preferred provider and an insurer may not prohibit, penalize, permit retaliation against, or terminate the provider for communicating with any individual listed in [~~the~~] Insurance Code §1301.067, concerning Interference with Relationship Between Patient and Physician or Health Care Provider Prohibited, about any of the matters set forth in the contract [~~therein~~].

(14) A contract between a preferred provider and an insurer conducting, using, or relying upon economic profiling to terminate physicians or health care providers from a plan must require the insurer to inform the provider of the insurer's obligation to comply with [~~the~~] Insurance Code §1301.058, concerning Economic Profiling.

(15) A contract between a preferred provider and an insurer that engages in quality assessment is required to disclose in the contract all requirements of [~~the~~] Insurance Code §1301.059(b), concerning Quality Assessment.

(16) A contract between a preferred provider and an insurer may not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an insured by a pharmacist.

(17) A contract between a preferred provider and an insurer may not prohibit a pharmacist from administering immunizations or vaccinations if they [~~such immunizations or vaccinations~~] are administered in accordance with the Texas Pharmacy Act, Chapters 551 - 566 and Chapters 568 - 569 of the Occupations Code, and implementing rules [~~promulgated thereunder~~].

(18) A contract between a preferred provider and an insurer must require a provider that voluntarily terminates the contract to provide reasonable notice to the insured, and must require the insurer to provide assistance to the provider as set forth in [~~the~~] Insurance Code §1301.160(b), concerning Notification of Termination of Participation of Preferred Provider.

(19) A contract between a preferred provider and an insurer must require written notice to the provider on termination of the contract by the insurer, and in the case of termination of a contract between an insurer and a physician or practitioner, the notice must include the provider's right to request a review, as specified in §3.3706(d) of this title.

(20) A contract between a preferred provider and an insurer must include provisions that will entitle the preferred provider upon request to all information necessary to determine that the preferred provider is being compensated in accordance with the contract. A preferred provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds. The insurer may provide the required information by any reasonable method through which the preferred provider can access the information, including email [~~e-mail~~], computer disks, paper, or access to an electronic database. Amendments, revisions, or substitutions of any information provided in accordance with [~~pursuant to~~] this paragraph are required to be made under [~~in accordance with~~] subparagraph (D) of this paragraph. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

(A) This information is required to include a preferred provider specific summary and explanation of all payment and reimbursement methods [~~methodologies~~] that will be used to pay claims submitted by the preferred provider. At a minimum, the information is required to include:

(i) a fee schedule, including, if applicable, CPT, HCPCS, ICD-9-CM codes or successor codes, and modifiers:

(I) by which all claims for covered services submitted by or on behalf of the preferred provider will be calculated and paid; or

(II) that pertains to the range of health care services reasonably expected to be delivered under the contract by that preferred provider on a routine basis along with a toll-free number or electronic address through which the preferred provider may request the fee schedules applicable to any covered services that the preferred provider intends to provide to an insured and any other information required by this paragraph that pertains to the service for which the fee schedule is being requested if that information has not previously been provided to the preferred provider;

(ii) all applicable coding methodologies;

(iii) all applicable bundling processes, which are required to be consistent with nationally recognized and generally accepted bundling edits and logic;

(iv) all applicable downcoding policies;

(v) a description of any other applicable policy or procedure the insurer may use that affects the payment of specific claims submitted by or on behalf of the preferred provider, including recoupment;

(vi) any addenda, schedules, exhibits, or policies used by the insurer in carrying out the payment of claims submitted by or on behalf of the preferred provider that are necessary to provide a reasonable understanding of the information provided under [~~pursuant to~~] this paragraph; and

(vii) the publisher, product name, and version of any software the insurer uses to determine bundling and unbundling of claims.

(B) In the case of a reference to source information as the basis for fee computation that is outside the control of the insurer, such as state Medicaid or federal Medicare fee schedules, the information provided by the insurer is required to clearly identify the source and explain the procedure by which the preferred provider may readily access the source electronically, telephonically, or as otherwise agreed to by the parties.

(C) Nothing in this paragraph may be construed to require an insurer to provide specific information that would violate any applicable copyright law or licensing agreement. However, the insurer is required to supply, in lieu of any information withheld on the basis of copyright law or licensing agreement, a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to insureds as required by subparagraph (A) of this paragraph.

(D) No amendment, revision, or substitution of claims payment procedures or any of the information required to be provided by this paragraph will be effective as to the preferred provider, unless the insurer provides at least 90 calendar days' [~~days~~] written notice to the preferred provider identifying with specificity the amendment, revision, or substitution. An insurer may not make retroactive changes to claims payment procedures or any of the information required to be provided by this paragraph. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this paragraph, the written notice specified in this section does not supersede the requirement for mutual agreement.

(E) Failure to comply with this paragraph constitutes a violation as set forth in subsection (b) of this section.

(F) This paragraph applies to all contracts entered into or renewed on or after the effective date of this paragraph. Upon re-

ceipt of a request, the insurer is required to provide the information required by subparagraphs (A) - (D) of this paragraph to the preferred provider by the 30th day after the date the insurer receives the preferred provider's request.

(G) A preferred provider that receives information under this paragraph:

(i) may not use or disclose the information for any purpose other than:

(I) the preferred provider's practice management;

(II) billing activities;

(III) other business operations; or

(IV) communications with a governmental agency involved in the regulation of health care or insurance;

(ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type, or amount of services that were actually provided to an insured or to misrepresent any aspect of the services; and

(iii) may not rely upon information provided in accordance with [~~pursuant to~~] this paragraph about a service as a representation that an insured is covered for that service under the terms of the insured's policy or certificate.

(H) A preferred provider that receives information under this paragraph may terminate the contract on or before the 30th day after the date the preferred provider receives information requested under this paragraph without penalty or discrimination in participation in other health care products or plans. If a preferred provider chooses to terminate the contract, the insurer is required to assist the preferred provider in providing the notice required by paragraph (18) of this subsection.

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

(21) An insurer may require a preferred provider to retain in the preferred provider's records updated information concerning a patient's other health benefit plan coverage.

(22) Upon request by a preferred provider, an insurer is required to include a provision in the preferred provider's contract providing that the insurer and the insurer's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is deficient. As used in this section, the term "batch submission" [~~batch submission~~] is a group of electronic claims submitted for processing at the same time within a HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. This paragraph applies to a contract entered into or renewed on or after January 1, 2006.

(23) A contract between an insurer and a preferred provider other than an institutional provider may contain a provision requiring a referring physician or provider, or a designee, to disclose to the insured:

(A) that the physician, provider, or facility to whom the insured is being referred might not be a preferred provider; and

(B) if applicable, that the referring physician or provider has an ownership interest in the facility to which the insured is being referred.

(24) A contract provision that requires notice as specified in paragraph (23)(A) of this subsection is required to allow for exceptions for emergency care and as necessary to avoid interruption or delay of medically necessary care and may not limit access to nonpreferred providers.

(25) A contract between an insurer and a preferred provider must require the preferred provider to comply with all applicable requirements of [~~the~~] Insurance Code §1661.005, concerning Refund of Overpayment. [~~(relating to refunds of overpayments from enrollees).~~]

(26) A contract between an insurer and a facility must require that the facility give notice to the insurer of the termination of a contract between the facility and a facility-based physician or provider group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

(27) A contract between an insurer and a preferred provider must require, except for instances of emergency care as defined under Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care and §1301.155(a), concerning Emergency Care, that a physician or provider referring an insured to a facility for surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information;

(B) notify the insurer that surgery has been recommended; and

(C) notify the insurer of the facility that has been recommended for the surgery.

(28) A contract between an insurer and a facility must require, except for instances of emergency care as defined under Insurance Code §1301.0053 and §1301.155(a), that the facility, when scheduling surgery:

(A) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and

(B) notify the insurer that surgery has been scheduled.

(29) A contract between an insurer and a preferred provider must comply with Insurance Code §1458.101, concerning Contract Requirements.

(30) A contract between an insurer and a preferred provider must comply with Insurance Code Chapter 1451, Subchapter D, concerning Access to Optometrists Used Under Managed Care Plan.

(b) In addition to all other contract rights, violations of these rules will be treated for purposes of complaint and action in accordance with Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, and the provisions of that subchapter will be employed to the extent [~~utilized insofar as~~] practicable, as it relates to the power of the department, hearings, orders, enforcement, and penalties.

(c) An insurer may enter into an agreement with a preferred provider organization, an exclusive provider network, or a health care collaborative for the purpose of offering a network of preferred providers, provided that it remains the insurer's responsibility to:

(1) meet the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter;

(2) ensure that the requirements of Insurance Code Chapter 1301 and this subchapter are met; and

(3) provide all documentation to demonstrate compliance with all applicable rules on request by the department.

§3.3704. Freedom of Choice; Availability of Preferred Providers.

(a) Fairness requirements. A preferred provider benefit plan is not considered unjust under Insurance Code Chapter 1701, concerning Policy Forms [~~§§1701.002 - 1701.005; 1701.051 - 1701.060; 1701.101 - 1701.103; and 1701.151~~], or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, concerning Unfair Claim Settlement Practices, or Chapter 544, Subchapter B, concerning Other General Prohibitions Against Discrimination by Insurers [~~§§544.051 - 544.054~~], or to violate [~~§§1451.001, 1451.053, 1451.054, or 1451.101 - 1451.127 of the~~] Insurance Code Chapter 1451, Subchapter A, concerning General Provisions; Subchapter B, concerning Designation of Practitioners Under Accident and Health Insurance Policy; or Subchapter C, concerning Selection of Practitioners, provided that:

(1) in accordance with [~~pursuant to~~] Insurance Code §§1251.005, concerning Payment of Benefits; 1251.006, concerning Policy May Not Specify Service Provider; 1301.003, concerning Preferred Provider Benefit Plans and Exclusive Provider Benefit Plans Permitted, 1301.006, concerning Availability of and Accessibility to Health Care Services; 1301.051, concerning Designation as Preferred Provider; 1301.053, concerning Appeal Relating to Designation as Preferred Provider; 1301.054, concerning Notice to Practitioners of Preferred Provider Benefit Plan; 1301.055, concerning Complaint Resolution; 1301.057 - 1301.062, concerning Termination of Participation; Expedited Review Process, Economic Profiling, Quality Assessment, Compensation on Discounted Fee Basis, Preferred Provider Networks, and Preferred Provider Contracts Between Insurers and Podiatrists; 1301.064, concerning Contract Provisions Relating to Payment of Claims; 1301.065, concerning Shifting of Insurer's Tort Liability Prohibited; 1301.151, concerning Insured's Right to Treatment; 1301.156, concerning Payment of Claims to Insured; and 1301.201, concerning Contracts with and Reimbursement for Nurse First Assistants, the preferred provider benefit plan does not require that a service be rendered by a particular hospital, physician, or practitioner;

(2) insureds are provided with direct and reasonable access to all classes of physicians and practitioners licensed to treat illnesses or injuries and to provide services covered by the preferred provider benefit plan;

(3) insureds have the right to treatment and diagnostic techniques as prescribed by a physician or other health care provider included in the preferred provider benefit plan;

(4) insureds have the right to continuity of care as set forth in [~~the~~] Insurance Code §§1301.152 - 1301.154, concerning Continuing Care in General, Continuity of Care, and Obligation for Continuity of Care of Insurer, respectively;

(5) insureds have the right to emergency care services as set forth in Insurance Code §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care; and §3.3708 of this title (relating to Payment of Certain Out-of-Network [~~Basic Benefit~~] Claims and Related Disclosures) [~~and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims)~~];

(6) the out-of-network (basic) [~~basic~~] level of coverage, excluding a reasonable difference in deductibles, is not more than 50% [~~50 percent~~] less than the higher level of coverage, except as provided under an exclusive provider benefit plan. A reasonable difference in deductibles is determined considering the benefits of each individual policy;

(7) the rights of an insured to exercise full freedom of choice in the selection of a physician or provider, or in the selection of a preferred provider under an exclusive provider benefit plan, are not restricted by the insurer, including by requiring an insured to select a primary care physician or provider or obtain a referral before seeking care;

(8) if the insurer is issuing other health insurance policies in the service area that do not provide for the use of preferred providers, the out-of-network [~~basic~~] level of coverage of a plan that is not an exclusive provider benefit plan is reasonably consistent with other health insurance policies offered by the insurer that do not provide for a different level of coverage for use of a preferred provider;

(9) any actions taken by an insurer engaged in utilization review under a preferred provider benefit plan [~~is~~] are taken under [~~pursuant to the~~] 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 [~~Review Agents~~]) and the insurer does not penalize an insured solely on the basis of a failure to obtain a preauthorization;

(10) a preferred provider benefit plan that is not an exclusive provider benefit plan may provide for a different level of coverage for use of a nonpreferred provider if the referral is made by a preferred provider only if full disclosure of the difference is included in the plan and the written description as required by §3.3705(b) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations);

(11) both preferred provider benefits and out-of-network [~~basic~~] level benefits are reasonably available to all insureds within a designated service area; and

(12) if medically necessary covered services are not reasonably available through preferred physicians or providers, insureds have the right to receive care from a nonpreferred provider in accordance [~~accord~~] with Insurance Code §1301.005, concerning Availability of Preferred Providers, and §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services, and §3.3708 [~~and §3.3725~~] of this title, as applicable.

(b) Notwithstanding subsection (a)(11) of this section, an exclusive provider benefit plan is not considered unjust under Insurance Code Chapter 1701 [~~§§1701.002 - 1701.005, 1701.051 - 1701.060, 1701.101 - 1701.103, and 1701.151~~]; or to unfairly discriminate under Insurance Code Chapter 542, Subchapter A, or Chapter 544, Subchapter B; [~~§§544.051 - 544.054,~~] or to violate Insurance Code Chapter 1451, Subchapter C [~~§§1451.101 - 1451.127~~], provided that:

(1) the exclusive provider benefit plan complies with subsection (a)(1) - (10) and (12) of this section; and

(2) for the purposes of subsection (a)(11) of this section, an exclusive provider benefit plan must only ensure that preferred provider benefits are reasonably available to all insureds within a designated service area.

(c) Payment of nonpreferred providers. Payment by the insurer must be made for covered services of a nonpreferred provider in the same prompt and efficient manner as to a preferred provider.

(d) Retaliatory action prohibited. An insurer is prohibited from engaging in retaliatory action against an insured, including cancellation of or refusal to renew a policy, because the insured or a person acting on behalf of the insured has filed a complaint with the department or the insurer against the insurer or a preferred provider or has appealed a decision of the insurer.

(e) Steering and tiering. An insurer may use steering or a tiered network to encourage an insured to obtain a health care service from a particular provider without impeding the insured's freedom of choice under this section only if the insurer engages in that conduct for the primary benefit of the insured or policyholder, consistent with Insurance Code §1458.101(i), concerning Contract Requirements. For the purposes of this section:

(1) "steering" refers to offering incentives to encourage enrollees to use specific providers;

(2) a "tiered network" refers to a network of preferred providers in which an insurer assigns preferred providers to tiers within the network that are associated with different levels of cost sharing.

[(e) Access to certain institutional providers. In addition to the requirements for availability of preferred providers set forth in Insurance Code §1301.005, any insurer offering a preferred provider benefit plan must make a good faith effort to have a mix of for-profit, non-profit, and tax-supported institutional providers under contract as preferred providers in the service area to afford all insureds under the plan freedom of choice in the selection of institutional providers at which they will receive care, unless the mix is not feasible due to geographic, economic, or other operational factors. An insurer must give special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load.]

(f) Network requirements.

(1) Each preferred provider benefit plan must include a health care service delivery network that complies with:

(A) Insurance Code §1301.005;

(B) Insurance Code §1301.0055, concerning Network Adequacy Standards;

(C) Insurance Code §1301.00553, concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, which applies maximum travel time in minutes and maximum distance in miles for a county based on the county's classification as specified in §3.3713 of this title (relating to County Classifications for Maximum Time and Distance Standards);

(D) Insurance Code §1301.00554, concerning Other Maximum Distance Standard Requirements; Commissioner Authority;

(E) Insurance Code §1301.00555, concerning Maximum Appointment Wait Time Standards, effective for a policy delivered, issued for delivery, or renewed on or after September 1, 2025; and

(F) Insurance Code §1301.006 [and the local market adequacy requirements described in this section].

(2) An adequate network must,[:] for each insured residing in the service area, ensure that all insureds can access at least one preferred provider and 90% of insureds can access a choice of at least two preferred providers within the time and distance standards specified in Insurance Code §1301.00553 and §1301.00554.

(3) To provide a sufficient number of the specified types of preferred providers with the specialty types listed in Insurance Code §1301.0055(b)(4), a network must include at least two preferred physicians for each applicable specialty type at each preferred hospital, ambulatory surgical center, or freestanding emergency medical care facility.

[(1) be sufficient, in number, size, and geographic distribution, to be capable of furnishing the preferred benefit health care services covered by the insurance contract within the insurer's designated service area, taking into account the number of insureds and their characteristics, medical, and health care needs, including the:]

[(A) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and]

[(B) projected utilization of covered health care services;]

[(2) include an adequate number of preferred providers available and accessible to insureds 24 hours a day, seven days a week, within the insurer's designated service area;]

[(3) include sufficient numbers and classes of preferred providers to ensure choice, access, and quality of care across the insurer's designated service area;]

[(4) include an adequate number of preferred provider physicians who have admitting privileges at one or more preferred provider hospitals located within the insurer's designated service area to make any necessary hospital admissions;]

[(5) provide for necessary hospital services by contracting with general, special, and psychiatric hospitals on a preferred benefit basis within the insurer's designated service area, as applicable;]

[(6) provide, if covered, for physical and occupational therapy services and chiropractic services by preferred providers that are available and accessible within the insurer's designated service area;]

[(7) provide for emergency care that is available and accessible 24 hours a day, seven days a week, by preferred providers;]

[(8) provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than:]

[(A) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and]

[(B) 75 miles for specialty care and specialty hospitals;]

[(9) ensure that covered urgent care is available and accessible from preferred providers within the insurer's designated service area within 24 hours for medical and behavioral health conditions;]

[(10) ensure that routine care is available and accessible from preferred providers:]

[(A) within three weeks for medical conditions; and]

[(B) within two weeks for behavioral health conditions;]

[(11) ensure that preventive health services are available and accessible from preferred providers:]

[(A) within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and]

[(B) within three months for an adult.]

(g) Network monitoring and corrective action. Insurers must monitor compliance with subsection (f) of this section on an ongoing basis, taking any needed corrective action as required to ensure that the network is adequate. Consistent with Insurance Code §1301.0055, an insurer must report any material deviation from the network adequacy standards to the department within 30 days of the date the material deviation occurred. Unless there are no uncontracted licensed physicians

or providers within the affected area, or the insurer requests a waiver, the insurer must take corrective action to ensure that the network is compliant not later than the 90th day after the date the material deviation occurred.

(h) Service areas. For purposes of this subchapter, a preferred provider benefit plan may have one or more contiguous or noncontiguous service areas, but may not divide a county. Any [~~any~~] service areas that are smaller than statewide must be defined in terms of one or more Texas counties. [~~one of the following:~~]

[~~(1) one or more of the 11 Texas geographic regions designated in §3.3711 of this title (relating to Geographic Regions);~~]

[~~(2) one or more Texas counties; or~~]

[~~(3) the first three digits of ZIP Codes in Texas.~~]

§3.3705. Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations.

(a) Readability. All health insurance policies, health benefit plan certificates, endorsements, amendments, applications, or riders are required to be written in a readable and understandable format that meets the requirements of §3.602 of this title [~~chapter~~] (relating to Plain Language Requirements).

(b) Plan disclosure. [~~Disclosure of terms and conditions of the policy.~~] The insurer is required, in any promotion, advertisement, or enrollment opportunity, [~~on request,~~] to provide to a current or prospective group contract holder or a current or prospective insured an accurate written description of the terms and conditions of the policy (plan disclosure) that allows the current or prospective group contract holder or current or prospective insured to make comparisons and informed decisions before selecting among health care plans. An insurer may utilize its policy, certificate, or handbook to satisfy this requirement provided that the insurer complies with all requirements set forth in this subsection, including the level of disclosure required. An insurer that is required by federal law to provide a summary of benefits and coverage (SBC) must include in the SBC a link to the plan disclosure required in this subsection. The written plan disclosure [~~description~~] must be in a readable and understandable format, by category, and must include a clear, complete, and accurate description of these items [~~in the following order~~]:

(1) a statement that the entity providing the coverage is an insurance company; the name of the insurance company; that, in the case of a preferred provider benefit plan, the insurance contract contains preferred provider benefits; and, in the case of an exclusive provider benefit plan, that the contract only provides benefits for services received from preferred providers, except as otherwise noted in the contract and written description or as otherwise required by law;

(2) a toll-free number, unless exempted by statute or rule, and website address to enable a current or prospective group contract holder or a current or prospective insured to obtain additional information;

(3) an explanation of the distinction between preferred and nonpreferred providers;

(4) all covered services and benefits, including payment for services of a preferred provider and a nonpreferred provider, and, if prescription drug coverage is included, the name of the formulary used by the plan, a link to the online formulary, and an explanation regarding how a nonelectronic copy may be obtained free of charge; [~~both generic and name brand;~~]

(5) emergency care services and benefits and information on access to after-hours care;

(6) out-of-area services and benefits;

(7) an explanation of the insured's financial responsibility for payment for any premiums, deductibles, copayments, coinsurance, or other out-of-pocket expenses for noncovered or nonpreferred services;

(8) any limitations and exclusions, including the existence of any drug formulary limitations, and any limitations regarding preexisting conditions;

(9) any authorization requirements, including preauthorization review, concurrent review, post-service review, and post-payment review; and an explanation that unless a provider obtains preauthorization, a claim could be denied if a service is not medically necessary or appropriate, or if a service is experimental or investigational; [~~any penalties or reductions in benefits resulting from the failure to obtain any required authorizations;~~]

(10) provisions for continuity of treatment in the event of termination of a preferred provider's participation in the plan;

(11) a summary of complaint resolution procedures, if any, and a statement that the insurer is prohibited from retaliating against the insured because the insured or another person has filed a complaint on behalf of the insured, or against a physician or provider who, on behalf of the insured, has reasonably filed a complaint against the insurer or appealed a decision of the insurer;

(12) the name of the provider network used by the plan, a link to the online provider listing, and information on [~~a current list of preferred providers and complete descriptions of the provider networks, including the name, street address, location, telephone number, and specialty, if any, of each physician and health care provider, and a disclosure of whether the preferred provider is accepting new patients. Both of these items may be provided electronically, if notice is also provided in the disclosure required by this subsection regarding~~] how a nonelectronic copy may be obtained free of charge;

(13) the counties included in the plan's service area [~~area(s)~~]; and

(14) information that is updated at least annually regarding the following network demographics for each county [~~service area, if the preferred provider benefit plan is not offered on a statewide service area basis, or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis~~]:

(A) the number of insureds in the service area or region; and

(B) for each provider area of practice and applicable network adequacy standard, [~~including at a minimum internal medicine, family/general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, and general surgery,~~] the number of preferred providers, as well as an indication of whether an active waiver and access plan [~~pursuant to~~] under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) [~~§3.3709 of this title (relating to Annual Network Adequacy Report; Access Plan)~~] applies to the services furnished by that class of provider in the county [~~service area or region~~] and how such access plan may be obtained or viewed, if applicable. [~~; and~~]

[~~(C) for hospitals, the number of preferred provider hospitals in the service area or region, as well as an indication of whether an active access plan pursuant to §3.3709 of this title applies to hospital services in that service area or region and how the access plan may be obtained or viewed.~~]

[(15) information that is updated at least annually regarding whether any waivers or local market access plans approved pursuant to §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) apply to the plan and that complies with the following:]

[(A) if a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, this must be specifically noted;]

[(B) the information may be categorized by service area or county if the preferred provider benefit plan is not offered on a statewide service area basis, and, if by county, the aggregate of counties is not more than those within a region; or for each of the 11 regions specified in §3.3711 of this title (relating to Geographic Regions), if the plan is offered on a statewide service area basis; and]

[(C) the information must identify how to obtain or view the local market access plan.]

(c) Filing required. A copy of the plan disclosure [written description] required in subsection (b) of this section must be filed with the department with the initial filing of the preferred provider benefit plan and within 60 days of any material changes being made in the information required in subsection (b) of this section. [Submission of listings of preferred providers as required in subsection (b)(12) of this section may be made electronically in a format acceptable to the department or by submitting with the filing the Internet website address at which the department may view the current provider listing. Acceptable formats include Microsoft Word and Excel documents. Submit provider listings as specified on the department's website.]

(d) Promotional disclosures required. The preferred provider benefit plan and all promotional, solicitation, and advertising material concerning the preferred provider benefit plan must clearly describe the distinction between preferred and nonpreferred providers. Any illustration of preferred provider benefits must be in close proximity to an equally prominent description of out-of-network [basic] benefits, except in the case of an exclusive provider benefit plan.

(e) Website [Internet website] disclosures. Insurers that maintain a [an Internet] website providing information regarding the insurer or the health insurance policies offered by the insurer for use by current or prospective insureds or group contract holders must provide on their website a:

(1) [an internet-based] provider listing for use by current and prospective insureds and group contract holders;

(2) [an internet-based] listing of the [state regions,] counties [, or three-digit ZIP Code areas] within the insurer's service area [area(s)], indicating as appropriate for each [region,] county [or ZIP Code area, as applicable,] that the insurer 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; and

(3) [an internet-based] listing of the information specified for disclosure in subsection (b) of this section.

(f) Notice of rights under a network plan required. An insurer must include the notice specified in Figure: 28 TAC §3.3705(f)(1) for a preferred provider benefit plan that provides major medical insurance and is not an exclusive provider benefit plan, or Figure: 28 TAC §3.3705(f)(2) for an exclusive provider benefit plan that provides major medical insurance, in all policies, certificates, plan disclosures [of policy terms and conditions] provided to comply with subsection (b) of this section, and outlines of coverage in at least 12-point font:

(1) Preferred provider benefit plan notice.
[Figure: 28 TAC §3.3705(f)(1)]
Figure: 28 TAC §3.3705(f)(1)

(2) Exclusive provider benefit plan notice.
[Figure 28 TAC §3.3705(f)(2)]
Figure 28 TAC §3.3705(f)(2)

(g) Untrue or misleading information prohibited. No insurer, or agent or representative of an insurer, may cause or permit the use or distribution of information which is untrue or misleading.

(h) Disclosure concerning access to preferred provider listing. The insurer must provide notice to all insureds at least annually describing how the insured may access a current listing of all preferred providers on a cost-free basis. The notice must include, at a minimum, information concerning how to obtain a nonelectronic copy of the listing and a telephone number through which insureds may obtain assistance during regular business hours to find available preferred providers.

(i) Required updates of available provider listings. The insurer must ensure that it updates its listing of preferred providers on its [Internet] website at least once a month, as required by Insurance Code §1451.505, concerning Physician and Health Care Provider Directory on Internet Website. The insurer must ensure that it updates all other electronic or nonelectronic listings of preferred providers made available to insureds at least every three months.

(j) Annual provision of provider listing required in certain cases. If no [Internet-based] preferred provider website listing or other method of identifying current preferred providers is maintained for use by insureds, the insurer must distribute a current preferred provider listing to all insureds no less than annually by mail, or by an alternative method of delivery if an alternative method is agreed to by the insured, group policyholder on behalf of the group, or certificate holder.

(k) Reliance on provider listing in certain cases. A claim for services rendered by a nonpreferred provider must be paid in the same manner as if no preferred provider had been available under §3.3708(a)(5) [§3.3708(b) - (d)] of this title (relating to Payment of Certain Out-of-Network [Basic Benefit] Claims [and Related Disclosures]), and the insurer must take responsibility for any balance bill amount the nonpreferred provider may charge in excess of the insurer's payment [and §3.3725(d) - (f) of this title (relating to Payment of Certain Out-of-Network Claims), as applicable,] if an insured demonstrates that:

(1) in obtaining services, the insured reasonably relied upon a statement that a physician or provider was a preferred provider as specified in:

(A) a provider listing; or

(B) provider information on the insurer's website;

(2) the provider listing or website information was obtained from the insurer, the insurer's website, or the website of a third party designated by the insurer to provide such information for use by its insureds;

(3) the provider listing or website information was obtained not more than 30 days prior to the date of services; and

(4) the provider listing or website information obtained indicates that the provider is a preferred provider within the insurer's network.

(l) Additional listing-specific disclosure requirements. In all preferred provider listings, including any website [~~Internet-based~~] postings by the insurer to insureds about preferred providers, the insurer must comply with the requirements in paragraphs (1) - (11) of this subsection.

(1) The provider information must include a method for insureds to identify those hospitals that have contractually agreed with the insurer to facilitate the usage of preferred providers as specified in subparagraphs (A) and (B) of this paragraph.

(A) The hospital will exercise good-faith efforts to accommodate requests from insureds to utilize preferred providers.

(B) In those instances in which a particular facility-based physician or provider or physician group is assigned at least 48 hours prior to services being rendered, the hospital will provide the insured with information that is:

(i) furnished at least 24 hours prior to services being rendered; and

(ii) sufficient to enable the insured to identify the physician or physician group with enough specificity to permit the insured to determine, along with preferred provider listings made available by the insurer, whether the assigned facility-based physician or provider or physician group is a preferred provider.

(2) The provider information must include a method for insureds to identify, for each preferred provider hospital, the percentage of the total dollar amount of claims filed with the insurer by or on behalf of facility-based physicians that are not under contract with the insurer. The information must be available by class of facility-based physician, including radiologists, anesthesiologists, pathologists, emergency department physicians, and neonatologists [~~, and assistant surgeons~~].

(3) In determining the percentages specified in paragraph (2) of this subsection, an insurer may consider claims filed in a 12-month period designated by the insurer ending not more than 12 months before the date the information specified in paragraph (2) of this subsection is provided to the insured.

(4) The provider information must indicate whether each preferred provider is accepting new patients.

(5) The provider information must provide a method by which insureds may notify the insurer of inaccurate information in the listing, with specific reference to:

(A) information about the provider's contract status; and

(B) whether the provider is accepting new patients.

(6) The provider information must provide a method by which insureds may identify preferred provider facility-based physicians or providers able to provide services at preferred provider facilities, if applicable.

(7) The provider information must be provided in at least 10-point type [~~font~~].

(8) The provider information must specifically identify those facilities at which the insurer has no contracts with a class of facility-based provider, specifying the applicable provider class.

(9) The provider information must be dated.

(10) Consistent with Insurance Code Chapter 1451, Subchapter K, concerning Health Care Provider Directories, for [~~For~~] each health care provider that is a facility included in the listing, the insurer must:

(A) create separate headings under the facility name for radiologists, anesthesiologists, anesthesiologist assistants, nurse anesthetists, nurse midwives, pathologists, emergency department physicians, neonatologists, physical therapists, occupational therapists, speech-language pathologists, and surgical assistants, except that a physician or health care provider who is employed by the facility is not required to be listed [~~assistant surgeons~~];

(B) under each heading described by subparagraph (A) of this paragraph, list each preferred facility-based physician or provider practicing in the specialty corresponding with that heading;

(C) for the facility and each facility-based physician or provider described by subparagraph (B) of this paragraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician or provider, or facility-based physician or provider group;

(D) for each facility-based physician or provider described by subparagraph (B) of this paragraph, include the name, street address, telephone number, and any physician or provider group in which the facility-based physician or provider practices; and

(E) include the facility in a listing of all facilities and indicate:

(i) the name of the facility;

(ii) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and

(iii) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.

(11) Consistent with Insurance Code Chapter 1451, Subchapter K, the [~~The~~] listing must list each facility-based physician or provider individually and, if a physician or provider belongs to a physician or provider group, also as part of the physician or provider group.

(m) Annual policyholder notice concerning use of an [~~a local market~~] access plan. An insurer operating a preferred provider benefit plan that relies on an [~~a local market~~] access plan as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets) must provide notice of this fact to each individual and group policyholder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy. The notice must include:

(1) a link to any webpage listing of information on network waivers and access plans [~~regions, counties, or ZIP codes~~] made available under [~~pursuant to~~] subsection (e)(2) of this section;

(2) information on how to obtain or view any [~~local market~~] access plan or plans the insurer uses; and

(3) a link to the department's website where the department posts information relevant to the grant of waivers.

(n) Disclosure of substantial decrease in the availability of certain preferred providers. An insurer is required to provide notice as specified in this subsection of a substantial decrease in the availability of preferred facility-based physicians or providers at a preferred provider facility.

(1) A decrease is substantial if:

(A) the contract between the insurer and any facility-based physician or provider group that comprises 75% or more of the preferred 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 preferred providers for that specialty at the facility terminates, and the insurer receives notice as required under §3.3703(a)(26) of this title (relating to Contracting Requirements).

(2) Notwithstanding paragraph (1) of this subsection, no notice of a substantial decrease is required if the requirements specified in either subparagraph (A) or (B) of this paragraph are met:

(A) alternative preferred 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 insureds at the facility so the percentage level of preferred providers of that specialty at the facility is returned to a level equal to or greater than the percentage level that was available prior to the substantial decrease; or

(B) the insurer determines [~~provides to the department, by email to mcqa@tdi.texas.gov, a certification of the insurer's determination~~] that the termination of the provider contract has not caused the preferred provider service delivery network for any plan supported by the network to be noncompliant with the adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers)[~~,~~] as those standards apply to the applicable provider specialty.

(3) An insurer 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 preferred providers on the portion of the insurer's website where its provider listing is available to insureds.

(4) Notice of any contract termination specified in paragraph (1)(A) or (B) of this subsection and of the decrease in availability of providers must be maintained on the insurer's website until the earlier of:

(A) the date on which adequate preferred providers of the same specialty become available to insureds at the facility at the percentage level specified in paragraph (2)(A) of this subsection; or

(B) six months from the date that the insurer initially posts the notice.[~~; or~~]

[~~(C) the date on which the insurer provides to the department, by email to mcqa@tdi.texas.gov, a certification as specified in paragraph (2)(B) of this subsection indicating the insurer's determination that the termination of provider contract does not cause noncompliance with adequacy standards.~~]

(5) An insurer must post notice as specified in paragraph (3) of this subsection and update its website [~~Internet-based~~] preferred 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 insurer 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.

(o) Disclosures concerning reimbursement of out-of-network services. An insurer must make disclosures in all insurance policies, certificates, and outlines of coverage concerning the reimbursement of out-of-network services as specified in this subsection.

(1) An insurer must disclose how reimbursements of nonpreferred providers will be determined.

(2) An insurer must disclose how the plan will cover out-of-network services received when medically necessary covered services are not reasonably available through a preferred provider, consistent with §3.3708 of this title and how an enrollee can obtain assistance with accessing care in these circumstances, consistent with §3.3707(k) of this title.

[~~(2) Except in an exclusive provider benefit plan, if an insurer reimburses nonpreferred providers based directly or indirectly on data regarding usual, customary, or reasonable charges by providers, the insurer must disclose the source of the data, how the data is used in determining reimbursements, and the existence of any reduction that will be applied in determining the reimbursement to nonpreferred providers.~~]

(3) Except in an exclusive provider benefit plan, if an insurer bases reimbursement of nonpreferred providers on any amount other than full billed charges, the insurer must:

(A) disclose that the insurer's reimbursement of claims for nonpreferred providers may be less than the billed charge for the service;

(B) disclose that the insured may be liable to the nonpreferred provider for any amounts not paid by the insurer, unless balance billing protections apply, as specified in §3.3708(a)(1) - (4) of this title;

(C) provide a description of the methodology by which the reimbursement amount for nonpreferred providers is calculated; and

(D) provide to insureds a method to obtain a real-time estimate of the amount of reimbursement that will be paid to a nonpreferred provider for a particular service.

[~~(p) Plan designations. A preferred provider benefit plan that utilizes a preferred provider service delivery network that complies with the network adequacy requirements for hospitals under §3.3704 of this title without reliance on an access plan may be designated by the insurer as having an "Approved Hospital Care Network" (AHCN). If a preferred provider benefit plan utilizes a preferred provider service delivery network that does not comply with the network adequacy requirements for hospitals specified in §3.3704 of this title, the insurer is required to disclose that the plan has a "Limited Hospital Care Network":~~]

[~~(1) on the insurer's outline of coverage; and~~]

[~~(2) on the cover page of any provider listing describing the network.~~]

[~~(q) Loss of status as an AHCN. If a preferred provider benefit plan designated as an AHCN under subsection (p) of this section no longer complies with the network adequacy requirements for hospitals under §3.3704 of this title and does not correct such noncompliant status within 30 days of becoming noncompliant, the insurer must:~~]

[~~(1) notify the department in writing concerning such change in status as specified on the department's website;~~]

[~~(2) cease marketing the plan as an AHCN; and~~]

[~~(3) inform all insureds of such change of status at the time of renewal.~~]

§3.3707. Waiver Due to Failure to Contract in Local Markets.

(a) Consistent [~~In accord~~] with Insurance Code §1301.0055(a)(3), concerning Network Adequacy Standards [~~§1301.0055(3)~~], where necessary to avoid a violation of the network adequacy requirements of §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) in a county [~~portion of the state~~] that the insurer wishes to include in its service area, an insurer may apply for a waiver from one or more of the network adequacy requirements in §3.3704(f) of this title. After considering all pertinent evidence in a public hearing under Insurance Code §1301.00565, concerning Public Hearing on Network Adequacy Standards Waivers, the [~~The~~] commissioner may grant the waiver if the requestor shows [~~there is~~] good cause based on one or more of the criteria specified in this subsection and subject to the limits on waivers provided in Insurance Code §1301.0055(a)(5). The commissioner may deny a waiver request if good cause is not shown and may impose reasonable conditions on the grant of the waiver. The commissioner may find good cause to grant the waiver if the insurer demonstrates that [~~providers or physicians necessary for an adequate local market network~~]:

(1) there is an insufficient number of uncontracted physicians or health care providers in the area to meet the specific standard for a county in a service area; [~~are not available to contract;~~] or

(2) physicians or health care providers necessary for an adequate network have refused to contract with the insurer on any terms or on terms that are reasonable.

(b) An insurer seeking a waiver under subsection (a) of this section must submit waiver and access plan information required under §3.3712(c) of this title (related to Network Configuration Filings) and information justifying the waiver request as specified in this subsection using the attempt to contract form available at www.tdi.texas.gov. An insurer must submit the network compliance and waiver request form and the attempt to contract form to the department using SERFF or another electronic method that is acceptable to the department. For each waiver requested with respect to a type of physician or provider in a given county, the insurer must provide [~~At a minimum, each waiver an insurer requests must include~~] either the information specified by paragraph (1) of this subsection or the information specified by paragraph (2) of this subsection, as appropriate.

(1) If providers or physicians are available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must include, within the attempt to contract form:

(A) a list of the providers or physicians within the relevant service area that the insurer attempted to contract with, identified by name and specialty or facility type, and including the physician or provider's address and county; national provider identifier, contact name, email, and phone number; and for facility-based physicians or providers, the group name and associated facility;

(B) a description of how and when the insurer last contacted each provider or physician that demonstrates that the insurer made a good faith effort to contract, including:

(i) in the case of a waiver that is being requested more than two consecutive times for the same network adequacy standard in the same county, evidence that the insurer made multiple good faith attempts during each of the prior consecutive waiver periods;

(ii) in the case of a waiver that is being requested more than four times within a 21-year period for the same network adequacy standard in the same county, evidence that the insurer has been unable to remedy the issue through good faith efforts;

(C) for each provider or physician contacted, a description of the best offer of reimbursement rates made by the issuer, computed by describing the rate for each service for which a contract was offered as a percent of:

(i) the Medicare rates for those services that applied at the time the contract was attempted and providing an average of the rates as a percent of the Medicare rate (e.g., rates offered were 135% of the Medicare rate); and

(ii) the insurer's average contracted rate with preferred providers in a similar geographic area for those services and providing an average of the rates as a percent of the average contracted rate (e.g., rates offered were 108% of the average contracted rate);

(D) [~~(C)~~] a description of any reason each provider or physician gave for refusing to contract with the insurer, including information on any exclusivity arrangement or other external factors that affect the ability of the parties to contract;

[~~(D) an estimate of total claims cost savings per year the insurer anticipates will result from using a local market access plan instead of contracting with providers located within the service area, and its impact on premium; and~~]

(E) a description of all steps the insurer will take to attempt to improve its network to make future requests to renew the waiver unnecessary;[~~.~~]

(F) a description of the source or sources the insurer uses to identify physicians and providers that are available in the service area, and how often the insurer monitors these sources for new physicians and providers entering the service area; and

(G) a description of the insurer's policies and procedures for reaching out to available physicians and providers, including how many attempts the insurer makes and if different policies and procedures apply for different specialty types.

(2) If an insufficient number of [~~no~~] providers or physicians is [~~are~~] available within the relevant service area for the covered service or services for which the insurer requests a waiver, the insurer's request for waiver must state this fact.

(c) At the same time an insurer files a request for waiver or a request to renew a waiver, it must file an [~~a local market~~] access plan, [~~as specified in subsection (i) of this section,~~] to be taken into consideration by the commissioner in deciding whether to grant or deny a waiver request, subject to Insurance Code §1301.00566, concerning Effect of Network Adequacy Standards Waiver on Balance Billing Prohibitions. The insurer must:

(1) develop access plan procedures consistent with subsection (j) of this section; and

(2) file the access plan as required in §3.3712(c)(2)(E)(iii) of this title.

(d) If the insurer believes that the information provided under subsection (b) of this section in the attempt to contract form includes proprietary information that is confidential and not subject to disclosure as public information under Government Code Chapter 552, concerning Public Information, the insurer must mark the document as confidential in SERFF. If the insurer marks the document as confidential, it must include in the filing an explanation of which information contained in the document is proprietary, and which information is not. However, consistent with Insurance Code 1301.00565(g), certain information is subject to release regardless of marking, and the department may publish or otherwise release such information. The insurer is not permitted to mark the entire filing as confidential. When

scheduling a hearing related to a waiver request, the department will send a notice of the hearing to any provider or physician named in the waiver request. [An insurer seeking a waiver under subsection (a) of this section must electronically file the request with the department at the Office of the Chief Clerk through the following email address: chiefclerk@tdi.texas.gov. The insurer must also submit a copy of the request to any provider or physician named in the waiver request at the same time the insurer files the request with the department, but is permitted to redact information from the copy where provision of the information to the provider or physician would violate state or federal law. The insurer may use any reasonable means to submit the copy of the request to the provider or physician. The insurer must maintain proof of the submission and include a copy of the redacted version with the waiver request submitted to the department.]

(e) Any provider or physician may elect to provide a response to an insurer's request for waiver by sending an email to networkwaivers@tdi.texas.gov within 15 days after receiving notice from the department. [filing the response within 30 days after the insurer files the request with the department.] The response, if filed, must indicate whether the provider or physician consents to being identified at a hearing related to the waiver request and may include evidence that is pertinent to the waiver request for the commissioner's consideration. [be filed at the same address specified in subsection (d) of this section for filing the request for waiver.]

(f) If the department grants a waiver under subsection (a) of this section, the department will post on the department's website information relevant to the grant of a waiver, consistent with Insurance Code §1301.0055(a)(3). [including:]

[(1) the name of the preferred provider benefit plan for which the request is granted;]

[(2) the insurer offering the plan; and]

[(3) the affected service area.]

(g) An insurer may apply for renewal of a waiver described in subsection (a) of this section annually.

(1) Application for renewal of a waiver must be filed in the manner described in subsection (d) of this section and submitted at the time the insurer files its annual report under §3.3709 of this title (relating to Annual Network Adequacy Report). [at least 30 days prior to the anniversary of the department's grant of waiver.]

(2) At the same time the insurer files an application for renewal of a waiver, the insurer must develop and file any applicable [local market] access plan the insurer uses in accordance with [pursuant to] the waiver, in the manner specified by subsection (c) [(i)(2)] of this section.

[(3) A waiver granted by the department will remain in effect unless the insurer fails to timely file an annual application for renewal of the waiver or the department denies the application for renewal.]

(h) When granting a waiver, the department will specify the one-year period for which the waiver will apply. A waiver will expire at the end of the period specified by the department unless the insurer requests [one year after the date the department granted it if an insurer fails to timely request] a renewal under subsection (g) of this section and [or if] the department approves [denies] the insurer's request for renewal.

(i) If the status of a network utilized in any preferred provider benefit plan changes so that the health benefit plan no longer complies with the network adequacy requirements specified in §3.3704 of this title for a specific county [service area], the insurer must establish an [a local market] access plan within 30 days of the date on which the network becomes noncompliant and, within 90 days of the date on which the network becomes noncompliant, apply for a waiver in accordance with [pursuant to] subsection (a) of this section requesting that the department approve the continued use of the [local market] access plan.

[(1) The local market access plan must contain all the information specified in subsection (j) of this section.]

[(2) The insurer must file the local market access plan with the department by email at: mcqa@tdi.texas.gov or through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing.]

[(j) A local market access plan required under subsection (i) of this section must specify for each service area that does not meet the network adequacy requirements:]

[(1) the geographic area within the service area in which a sufficient number of preferred providers are not available as specified in §3.3704 of this title, including a specification of the class of provider that is not sufficiently available;]

[(2) a map, with key and scale, that identifies the geographic areas within the service area in which the health care services, physicians, or providers are not available;]

[(3) the reason(s) that the preferred provider network does not meet the adequacy requirements specified in §3.3704 of this title;]

[(4) procedures that the insurer will utilize to assist insureds in obtaining medically necessary services when no preferred provider is reasonably available, including procedures to coordinate care to limit the likelihood of balance billing; and]

[(5) procedures detailing how out-of-network benefit claims will be handled when no preferred or otherwise contracted provider is available, including procedures for compliance with §3.3708 of this title (relating to Payment of Certain Basic Benefit Claims and Related Disclosures) and §3.3725 of this title (relating to Payment of Certain Out-of-Network Claims).]

(j) [(k)] An insurer must establish and implement documented procedures, as specified in this subsection, for use in all service areas for which an [a local market] access plan is submitted, as required by subsections (c), (i), or (m) of this section. These procedures must be made available to the department upon request. When a preferred provider is not available within the network adequacy standards under §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) to provide a medically necessary covered service, the insurer must use a documented procedure to:

[(1) The insurer must utilize a documented procedure to:]

(1) [(A)] identify requests for preauthorization of services for insureds that are likely to require the rendition of services by physicians or providers that do not have a contract with the insurer;

(2) upon request by an insured or an individual acting on behalf of an insured, and 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, approve a network gap exception and facilitate access to care by recommending at least one physician or provider that:

(A) has expertise in the necessary specialty;

(B) is reasonably available considering the medical condition and location of the insured; and

(C) the insured may choose to use without being liable for any amount charged by the physician or provider that exceeds the

insured's cost-sharing responsibilities under the preferred provider benefit level;

(3) [~~(B)~~] furnish to insureds, prior to the services being rendered, an explanation of their rights, consistent with §3.3708(b)(1)(B) of this title (relating to Payment of Certain Out-of-Network Claims); [~~estimate of the amount the insurer will pay the physician or provider; and~~]

(4) [~~(C)~~] except when a provider is prohibited from balance billing, as specified in §3.3708(a)(1) - (4) of this title [~~in the case of an exclusive provider benefit plan~~], notify insureds that they may be liable for any amounts charged by the physician or provider that are more than the insurer's reimbursement rate, unless the insured uses a provider recommended by the insurer [~~not paid in full by the insurer~~].

[~~(2) The insurer must utilize a documented procedure to:~~]

(5) [~~(A)~~] identify claims filed by nonpreferred providers in instances in which no preferred provider was [~~reasonably~~] available to the insured; and

(6) [~~(B)~~] make initial and, if required, subsequent payment of the claims in the manner required by this subchapter.

(k) For the purposes of paragraph (j)(2) of this section, a network gap exception means an insurer's approval for an insured to receive care from a nonpreferred provider under the preferred provider benefit level because access to care through a preferred provider is not available within network adequacy standards. When facilitating care as required under paragraph (j)(2) of this section, a recommended physician or provider is reasonably available if they are:

(1) a nonpreferred provider within the network adequacy standards in §3.3704(f) of this title; or

(2) a preferred or nonpreferred provider outside of the network adequacy standards in §3.3704(f) of this title, only if the distance to reach the recommended physician or provider is not more than 15% farther than the distance to reach the nearest available physician or provider.

(l) An [~~A local market~~] access plan may include a process for negotiating with a nonpreferred provider prior to services being rendered, when feasible.

(m) As a contingency, and to protect insureds from any unforeseen circumstance in which an insured is unable to reasonably access covered health care services within the network adequacy standards provided in §3.3704 of this title, an insurer must submit an access plan that applies broadly to all counties within the service area and all types of physicians and providers, and includes the information specified in §3.3712(c)(2)(E)(iii) of this title.

[~~(m) An insurer must submit a local market access plan established pursuant to this section as a part of the annual report on network adequacy required under §3.3709 of this title (relating to Annual Network Adequacy Report).~~]

[~~(n) An insurer that is granted a waiver under this section concerning network adequacy requirements for hospital based services is required to comply with §3.3705(p) of this title (relating to Nature of Communications with Insureds; Readability, Mandatory Disclosure Requirements, and Plan Designations). The insurer is required to designate such plan as having a "Limited Hospital Care Network".~~]

§3.3708. Payment of Certain Out-of-Network [~~Basic Benefit~~] Claims [~~and Related Disclosures~~].

(a) For an out-of-network claim for which the insured is protected from balance billing under Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, or when no preferred provider is reasonably available, an insurer must pay the claim at the preferred level of coverage, including with respect to any applicable copay, coinsurance, deductible, or maximum out-of-pocket amount. The insurer must pay the claim according to the following payment standards:

(1) for emergency care and post-emergency stabilization care, the applicable payment standards are under §1301.0053, concerning Exclusive Provider Benefit Plans: Emergency Care; and §1301.155, concerning Emergency Care;

(2) for certain care provided in a health care facility, the applicable payment standards are under §1301.164, concerning Out-of-Network Facility-Based Providers;

(3) for certain diagnostic imaging or laboratory services performed in connection with care provided by a preferred provider, the applicable payment standards are under §1301.165, concerning Out-of-Network Diagnostic Imaging Provider or Laboratory Service Provider;

(4) until August 31, 2025, for certain services and transports provided by an emergency medical services provider, other than air ambulance, the applicable payment standards are under §1301.166, concerning Out-of-Network Emergency Medical Services Provider; and

(5) for services provided by a nonpreferred provider when a preferred provider is not available within the network adequacy standards established in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers), the applicable payment standards are under Insurance Code §1301.005, concerning Availability of Preferred Providers; Service Area Limitations, and Insurance Code §1301.0052, concerning Exclusive Provider Benefit Plans: Referrals for Medically Necessary Services.

[~~(a) An insurer must comply with the requirements of subsections (b) and (c) of this section when a preferred provider is not reasonably available to an insured and services are instead rendered by a nonpreferred provider, including circumstances:~~]

[~~(1) requiring emergency care;~~]

[~~(2) when no preferred provider is reasonably available within the designated service area for which the policy was issued; and~~]

[~~(3) when a nonpreferred provider's services were pre-approved or preauthorized based upon the unavailability of a preferred provider.~~]

(b) If medically necessary covered services are not available through a preferred provider within the network adequacy standards under §3.3704(f) of this title (relating to Network Requirements) and the services are not subject to subsection (a)(1) - (4) of this section, the insurer must:

(1) for a preferred or exclusive provider benefit plan:

(A) facilitate the insured's access to care consistent with the access plan and documented plan procedures specified in §3.3707(j) of this title (relating to Waiver Due to Failure to Contract in Local Markets); and

(B) inform the insured that:

(i) the out-of-network care the insured receives for the identified services will be covered under the preferred level of coverage with respect to any applicable cost-sharing and will not be subject to any service area limitation;

(ii) the insured can choose to use a physician or provider recommended by the insurer without being responsible for an

amount in excess of the cost sharing under the plan, or an alternative nonpreferred provider chosen by the insured, with the understanding that the insured will be responsible for any balance bill amount the alternative nonpreferred provider may charge in excess of the insurer's reimbursement rate; and

(iii) the amount the insurer will reimburse for the anticipated services.

(2) for an exclusive provider plan:

(A) process a referral to a nonpreferred 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; and

(B) provide for a review by a physician or provider with expertise in the same specialty as or a specialty similar to the type of physician or provider to whom a referral is requested under subparagraph (A) of this paragraph before the insurer may deny the referral;

[(b) When services are rendered to an insured by a nonpreferred provider because no preferred provider is reasonably available to the insured under subsection (a) of this section, the insurer must:]

[(1) pay the claim, at a minimum, at the usual or customary charge for the service, less any patient coinsurance, copayment, or deductible responsibility under the plan;]

[(2) pay the claim at the preferred benefit coinsurance level; and]

[(3) in addition to any amounts that would have been credited had the provider been a preferred provider, credit any out-of-pocket amounts shown by the insured to have been actually paid to the nonpreferred provider for charges for covered services that were above and beyond the allowed amount toward the insured's deductible and annual out-of-pocket maximum applicable to in-network services.]

(c) Reimbursements of all nonpreferred providers for services that are covered under the health insurance policy are required to be calculated pursuant to an appropriate methodology that:

[(1) if based upon usual, reasonable, or customary charges, is based on generally accepted industry standards and practices for determining the customary billed charge for a service and that fairly and accurately reflects market rates, including geographic differences in costs;]

(1) [(2)] if based on claims data, is based upon sufficient data to constitute a representative and statistically valid sample;

(2) [(3)] is updated no less than once per year;

(3) [(4)] does not use data that is more than three years old; and

(4) [(5)] is consistent with nationally recognized and generally accepted bundling edits and logic.

(d) Except for an exclusive provider benefit plan, an [An] insurer is required to pay all covered out-of-network [basic] benefits for services obtained from health care providers or physicians at least at the plan's out-of-network [basic] benefit level of coverage, regardless of whether the service is provided within the designated service area for the plan. Provision of services by health care providers or physicians outside the designated service area for the plan must [shall] not be a basis for denial of a claim.

(e) Consistent with Insurance Code §1301.140, concerning Out-of-Pocket Expense Credit, an insurer must establish a procedure by which an insured may:

(1) identify the average discounted rate paid by the insurer to a given type of preferred provider for a covered service or supply;

(2) obtain a covered service or supply from a nonpreferred provider; and

(3) claim a credit, under the preferred level of coverage, toward the insured's deductible and annual maximum out-of-pocket amount, for the amount paid by the insured to the nonpreferred provider, if:

(A) the amount the insured paid to the nonpreferred provider is less than the insurer's average discounted rate;

(B) the insurer has not paid a claim for the service or supply; and

(C) the insured submits the documentation identified by the insurer, according to the process set forth on the insurer's website and in the insured's certificate of insurance.

[(e) When services are rendered to an insured by a nonpreferred hospital-based physician in an in-network hospital and the difference between the allowed amount and the billed charge is at least $500, the insurer must include a notice on the applicable explanation of benefits that the insured may have the right to request mediation of the claim of an uncontracted facility-based provider under Insurance Code Chapter 1467 and may obtain more information at www.tdi.texas.gov/consumer/epmmediation.html. An insurer is not in violation of this subsection if it provides the required notice in connection with claims that are not eligible for mediation. In this paragraph, "facility-based physician" has the meaning given to it by §21.5003(6) of this title (relating to Definitions).]

(f) An insurer must cover a clinician-administered drug under the preferred level of coverage if it meets the criteria under Insurance Code §1369.764, concerning Certain Limitations on Coverage of Clinician-Administered Drugs Prohibited, even if it is dispensed by a nonpreferred provider.

[(f) This section does not apply to an exclusive provider benefit plan.]

§3.3709. Annual Network Adequacy Report.

(a) Network adequacy report required. On [An insurer must file a network adequacy report with the department on] or before April 1 of each year and prior to marketing any plan in a new service area, an insurer must submit a network adequacy report for each network to be used with a preferred or exclusive provider benefit plan. The network adequacy report must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(b) General content of report. The report required in subsection (a) of this section must specify:

(1) the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(2) the network configuration information specified in §3.3712 of this title (relating to Network Configuration Filings);

[(1) the trade name of each preferred provider benefit plan in which insureds currently participate];

[(2) the applicable service area of each plan; and]

(3) whether the preferred provider service delivery network supporting each plan is adequate under the standards in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers); and[.]

(4) if applicable, the waiver request and access plan information as specified in §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets).

(c) Additional content applicable only to annual reports. As part of the annual report on network adequacy, each insurer must provide additional demographic data as specified in paragraphs (1) - (7) [~~(6)~~] of this subsection for the previous calendar year. The data must be reported on the basis of each of the geographic regions specified in §3.3711 of this title (relating to Geographic Regions). If none of the insurer's preferred provider benefit plans includes a service area that is located within a particular geographic region, the insurer must specify in the report that there is no applicable data for that region. The report must include the number of:

(1) insureds served by the network in the most recent calendar year and the number of insureds projected to be served by the network in the upcoming calendar year;

(2) total complaints;

[~~(1) claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;~~]

[~~(2) claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;~~]

(3) complaints by nonpreferred providers;

(4) complaints by insureds relating to the dollar amount of the insurer's payment for out-of-network [~~basic~~] benefits or concerning balance billing;

(5) complaints [~~by insureds~~] relating to the availability of preferred providers; [~~and~~]

(6) complaints [~~by insureds~~] relating to the accuracy of preferred provider listings; and [.]

(7) actuarial data on the current and projected utilization of each type of physician or provider within each region, including:

(A) the current and projected number of preferred providers of each specialty type;

(B) claims data for the most recent calendar year, including:

(i) the number of preferred provider claims;

(ii) the number of claims for out-of-network benefits, excluding claims paid at the preferred benefit coinsurance level;

(iii) the number of claims for out-of-network benefits that were paid at the preferred benefit coinsurance level;

(iv) the number of unique enrollees with one or more claims; and

(v) the number of unique providers with one or more claims.

(d) Filing the report. The annual report required under this section must be submitted electronically in SERFF or another electronic method that is [~~in a format~~] acceptable to the department using the annual network adequacy report form available at www.tdi.texas.gov. [~~Acceptable formats include Microsoft Word and Excel documents. The report must be submitted to the following email address: Life-Health@tdi.texas.gov.~~]

(e) Exceptions. This section does not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3710. Failure to Provide an Adequate Network.

(a) If the commissioner determines, after notice and opportunity for hearing, that the insurer's network and any [~~local market~~] access plan supporting the network are inadequate to ensure that preferred provider benefits are reasonably available to all insureds or are inadequate to ensure that all medical and health care services and items covered under [~~pursuant to~~] the health insurance policy are provided in a manner ensuring availability of and accessibility to adequate personnel, specialty care, and facilities, the commissioner may order one or more [~~of the following~~] sanctions under [~~pursuant to~~] the authority of the commissioner in Insurance Code Chapters 82, concerning Sanctions, and 83, concerning Emergency Cease and Desist Orders, including [~~to issue cease and desist orders~~]:

(1) reduction of a service area;

(2) cessation of marketing in parts of the state; and [~~and/or~~]

(3) cessation of marketing entirely and withdrawal from the preferred provider benefit plan market.

(b) This section does not affect the authority of the commissioner to order any other appropriate corrective action, sanction, or penalty under [~~pursuant to~~] the authority of the commissioner in the Insurance Code in addition to or in lieu of the sanctions specified in subsection (a) of this section.

§3.3711. Geographic Regions.

For the purposes of this subchapter, the [~~The~~] 11 Texas geographic regions that an insurer is required to use for reporting data under §3.3709 of this title (relating to Annual Network Adequacy Report [~~permitted to use for purposes of defining a smaller than statewide service area as described in §3.3704(g)(1) of this subchapter (relating to Freedom of Choice; Availability of Preferred Providers)~~] are as follows:

(1) Region 1--Panhandle, including Amarillo and Lubbock, composed [~~comprised~~] of the following counties: Armstrong, Bailey, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Crosby, Dallam, Deaf Smith, Dickens, Donley, Floyd, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Sherman, Swisher, Terry, Wheeler, and Yoakum; [~~ZIP Coded areas: 79001, 79002, 79003, 79005, 79007, 79008, 79009, 79010, 79011, 79012, 79013, 79014, 79015, 79016, 79018, 79019, 79021, 79022, 79024, 79025, 79027, 79029, 79031, 79032, 79033, 79034, 79035, 79036, 79039, 79040, 79041, 79042, 79043, 79044, 79045, 79046, 79051, 79052, 79053, 79054, 79056, 79057, 79058, 79059, 79061, 79062, 79063, 79064, 79065, 79066, 79068, 79070, 79072, 79073, 79077, 79078, 79079, 79080, 79081, 79082, 79083, 79084, 79085, 79086, 79087, 79088, 79091, 79092, 79093, 79094, 79095, 79096, 79097, 79098, 79101, 79102, 79103, 79104, 79105, 79106, 79107, 79108, 79109, 79110, 79111, 79114, 79116, 79117, 79118, 79119, 79120, 79121, 79124, 79159, 79166, 79168, 79172, 79174, 79178, 79185, 79187, 79189, 79201, 79220, 79221, 79226, 79229, 79230, 79231, 79233, 79234, 79235, 79236, 79237, 79239, 79240, 79241, 79243, 79244, 79245, 79250, 79251, 79255, 79256, 79257, 79258, 79259, 79261, 79311, 79312, 79313, 79314, 79316, 79320, 79322, 79323, 79324, 79325, 79326, 79329, 79330, 79336, 79338, 79339, 79343, 79344, 79345, 79346, 79347, 79350, 79351, 79353, 79355, 79356, 79357, 79358, 79363, 79364, 79366, 79367, 79369, 79370, 79371, 79372, 79373, 79376, 79378, 79379, 79380, 79381, 79382, 79383, 79401, 79402, 79403, 79404, 79405, 79406, 79407, 79408, 79409, 79410, 79411, 79412, 79413, 79414, 79415, 79416, 79423, 79424, 79430, 79452, 79453, 79457, 79464, 79490, 79491, 79493, and 79499;~~]

(2) Region 2--Northwest Texas, including Wichita Falls and Abilene, composed [~~comprised~~] of the following counties: Archer, Baylor, Brown, Callahan, Clay, Coleman, Comanche, Cottle, Eastland, Fisher, Foard, Hardeman, Haskell, Jack, Jones, Kent, Knox, Mitchell, Montague, Nolan, Runnels, Scurry, Shackelford, Stephens, Stonewall, Taylor, Throckmorton, Wichita, Wilbarger, and Young; [~~ZIP Coded areas: 76228, 76230, 76239, 76251, 76255, 76261, 76265, 76270, 76301, 76302, 76305, 76306, 76307, 76308, 76309, 76310, 76311, 76351, 76352, 76354, 76357, 76360, 76363, 76364, 76365, 76366, 76367, 76369, 76370, 76371, 76372, 76373, 76374, 76377, 76379, 76380, 76384, 76385, 76388, 76389, 76424, 76427, 76429, 76430, 76432, 76435, 76437, 76442, 76443, 76444, 76445, 76448, 76450, 76452, 76454, 76455, 76458, 76459, 76460, 76464, 76466, 76468, 76469, 76470, 76471, 76474, 76481, 76483, 76486, 76491, 76801, 76802, 76803, 76804, 76821, 76823, 76827, 76828, 76834, 76845, 76857, 76861, 76865, 76873, 76875, 76878, 76882, 76884, 76888, 76890, 79223, 79225, 79227, 79247, 79248, 79252, 79501, 79502, 79503, 79504, 79505, 79506, 79508, 79510, 79512, 79516, 79517, 79518, 79519, 79520, 79521, 79525, 79526, 79527, 79528, 79529, 79530, 79532, 79533, 79534, 79535, 79536, 79537, 79538, 79539, 79540, 79541, 79543, 79544, 79545, 79546, 79547, 79548, 79549, 79550, 79553, 79556, 79560, 79561, 79562, 79563, 79565, 79566, 79567, 79601, 79602, 79603, 79604, 79605, 79606, 79607, 79608, 79697, 79698, and 79699;~~]

(3) Region 3--Metroplex, including Fort Worth and Dallas, composed [~~comprised~~] of the following counties: Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant, and Wise; [~~ZIP Coded areas: 75001, 75002, 75006, 75007, 75009, 75010, 75011, 75013, 75014, 75015, 75016, 75017, 75019, 75020, 75021, 75022, 75023, 75024, 75025, 75026, 75027, 75028, 75029, 75030, 75032, 75034, 75035, 75037, 75038, 75039, 75040, 75041, 75042, 75043, 75044, 75045, 75046, 75047, 75048, 75049, 75050, 75051, 75052, 75053, 75054, 75056, 75057, 75058, 75060, 75061, 75062, 75063, 75065, 75067, 75068, 75069, 75070, 75071, 75074, 75075, 75076, 75077, 75078, 75080, 75081, 75082, 75083, 75085, 75086, 75087, 75088, 75089, 75090, 75091, 75092, 75093, 75094, 75097, 75098, 75099, 75101, 75102, 75104, 75105, 75106, 75109, 75110, 75114, 75115, 75116, 75118, 75119, 75120, 75121, 75123, 75125, 75126, 75132, 75134, 75135, 75137, 75138, 75141, 75142, 75143, 75144, 75146, 75147, 75149, 75150, 75151, 75152, 75153, 75154, 75155, 75157, 75158, 75159, 75160, 75161, 75164, 75165, 75166, 75167, 75168, 75172, 75173, 75180, 75181, 75182, 75185, 75187, 75189, 75201, 75202, 75203, 75204, 75205, 75206, 75207, 75208, 75209, 75210, 75211, 75212, 75214, 75215, 75216, 75217, 75218, 75219, 75220, 75221, 75222, 75223, 75224, 75225, 75226, 75227, 75228, 75229, 75230, 75231, 75232, 75233, 75234, 75235, 75236, 75237, 75238, 75240, 75241, 75242, 75243, 75244, 75245, 75246, 75247, 75248, 75249, 75250, 75251, 75252, 75253, 75254, 75258, 75260, 75261, 75262, 75263, 75264, 75265, 75266, 75267, 75270, 75275, 75277, 75283, 75284, 75285, 75286, 75287, 75301, 75303, 75310, 75312, 75313, 75315, 75320, 75323, 75326, 75334, 75336, 75339, 75340, 75342, 75343, 75344, 75353, 75354, 75355, 75356, 75357, 75358, 75359, 75360, 75363, 75364, 75367, 75368, 75370, 75371, 75372, 75373, 75374, 75376, 75378, 75379, 75380, 75381, 75382, 75386, 75387, 75388, 75389, 75390, 75391, 75392, 75393, 75394, 75395, 75396, 75397, 75398, 75401, 75402, 75403, 75404, 75407, 75409, 75413, 75414, 75418, 75422, 75423, 75424, 75428, 75429, 75438, 75439, 75442, 75443, 75446, 75447, 75449, 75452, 75453, 75454, 75458, 75459, 75474, 75475, 75476, 75479, 75485, 75488, 75489, 75490, 75491, 75492, 75495, 75496, 76001, 76002, 76003, 76004, 76005, 76006, 76007, 76008, 76009, 76010, 76011, 76012, 76013, 76014, 76015, 76016, 76017, 76018, 76019, 76020, 76021, 76022, 76023, 76028, 76031, 76033, 76034, 76035, 76036, 76039, 76040, 76041, 76043, 76044, 76048, 76049, 76050, 76051, 76052, 76053, 76054, 76058, 76059, 76060, 76061, 76063, 76064, 76065, 76066, 76067, 76068, 76070, 76071, 76073, 76077, 76078, 76082, 76084, 76085, 76086, 76087, 76088, 76092, 76093, 76094, 76095, 76096, 76097, 76098, 76099, 76101, 76102, 76103, 76104, 76105, 76106, 76107, 76108, 76109, 76110, 76111, 76112, 76113, 76114, 76115, 76116, 76117, 76118, 76119, 76120, 76121, 76122, 76123, 76124, 76126, 76127, 76129, 76130, 76131, 76132, 76133, 76134, 76135, 76136, 76137, 76140, 76147, 76148, 76150, 76155, 76161, 76162, 76163, 76164, 76166, 76177, 76179, 76180, 76181, 76182, 76185, 76191, 76192, 76193, 76195, 76196, 76197, 76198, 76199, 76201, 76202, 76203, 76204, 76205, 76206, 76207, 76208, 76209, 76210, 76225, 76226, 76227, 76233, 76234, 76238, 76240, 76241, 76244, 76245, 76246, 76247, 76248, 76249, 76250, 76252, 76253, 76258, 76259, 76262, 76263, 76264, 76266, 76267, 76268, 76271, 76272, 76273, 76299, 76401, 76402, 76426, 76431, 76433, 76439, 76446, 76449, 76453, 76461, 76462, 76463, 76465, 76467, 76472, 76475, 76476, 76484, 76485, 76487, 76490, 76623, 76626, 76639, 76641, 76651, 76670, 76679, and 76681;~~]

(4) Region 4--Northeast Texas, including Tyler, composed [~~comprised~~] of the following counties: Anderson, Bowie, Camp, Cass, Cherokee, Delta, Franklin, Gregg, Harrison, Henderson, Hopkins, Lamar, Marion, Morris, Panola, Rains, Red River, Rusk, Smith, Titus, Upshur, Van Zandt, and Wood; [~~ZIP Coded areas: 75103, 75117, 75124, 75127, 75140, 75148, 75156, 75163, 75169, 75410, 75411, 75412, 75415, 75416, 75417, 75420, 75421, 75425, 75426, 75431, 75432, 75433, 75434, 75435, 75436, 75437, 75440, 75441, 75444, 75448, 75450, 75451, 75455, 75456, 75457, 75460, 75461, 75462, 75468, 75469, 75470, 75471, 75472, 75473, 75477, 75478, 75480, 75481, 75482, 75483, 75486, 75487, 75493, 75494, 75497, 75501, 75503, 75504, 75505, 75507, 75550, 75551, 75554, 75555, 75556, 75558, 75559, 75560, 75561, 75562, 75563, 75564, 75565, 75566, 75567, 75568, 75569, 75570, 75571, 75572, 75573, 75574, 75599, 75601, 75602, 75603, 75604, 75605, 75606, 75607, 75608, 75615, 75630, 75631, 75633, 75636, 75637, 75638, 75639, 75640, 75641, 75642, 75643, 75644, 75645, 75647, 75650, 75651, 75652, 75653, 75654, 75656, 75657, 75658, 75659, 75660, 75661, 75662, 75663, 75666, 75667, 75668, 75669, 75670, 75671, 75672, 75680, 75681, 75682, 75683, 75684, 75685, 75686, 75687, 75688, 75689, 75691, 75692, 75693, 75694, 75701, 75702, 75703, 75704, 75705, 75706, 75707, 75708, 75709, 75710, 75711, 75712, 75713, 75750, 75751, 75752, 75754, 75755, 75756, 75757, 75758, 75759, 75762, 75763, 75764, 75765, 75766, 75770, 75771, 75772, 75773, 75778, 75779, 75780, 75782, 75783, 75784, 75785, 75789, 75790, 75791, 75792, 75797, 75798, 75799, 75801, 75802, 75803, 75832, 75839, 75853, 75861, 75880, 75882, 75884, 75886, 75925, and 75976;~~]

(5) Region 5--Southeast Texas, including Beaumont, composed [~~comprised~~] of the following counties: Angelina, Hardin, Houston, Jasper, Jefferson, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler; [~~ZIP Coded areas: 75760, 75788, 75834, 75835, 75844, 75845, 75847, 75849, 75851, 75856, 75858, 75862, 75865, 75901, 75902, 75903, 75904, 75915, 75926, 75928, 75929, 75930, 75931, 75932, 75933, 75934, 75935, 75936, 75937, 75938, 75939, 75941, 75942, 75943, 75944, 75946, 75948, 75949, 75951, 75954, 75956, 75958, 75959, 75960, 75961, 75962, 75963, 75964, 75965, 75966, 75968, 75969, 75972, 75973, 75974, 75975, 75977, 75978, 75979, 75980, 75990, 77326, 77331, 77332, 77335, 77350, 77351, 77359, 77360, 77364, 77371, 77374, 77376, 77399, 77519, 77585, 77611, 77612, 77613, 77614, 77615, 77616, 77619, 77622, 77624, 77625, 77626, 77627, 77629, 77630, 77631, 77632, 77639, 77640, 77641, 77642, 77643, 77651, 77655, 77656, 77657, 77659, 77660, 77662, 77663, 77664,~~

77670, 77701, 77702, 77703, 77704, 77705, 77706, 77707, 77708, 77709, 77710, 77713, 77720, 77725, and 77726;]

(6) Region 6--Gulf Coast, including Houston and Huntsville, composed [comprised] of the following counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Harris, Liberty, Matagorda, Montgomery, Walker, Waller, and Wharton; [ZIP Coded areas: 77001, 77002, 77003, 77004, 77005, 77006, 77007, 77008, 77009, 77010, 77011, 77012, 77013, 77014, 77015, 77016, 77017, 77018, 77019, 77020, 77021, 77022, 77023, 77024, 77025, 77026, 77027, 77028, 77029, 77030, 77031, 77032, 77033, 77034, 77035, 77036, 77037, 77038, 77039, 77040, 77041, 77042, 77043, 77044, 77045, 77046, 77047, 77048, 77049, 77050, 77051, 77052, 77053, 77054, 77055, 77056, 77057, 77058, 77059, 77060, 77061, 77062, 77063, 77064, 77065, 77066, 77067, 77068, 77069, 77070, 77071, 77072, 77073, 77074, 77075, 77076, 77077, 77078, 77079, 77080, 77081, 77082, 77083, 77084, 77085, 77086, 77087, 77088, 77089, 77090, 77091, 77092, 77093, 77094, 77095, 77096, 77097, 77098, 77099, 77201, 77202, 77203, 77204, 77205, 77206, 77207, 77208, 77209, 77210, 77212, 77213, 77215, 77216, 77217, 77218, 77219, 77220, 77221, 77222, 77223, 77224, 77225, 77226, 77227, 77228, 77229, 77230, 77231, 77233, 77234, 77235, 77236, 77237, 77238, 77240, 77241, 77242, 77243, 77244, 77245, 77246, 77247, 77248, 77249, 77250, 77251, 77252, 77253, 77254, 77255, 77256, 77257, 77258, 77259, 77260, 77261, 77262, 77263, 77265, 77266, 77267, 77268, 77269, 77270, 77271, 77272, 77273, 77274, 77275, 77276, 77277, 77278, 77279, 77280, 77282, 77284, 77285, 77286, 77287, 77288, 77289, 77290, 77291, 77292, 77293, 77294, 77296, 77297, 77298, 77299, 77301, 77302, 77303, 77304, 77305, 77306, 77315, 77316, 77318, 77320, 77325, 77327, 77328, 77333, 77334, 77336, 77337, 77338, 77339, 77340, 77341, 77342, 77343, 77344, 77345, 77346, 77347, 77348, 77349, 77353, 77354, 77355, 77356, 77357, 77358, 77362, 77365, 77367, 77368, 77369, 77372, 77373, 77375, 77377, 77378, 77379, 77380, 77381, 77382, 77383, 77384, 77385, 77386, 77387, 77388, 77389, 77391, 77393, 77396, 77401, 77402, 77404, 77406, 77410, 77411, 77412, 77413, 77414, 77415, 77417, 77418, 77419, 77420, 77422, 77423, 77428, 77429, 77430, 77431, 77432, 77433, 77434, 77435, 77436, 77437, 77440, 77441, 77442, 77443, 77444, 77445, 77446, 77447, 77448, 77449, 77450, 77451, 77452, 77453, 77454, 77455, 77456, 77457, 77458, 77459, 77460, 77461, 77463, 77464, 77465, 77466, 77467, 77468, 77469, 77470, 77471, 77473, 77474, 77475, 77476, 77477, 77478, 77479, 77480, 77481, 77482, 77483, 77484, 77485, 77486, 77487, 77488, 77489, 77491, 77492, 77493, 77494, 77496, 77497, 77501, 77502, 77503, 77504, 77505, 77506, 77507, 77508, 77510, 77511, 77512, 77514, 77515, 77516, 77517, 77518, 77520, 77521, 77522, 77530, 77531, 77532, 77533, 77534, 77535, 77536, 77538, 77539, 77541, 77542, 77545, 77546, 77547, 77549, 77550, 77551, 77552, 77553, 77554, 77555, 77560, 77561, 77562, 77563, 77564, 77565, 77566, 77568, 77571, 77572, 77573, 77574, 77575, 77577, 77578, 77580, 77581, 77582, 77583, 77584, 77586, 77587, 77588, 77590, 77591, 77592, 77597, 77598, 77617, 77623, 77650, 77661, 77665, 78931, 78933, 78934, 78935, 78943, 78944, 78950, 78951, and 78962;]

(7) Region 7--Central Texas, including Austin and Waco, composed [comprised] of the following counties: Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington, and Williamson; [ZIP Coded areas: 73301, 73344, 75831, 75833, 75838, 75840, 75846, 75848, 75850, 75852, 75855, 75859, 75860, 76055, 76436, 76457, 76501, 76502, 76503, 76504, 76505, 76508, 76511, 76513, 76518, 76519, 76520, 76522, 76523, 76524, 76525, 76526, 76527, 76528, 76530, 76531, 76533, 76534, 76537, 76538, 76539, 76540, 76541, 76542, 76543, 76544, 76545, 76546, 76547, 76548, 76549, 76550, 76554, 76556, 76557, 76558, 76559, 76561, 76564, 76565, 76566, 76567, 76569, 76570, 76571, 76573, 76574, 76577, 76578, 76579, 76596, 76597, 76598, 76599, 76621, 76622, 76624, 76627, 76628, 76629, 76630, 76631, 76632, 76633, 76634, 76635, 76636, 76637, 76638, 76640, 76642, 76643, 76644, 76645, 76648, 76649, 76650, 76652, 76653, 76654, 76655, 76656, 76657, 76660, 76661, 76664, 76665, 76666, 76667, 76671, 76673, 76676, 76678, 76680, 76682, 76684, 76685, 76686, 76687, 76689, 76690, 76691, 76692, 76693, 76701, 76702, 76703, 76704, 76705, 76706, 76707, 76708, 76710, 76711, 76712, 76714, 76715, 76716, 76795, 76797, 76798, 76799, 76824, 76831, 76832, 76844, 76853, 76864, 76870, 76871, 76877, 76880, 76885, 77363, 77426, 77801, 77802, 77803, 77805, 77806, 77807, 77808, 77830, 77831, 77833, 77834, 77835, 77836, 77837, 77838, 77840, 77841, 77842, 77843, 77844, 77845, 77850, 77852, 77853, 77855, 77856, 77857, 77859, 77861, 77862, 77863, 77864, 77865, 77866, 77867, 77868, 77869, 77870, 77871, 77872, 77873, 77875, 77876, 77878, 77879, 77880, 77881, 77882, 78602, 78605, 78606, 78607, 78608, 78609, 78610, 78611, 78612, 78613, 78615, 78616, 78617, 78619, 78620, 78621, 78622, 78626, 78627, 78628, 78630, 78633, 78634, 78635, 78636, 78639, 78640, 78641, 78642, 78643, 78644, 78645, 78646, 78648, 78650, 78651, 78652, 78653, 78654, 78655, 78656, 78657, 78659, 78660, 78661, 78662, 78663, 78664, 78665, 78666, 78667, 78669, 78672, 78673, 78674, 78676, 78680, 78681, 78682, 78683, 78691, 78701, 78702, 78703, 78704, 78705, 78708, 78709, 78710, 78711, 78712, 78713, 78714, 78715, 78716, 78717, 78718, 78719, 78720, 78721, 78722, 78723, 78724, 78725, 78726, 78727, 78728, 78729, 78730, 78731, 78732, 78733, 78734, 78735, 78736, 78737, 78738, 78739, 78741, 78742, 78744, 78745, 78746, 78747, 78748, 78749, 78750, 78751, 78752, 78753, 78754, 78755, 78756, 78757, 78758, 78759, 78760, 78761, 78762, 78763, 78764, 78765, 78766, 78767, 78768, 78769, 78772, 78773, 78774, 78778, 78779, 78780, 78781, 78783, 78785, 78786, 78788, 78789, 78798, 78799, 78932, 78938, 78940, 78941, 78942, 78945, 78946, 78947, 78948, 78949, 78952, 78953, 78954, 78956, 78957, 78960, 78961, and 78963;]

(8) Region 8--South Central Texas, including San Antonio, composed [comprised] of the following counties: Atascosa, Bandera, Bexar, Calhoun, Comal, DeWitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, La Salle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala; [ZIP Coded areas: 76883, 77901, 77902, 77903, 77904, 77905, 77951, 77954, 77957, 77960, 77961, 77962, 77963, 77964, 77967, 77968, 77969, 77970, 77971, 77973, 77974, 77975, 77976, 77977, 77978, 77979, 77982, 77983, 77984, 77986, 77987, 77988, 77989, 77991, 77993, 77994, 77995, 78001, 78002, 78003, 78004, 78005, 78006, 78008, 78009, 78010, 78011, 78012, 78013, 78014, 78015, 78016, 78017, 78019, 78021, 78023, 78024, 78025, 78026, 78027, 78028, 78029, 78039, 78050, 78052, 78054, 78055, 78056, 78057, 78058, 78059, 78061, 78062, 78063, 78064, 78065, 78066, 78069, 78070, 78073, 78074, 78101, 78107, 78108, 78109, 78111, 78112, 78113, 78114, 78115, 78116, 78117, 78118, 78119, 78121, 78122, 78123, 78124, 78130, 78131, 78132, 78133, 78135, 78140, 78141, 78143, 78144, 78147, 78148, 78150, 78151, 78152, 78154, 78155, 78156, 78159, 78160, 78161, 78163, 78164, 78201, 78202, 78203, 78204, 78205, 78206, 78207, 78208, 78209, 78210, 78211, 78212, 78213, 78214, 78215, 78216, 78217, 78218, 78219, 78220, 78221, 78222, 78223, 78224, 78225, 78226, 78227, 78228, 78229, 78230, 78231, 78232, 78233, 78234, 78235, 78236, 78237, 78238, 78239, 78240, 78241, 78242, 78243, 78244, 78245, 78246, 78247, 78248, 78249, 78250, 78251, 78252, 78253, 78254, 78255, 78256, 78257, 78258, 78259, 78260, 78261, 78262, 78263, 78264, 78265, 78266, 78268, 78269, 78270, 78275, 78278, 78279, 78280, 78283, 78284, 78285, 78286, 78287, 78288, 78289, 78291,

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(9) Region 9--West Texas, including Midland, Odessa, and San Angelo composed [~~comprised~~] of the following counties: Andrews, Borden, Coke, Concho, Crane, Crockett, Dawson, Ector, Gaines, Glasscock, Howard, Irion, Kimble, Loving, Martin, Mason, McCulloch, Menard, Midland, Pecos, Reagan, Reeves, Schleicher, Sterling, Sutton, Terrell, Tom Green, Upton, Ward, and Winkler; [~~ZIP Coded areas:~~ ~~76820,~~ ~~76825,~~ ~~76836,~~ ~~76837,~~ ~~76841,~~ ~~76842,~~ ~~76848,~~ ~~76849,~~ ~~76852,~~ ~~76854,~~ ~~76855,~~ ~~76856,~~ ~~76858,~~ ~~76859,~~ ~~76862,~~ ~~76866,~~ ~~76869,~~ ~~76872,~~ ~~76874,~~ ~~76886,~~ ~~76887,~~ ~~76901,~~ ~~76902,~~ ~~76903,~~ ~~76904,~~ ~~76905,~~ ~~76906,~~ ~~76908,~~ ~~76909,~~ ~~76930,~~ ~~76932,~~ ~~76933,~~ ~~76934,~~ ~~76935,~~ ~~76936,~~ ~~76937,~~ ~~76939,~~ ~~76940,~~ ~~76941,~~ ~~76943,~~ ~~76945,~~ ~~76949,~~ ~~76950,~~ ~~76951,~~ ~~76953,~~ ~~76955,~~ ~~76957,~~ ~~76958,~~ ~~78851,~~ ~~79331,~~ ~~79342,~~ ~~79359,~~ ~~79360,~~ ~~79377,~~ ~~79511,~~ ~~79701,~~ ~~79702,~~ ~~79703,~~ ~~79704,~~ ~~79705,~~ ~~79706,~~ ~~79707,~~ ~~79708,~~ ~~79710,~~ ~~79711,~~ ~~79712,~~ ~~79713,~~ ~~79714,~~ ~~79718,~~ ~~79719,~~ ~~79720,~~ ~~79721,~~ ~~79730,~~ ~~79731,~~ ~~79733,~~ ~~79735,~~ ~~79738,~~ ~~79739,~~ ~~79740,~~ ~~79741,~~ ~~79742,~~ ~~79743,~~ ~~79744,~~ ~~79745,~~ ~~79748,~~ ~~79749,~~ ~~79752,~~ ~~79754,~~ ~~79755,~~ ~~79756,~~ ~~79758,~~ ~~79759,~~ ~~79760,~~ ~~79761,~~ ~~79762,~~ ~~79763,~~ ~~79764,~~ ~~79765,~~ ~~79766,~~ ~~79768,~~ ~~79769,~~ ~~79770,~~ ~~79772,~~ ~~79776,~~ ~~79777,~~ ~~79778,~~ ~~79780,~~ ~~79781,~~ ~~79782,~~ ~~79783,~~ ~~79785,~~ ~~79786,~~ ~~79788,~~ ~~79789,~~ ~~and~~ ~~79848;~~]

(10) Region 10--Far West Texas, including El Paso, composed [~~comprised~~] of the following counties: Brewster, Culberson, El Paso, Hudspeth, Jeff Davis, and Presidio; [~~ZIP Coded areas:~~ ~~79734,~~ ~~79821,~~ ~~79830,~~ ~~79831,~~ ~~79832,~~ ~~79834,~~ ~~79835,~~ ~~79836,~~ ~~79837,~~ ~~79838,~~ ~~79839,~~ ~~79842,~~ ~~79843,~~ ~~79845,~~ ~~79846,~~ ~~79847,~~ ~~79849,~~ ~~79851,~~ ~~79852,~~ ~~79853,~~ ~~79854,~~ ~~79855,~~ ~~79901,~~ ~~79902,~~ ~~79903,~~ ~~79904,~~ ~~79905,~~ ~~79906,~~ ~~79907,~~ ~~79908,~~ ~~79910,~~ ~~79911,~~ ~~79912,~~ ~~79913,~~ ~~79914,~~ ~~79915,~~ ~~79916,~~ ~~79917,~~ ~~79918,~~ ~~79920,~~ ~~79922,~~ ~~79923,~~ ~~79924,~~ ~~79925,~~ ~~79926,~~ ~~79927,~~ ~~79928,~~ ~~79929,~~ ~~79930,~~ ~~79931,~~ ~~79932,~~ ~~79934,~~ ~~79935,~~ ~~79936,~~ ~~79937,~~ ~~79938,~~ ~~79940,~~ ~~79941,~~ ~~79942,~~ ~~79943,~~ ~~79944,~~ ~~79945,~~ ~~79946,~~ ~~79947,~~ ~~79948,~~ ~~79949,~~ ~~79950,~~ ~~79951,~~ ~~79952,~~ ~~79953,~~ ~~79954,~~ ~~79955,~~ ~~79958,~~ ~~79960,~~ ~~79961,~~ ~~79968,~~ ~~79976,~~ ~~79978,~~ ~~79980,~~ ~~79990,~~ ~~79995,~~ ~~79996,~~ ~~79997,~~ ~~79998,~~ ~~79999,~~ ~~88510,~~ ~~88511,~~ ~~88512,~~ ~~88513,~~ ~~88514,~~ ~~88515,~~ ~~88516,~~ ~~88517,~~ ~~88518,~~ ~~88519,~~ ~~88520,~~ ~~88521,~~ ~~88523,~~ ~~88524,~~ ~~88525,~~ ~~88526,~~ ~~88527,~~ ~~88528,~~ ~~88529,~~ ~~88530,~~ ~~88531,~~ ~~88532,~~ ~~88533,~~ ~~88534,~~ ~~88535,~~ ~~88536,~~ ~~88538,~~ ~~88539,~~ ~~88540,~~ ~~88541,~~ ~~88542,~~ ~~88543,~~ ~~88544,~~ ~~88545,~~ ~~88546,~~ ~~88547,~~ ~~88548,~~ ~~88549,~~ ~~88550,~~ ~~88553,~~ ~~88554,~~ ~~88555,~~ ~~88556,~~ ~~88557,~~ ~~88558,~~ ~~88559,~~ ~~88560,~~ ~~88561,~~ ~~88562,~~ ~~88563,~~ ~~88565,~~ ~~88566,~~ ~~88567,~~ ~~88568,~~ ~~88569,~~ ~~88570,~~ ~~88571,~~ ~~88572,~~ ~~88573,~~ ~~88574,~~ ~~88575,~~ ~~88576,~~ ~~88577,~~ ~~88578,~~ ~~88579,~~ ~~88580,~~ ~~88581,~~ ~~88582,~~ ~~88583,~~ ~~88584,~~ ~~88585,~~ ~~88586,~~ ~~88587,~~ ~~88588,~~ ~~88589,~~ ~~88590,~~ ~~and~~ ~~88595;~~] and

(11) Region 11--Rio Grande Valley, including Brownsville, Corpus Christi, and Laredo, composed [~~comprised~~] of the following counties: Aransas, Bee, Brooks, Cameron, Duval, Hidalgo, Jim Hogg, Jim Wells, Kenedy, Kleberg, Live Oak, McMullen, Nueces, Refugio, San Patricio, Starr, Webb, Willacy, and Zapata. [~~ZIP Coded areas:~~ ~~77950,~~ ~~77990,~~ ~~78007,~~ ~~78022,~~ ~~78040,~~ ~~78041,~~ ~~78042,~~ ~~78043,~~ ~~78044,~~ ~~78045,~~ ~~78046,~~ ~~78049,~~ ~~78060,~~ ~~78067,~~ ~~78071,~~ ~~78072,~~ ~~78075,~~ ~~78076,~~ ~~78102,~~ ~~78104,~~ ~~78125,~~ ~~78142,~~ ~~78145,~~ ~~78146,~~ ~~78162,~~ ~~78330,~~ ~~78332,~~ ~~78333,~~ ~~78335,~~ ~~78336,~~ ~~78338,~~ ~~78339,~~ ~~78340,~~ ~~78341,~~ ~~78342,~~ ~~78343,~~ ~~78344,~~ ~~78347,~~ ~~78349,~~ ~~78350,~~ ~~78351,~~ ~~78352,~~ ~~78353,~~ ~~78355,~~ ~~78357,~~ ~~78358,~~ ~~78359,~~ ~~78360,~~ ~~78361,~~ ~~78362,~~ ~~78363,~~ ~~78364,~~ ~~78368,~~ ~~78369,~~ ~~78370,~~ ~~78371,~~ ~~78372,~~ ~~78373,~~ ~~78374,~~ ~~78375,~~ ~~78376,~~ ~~78377,~~ ~~78379,~~ ~~78380,~~ ~~78381,~~ ~~78382,~~ ~~78383,~~ ~~78384,~~ ~~78385,~~ ~~78387,~~ ~~78389,~~ ~~78390,~~ ~~78391,~~ ~~78393,~~ ~~78401,~~ ~~78402,~~ ~~78403,~~ ~~78404,~~ ~~78405,~~ ~~78406,~~ ~~78407,~~ ~~78408,~~ ~~78409,~~ ~~78410,~~ ~~78411,~~ ~~78412,~~ ~~78413,~~ ~~78414,~~ ~~78415,~~ ~~78416,~~ ~~78417,~~ ~~78418,~~ ~~78419,~~ ~~78426,~~ ~~78427,~~ ~~78460,~~ ~~78461,~~ ~~78463,~~ ~~78465,~~ ~~78466,~~ ~~78467,~~ ~~78468,~~ ~~78469,~~ ~~78470,~~ ~~78471,~~ ~~78472,~~ ~~78473,~~ ~~78474,~~ ~~78475,~~ ~~78476,~~ ~~78477,~~ ~~78478,~~ ~~78480,~~ ~~78501,~~ ~~78502,~~ ~~78503,~~ ~~78504,~~ ~~78505,~~ ~~78516,~~ ~~78520,~~ ~~78521,~~ ~~78522,~~ ~~78523,~~ ~~78526,~~ ~~78535,~~ ~~78536,~~ ~~78537,~~ ~~78538,~~ ~~78539,~~ ~~78540,~~ ~~78541,~~ ~~78543,~~ ~~78545,~~ ~~78547,~~ ~~78548,~~ ~~78549,~~ ~~78550,~~ ~~78551,~~ ~~78552,~~ ~~78553,~~ ~~78557,~~ ~~78558,~~ ~~78559,~~ ~~78560,~~ ~~78561,~~ ~~78562,~~ ~~78563,~~ ~~78564,~~ ~~78565,~~ ~~78566,~~ ~~78567,~~ ~~78568,~~ ~~78569,~~ ~~78570,~~ ~~78572,~~ ~~78573,~~ ~~78574,~~ ~~78575,~~ ~~78576,~~ ~~78577,~~ ~~78578,~~ ~~78579,~~ ~~78580,~~ ~~78582,~~ ~~78583,~~ ~~78584,~~ ~~78585,~~ ~~78586,~~ ~~78588,~~ ~~78589,~~ ~~78590,~~ ~~78591,~~ ~~78592,~~ ~~78593,~~ ~~78594,~~ ~~78595,~~ ~~78596,~~ ~~78597,~~ ~~78598,~~ ~~and~~ ~~78599.~~]

§3.3712. Network Configuration Filings.

(a) An insurer must submit network configuration information as specified in this section in connection with a request for a waiver under §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), an annual network adequacy report required under §3.3709 of this title (relating to Annual Network Adequacy Report), or an application for a network modification under §3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications).

(b) A network configuration filing must be submitted to the department using SERFF or another electronic method that is acceptable to the department.

(c) A network configuration filing must contain the following items.

(1) Provider listing data. The insurer must use the provider listings form available at www.tdi.texas.gov to provide a comprehensive searchable and sortable listing of physicians and health care providers in the plan's network that includes:

(A) information about the insurer, including the insurer's name, National Association of Insurance Commissioners number, network name, and network ID;

(B) information about each preferred provider, including:

(i) the preferred provider's name, address of practice location, county, and telephone number;

(ii) the provider's national provider identifier (NPI) number and Texas license number;

(iii) the provider's specialty type or facility type, as applicable, using the categories specified in the form; and

(iv) whether the provider offers telehealth; and

(C) information about a preferred provider that is not a facility, including information on the preferred provider's facility privileges.

(2) Network compliance analysis. The insurer must use the network compliance and waiver request form available at www.tdi.texas.gov to provide a listing of each county in the insurer's service area and data regarding network compliance for each county, including:

(A) the number of each type of preferred provider in the plan's network, using the provider specialty types specified in the form;

(B) information indicating whether the network adequacy standards specified in §3.3704 of this title (relating to Freedom of Choice; Availability of Preferred Providers) are met with respect to each type of physician or provider, including specifying the nature of

the deficiency (such as insufficient providers, insufficient choice, or deficient appointment wait times);

(C) if the network adequacy standards are not met for a given type of physician or provider, a waiver request and an access plan consistent with §3.3707 of this title (relating to Waiver Due to Failure to Contract in Local Markets), including an explanation of:

(i) the reason the waiver is needed, including whether the waiver is needed because of an insufficient number of physicians or providers available within the network adequacy standards, or because of a failure to contract with available providers;

(ii) if the waiver is needed because of a failure to contract with available providers, each year for which the waiver has previously been approved, beginning with 2024;

(iii) the total number of currently practicing physicians or providers that are located within each county and the source of this information;

(iv) the access plan procedures the insurer will use to assist insureds in obtaining medically necessary services when no preferred provider is available within the network adequacy standards, including procedures to coordinate care to limit the likelihood of balance billing, consistent with the procedures established in §3.3707(j) of this title; and

(v) actions to eliminate network adequacy gaps and mitigate the need for future waivers.

(D) except for a network offered in connection with an exclusive provider benefit plan, an insurer must include a description of how the insurer provides access to different types of facilities, as required by Insurance Code §1301.0055(b)(6), concerning Network Adequacy Standards.

(3) Online provider listing. The insurer must include a link to the online provider listing made available to insureds and a pdf copy of the provider listing that is made available to insureds that request a nonelectronic version.

(4) Access plan for unforeseen network gaps. The insurer must include a copy of the access plan required in §3.3707(m) of this title, which applies to any unforeseen circumstance in which an insured is unable to access covered health care services within the network adequacy standards provided in §3.3704 of this title.

(d) The information submitted as required under this section is considered public information under Government Code Chapter 552, concerning Public Information, and the insurer may not submit the provider listings form or network compliance and waiver request form in a manner that precludes the public release of the information. The department will use the data submitted under this section to publish network data consistent with Insurance Code §§1301.0055(a)(3), concerning Network Adequacy Standards, 1301.00565(g), concerning Public Hearing on Network Adequacy Standards Waivers, and 1301.009, concerning Annual Report.

§3.3713. County Classifications for Maximum Time and Distance Standards.

(a) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(c), concerning Maximum Travel Time and Distance Standards by Preferred Provider Type, the following counties are classified as a large metro county: Bexar, Collin, Dallas, Harris, Tarrant, and Travis.

(b) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(d), the following counties are classified as a metro county: Angelina, Bastrop, Bell, Bowie, Brazoria, Brazos, Cameron, Comal, Denton, Ector, Ellis, El Paso, Fort Bend, Galveston, Grayson, Gregg, Guadalupe, Hays, Hidalgo, Hood, Hunt, Jefferson, Johnson, Kaufman, Lubbock, McLennan, Midland, Montgomery, Nueces, Orange, Parker, Potter, Randall, Rockwall, San Patricio, Smith, Taylor, Victoria, Waller, Webb, Wichita, and Williamson.

(c) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(e), the following counties are classified as a micro county: Anderson, Aransas, Burnet, Caldwell, Camp, Chambers, Cherokee, Coryell, Hardin, Harrison, Henderson, Kendall, Kerr, Lamar, Liberty, Maverick, Medina, Nacogdoches, Navarro, Polk, Rains, Rusk, Starr, Titus, Tom Green, Upshur, Van Zandt, Walker, Washington, Wilson, Wise, and Wood.

(d) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(f), the following counties are classified as a rural county: Andrews, Atascosa, Austin, Bandera, Bee, Blanco, Bosque, Brown, Burleson, Calhoun, Callahan, Cass, Colorado, Comanche, Cooke, Dawson, Deaf Smith, Delta, DeWitt, Eastland, Erath, Falls, Fannin, Fayette, Franklin, Freestone, Frio, Gaines, Gillespie, Gonzales, Gray, Grimes, Hale, Hill, Hockley, Hopkins, Houston, Howard, Hutchinson, Jackson, Jasper, Jim Wells, Jones, Karnes, Kleberg, Lamb, Lampasas, Lavaca, Lee, Leon, Limestone, Live Oak, Llano, Madison, Marion, Matagorda, Milam, Montague, Moore, Morris, Newton, Nolan, Ochiltree, Palo Pinto, Panola, Parmer, Red River, Robertson, Sabine, San Augustine, San Jacinto, Scurry, Shelby, Somervell, Stephens, Terry, Trinity, Tyler, Uvalde, Val Verde, Ward, Wharton, Wilbarger, Willacy, Young, and Zapata.

(e) For the purposes of this subchapter and the maximum travel time and distance standards specified in Insurance Code §1301.00553(g), the following counties are classified as a county with extreme access considerations: Archer, Armstrong, Bailey, Baylor, Borden, Brewster, Briscoe, Brooks, Carson, Castro, Childress, Clay, Cochran, Coke, Coleman, Collingsworth, Concho, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dickens, Dimmit, Donley, Duval, Edwards, Fisher, Floyd, Foard, Garza, Glasscock, Goliad, Hall, Hamilton, Hansford, Hardeman, Hartley, Haskell, Hemphill, Hudspeth, Irion, Jack, Jeff Davis, Jim Hogg, Kenedy, Kent, Kimble, King, Kinney, Knox, La Salle, Lipscomb, Loving, Lynn, McCulloch, McMullen, Martin, Mason, Menard, Mills, Mitchell, Motley, Oldham, Pecos, Presidio, Reagan, Real, Reeves, Refugio, Roberts, Runnels, San Saba, Schleicher, Shackelford, Sherman, Sterling, Stonewall, Sutton, Swisher, Terrell, Throckmorton, Upton, Wheeler, Winkler, Yoakum, and Zavala.

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

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DIVISION 2. APPLICATION, EXAMINATION, AND ~~EXCLUSIVE PROVIDER BENEFIT~~ PLAN REQUIREMENTS

28 TAC §§3.3720, 3.3722, 3.3723

STATUTORY AUTHORITY. TDI proposes amendments to §§3.3720, 3.3722, and 3.3723 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonable accessibility and availability of preferred provider 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.

CROSS-REFERENCE TO STATUTE. The proposed amendments to §3.3722 implement Insurance Code Chapter 1301.

§3.3720. Preferred and Exclusive Provider Benefit Plan Requirements.

Sections 3.3721 [~~- 3.3723~~] of this title (relating to Preferred and Exclusive Provider Benefit Plan Network Approval Required), 3.3722 of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications), and 3.3723 of this title (relating to Examinations) [~~, Application for Preferred and Exclusive Provider Benefit Plan Approval and Qualifying Examination, and Examinations)~~] apply to preferred and exclusive provider benefit plans offered pursuant to Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, in commercial markets. Section 3.3724 [~~Sections 3.3274 - 3.3725~~] of this title (relating to Quality Improvement Program) applies [~~and Payment of Certain Out-of-Network Claims) apply~~] only to exclusive provider benefit plans offered under [~~pursuant to~~] Insurance Code Chapter 1301 in commercial markets.

§3.3722. Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications.

(a) Where to file application. An insurer that seeks to offer a preferred or exclusive provider benefit plan must file an application for approval with the Texas Department of Insurance as specified on the department's website and use the [~~. A~~] form titled Application for Approval of Provider Benefit Plan, which is available [~~on the department's website~~] at www.tdi.texas.gov/forms. [~~An insurer may use this form to prepare the application.~~]

(b) Filing requirements.

(1) An applicant must provide the department with a complete application that includes the elements in the order set forth in subsection (c) of this section.

(2) All pages must be clearly legible and numbered.

(3) If the application is revised or supplemented during the review process, the applicant must submit a transmittal letter describing the revision or supplement plus the specified revision or supplement.

(4) If a page is to be revised, the applicant must submit a complete new page [~~must be submitted~~] with the changed item or information clearly marked.

(c) Contents of application. A complete application includes the elements specified in paragraphs (1) - (12) of this subsection.

(1) The applicant must provide a statement that the filing is:

(A) an application for approval; or

(B) a modification to an approved application.

(2) The applicant must provide organizational information for the applicant, including:

(A) the full name of the applicant;

(B) the applicant's Texas Department of Insurance license or certificate number;

(C) the applicant's home office address, including city, state, and ZIP code; and

(D) the applicant's telephone number.

(3) The applicant must provide the name and telephone number of an individual to be the contact person who will facilitate requests from the department regarding the application.

(4) The applicant must provide an attestation signed by the applicant's corporate president, corporate secretary, or the president's or secretary's authorized representative that:

(A) the person has read the application, is familiar with its contents, and asserts that all of the information submitted in the application, including the attachments, is true and complete; and

(B) the network, including any requested or granted waiver and any access plan as applicable, is adequate for the services to be provided under the preferred or exclusive provider benefit plan.

(5) The applicant must provide a description and a map of the service area, with key and scale, identifying the county or counties [~~area~~] to be served [~~by geographic region(s), county(ies), or ZIP code(s)~~]. If the map is in color, the original and all copies must also be in color.

(6) The applicant must provide a list of all plan documents and each document's associated form filing ID number or the form number of each plan document that is pending the department's approval or review.

(7) The applicant must provide the form(s) of physician contract(s) and provider contract(s) that include the provisions required in §3.3703 of this title (relating to Contracting Requirements) or an attestation by the insurer's corporate president, corporate secretary, or the president's or secretary's authorized representative that the physician and provider contracts applicable to services provided under the preferred or exclusive provider benefit plan comply with the requirements of Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans, and this subchapter.

(8) The applicant, if applying for approval of an exclusive provider benefit plan offered under [~~pursuant to~~] Insurance Code Chapter 1301 in commercial markets, must provide a description of the quality improvement program and work plan that includes a process for physician [~~medical peer~~] review required by Insurance Code §1301.0051, concerning Exclusive Provider Benefit Plans: Quality Improvement and Utilization Management, and that explains arrangements for sharing pertinent medical records between preferred providers and for ensuring the records' confidentiality.

(9) The applicant must provide network configuration information, as specified in §3.3712 of this title (relating to Network Configuration Filings). [~~including:~~]

[~~(A) maps for each specialty demonstrating the location and distribution of the physician and provider network within the pro-~~

posed service area by geographic region(s), county(ies) or ZIP code(s); and]

[(B) lists of:]

[(i) physicians and individual providers who are preferred providers, including license type and specialization and an indication of whether they are accepting new patients; and]

[(ii) institutional providers that are preferred providers.]

[(C) For each health care provider that is a facility included in the list under subparagraph (B) of this paragraph, the applicant must:]

[(i) create separate headings under the facility name for radiologists, anesthesiologists, pathologists, emergency department physicians, neonatologists, and assistant surgeons;]

[(ii) under each heading described by clause (i) of this subparagraph, list each preferred facility-based physician practicing in the specialty corresponding with that heading;]

[(iii) for the facility and each facility-based physician described by clause (ii) of this subparagraph, clearly indicate each health benefit plan issued by the insurer that may provide coverage for the services provided by that facility, physician, or facility-based physician group;]

[(iv) for each facility-based physician described by clause (ii) of this subparagraph, include the name, street address, telephone number, and any physician group in which the facility-based physician practices; and]

[(v) include the facility in a listing of all facilities and indicate:]

[(I) the name of the facility;]

[(II) the municipality in which the facility is located or county in which the facility is located if the facility is in the unincorporated area of the county; and]

[(III) each health benefit plan issued by the insurer that may provide coverage for the services provided by the facility.]

[(D) The list required by subparagraph (B) of this paragraph must list each facility-based physician individually and, if a physician belongs to a physician group, also as part of the physician group.]

(10) The applicant [, if applying for approval of an exclusive provider benefit plan offered pursuant to Insurance Code Chapter 1301 in commercial markets,] must provide documentation demonstrating that its plan documents and procedures are compliant with §3.3707(k) of this title (relating to Waiver Due to Failure to Contract in Local Markets) and §3.3708 of this title (relating to Payment of Certain Out-of-Network Claims). [§3.3725(a) of this title (relating to Payment of Certain Out-of-Network Claims) and that the policy contains, without regard to whether the physician or provider furnishing the services has a contractual or other arrangement to provide items or services to insureds, the provisions and procedures for coverage of emergency care services as set forth in §3.3725 of this title.]

(11) The applicant must provide documentation demonstrating that the insurer maintains a complaint system that provides reasonable procedures to resolve a written complaint initiated by a complainant.

(12) The applicant must provide notification of the physical address of all books and records described in subsection (d) of this section.

(d) Qualifying examinations; documents to be available. The following documents must be available during the qualifying examination at the physical address designated by the insurer in accordance with [pursuant to] subsection (c)(12) of this section:

(1) quality improvement--program description and work plan as required by §3.3724 of this title (relating to Quality Improvement Program) if the applicant is applying for approval of an exclusive provider benefit plan offered under [pursuant to] Insurance Code Chapter 1301 in commercial markets;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and examples of adverse determination letters, adverse determination logs, and independent review organization logs;

(3) network configuration information as outlined in §3.3712 of this title that demonstrates compliance with network adequacy requirements described in §3.3704(f) of this title (relating to Freedom of Choice; Availability of Preferred Providers) [demonstrating adequacy of the provider network, as outlined in subsection (c)(9) of this section], and all executed physician and provider contracts applicable to the network, which may be satisfied by contract forms and executed signature pages;

(4) credentialing files;

(5) all written materials to be presented to prospective insureds that discuss the provider network available to insureds under the plan and how preferred and nonpreferred physicians or providers will be paid under the plan;

(6) the policy and certificate of insurance; and

(7) a complaint log that is categorized and completed in accordance [accord] with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions).

(e) Network modifications.

(1) An insurer must file a network configuration filing as specified in §3.3712 of this title [an application] for approval with the department before the insurer may make changes to network configuration that impact the adequacy of the network, expand an existing service area, reduce an existing service area, or add a new service area. If any insured will be nonrenewed as a result of a service area reduction, the insurer must comply with the requirements under §3.3038 of this title (relating to Mandatory Guaranteed Renewability Provisions for Individual Hospital, Medical, or Surgical Coverage; Exceptions).

(2) In accordance with [Pursuant to] paragraph (1) of this subsection, if an insurer submits any of the following items to the department and then replaces or materially changes them, the insurer must submit the new item or any amendments to an existing item along with an indication of the changes:

(A) descriptions and maps of the service area, as required by subsection (c)(5) of this section;

(B) forms of contracts, as described in subsection (c) of this section; or

(C) network configuration information, as required by §3.3712 of this title [subsection (c)(9) of this section].

[(3) Before the department grants approval of a service area expansion or reduction application for an exclusive provider benefit plan offered pursuant to Insurance Code Chapter 1301 in commercial

~~markets, the insurer must comply with the requirements of §3.3724 of this title in the existing service areas and in the proposed service areas.]~~

(3) [~~(4)~~] An insurer must file with the department any information other than the information described in paragraph (2) of this subsection that amends, supplements, or replaces the items required under subsection (c) of this section no later than 30 days after the implementation of any change.

(f) Exceptions. Paragraphs (c)(9) and (d)(3) and subsection (e) of this section do not apply to a preferred or exclusive provider benefit plan written by an insurer for a contract with the Health and Human Services Commission to provide services under the Texas Children's Health Insurance Program (CHIP), Medicaid, or with the State Rural Health Care System.

§3.3723. Examinations.

(a) The Commissioner may conduct an examination relating to a preferred or exclusive provider benefit plan as often as the Commissioner considers necessary, but no less than once every three years.

(b) On-site financial, market conduct, complaint, or quality of care exams will be conducted under [~~pursuant to~~] Insurance Code Chapter 401, Subchapter B, concerning Examination of Carriers; Insurance Code Chapter 751, concerning Market Conduct Surveillance; Insurance Code Chapter 1301, concerning Preferred Provider Benefit Plans; and §7.83 of this title (relating to Appeal of Examination Reports).

(c) An insurer must make its books and records relating to its operations available to the department to facilitate an examination.

(d) On request of the Commissioner, an insurer must provide to the Commissioner a copy of any contract, agreement, or other arrangement between the insurer and a physician or provider. Documentation provided to the Commissioner under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056, concerning Examinations and Fees.

(e) The Commissioner may examine and use the records of an insurer, including records of a quality of care program and records of a medical peer review committee, as necessary to implement the purposes of this subchapter, including commencement and prosecution of an enforcement action under Insurance Code Title 2, Subtitle B, concerning Discipline and Enforcement, and §3.3710 of this title (relating to Failure to Provide an Adequate Network). Information obtained under this subsection will be maintained as confidential as specified in Insurance Code §1301.0056. In this subsection, "medical peer review committee" has the meaning assigned by the Occupations Code §151.002, concerning Definitions.

(f) The following documents must be available for review at the physical address designated by the insurer in accordance with [~~pursuant to~~] §3.3722(c)(12) of this title (relating to Application for Preferred and Exclusive Provider Benefit Plan Approval; Qualifying Examination; Network Modifications):

(1) quality improvement--program description, work plans, program evaluations, and committee and subcommittee meeting minutes as required by §3.3724 of this title (relating to Quality Improvement Program) must be available for examinations of an exclusive provider benefit plan offered under Insurance Code Chapter 1301 in the commercial market;

(2) utilization management--program description, policies and procedures, criteria used to determine medical necessity, and templates of adverse determination letters; adverse determination logs, including all levels of appeal; and utilization management files;

(3) complaints--complaint files and complaint logs, including documentation and details of actions taken. All complaints must be categorized and completed in accordance [~~accord~~] with §21.2504 of this title (relating to Complaint Record; Required Elements; Explanation and Instructions);

(4) satisfaction surveys--any insured, physician, and provider satisfaction surveys, and any insured disenrollment and termination logs;

(5) network configuration information as required by §3.3712 [~~§3.3722(c)(9)~~] of this title (relating to Network Configuration Filings) demonstrating adequacy of the provider network;

(6) credentialing--credentialing files; and

(7) reports--any reports the insurer submits to a governmental entity.

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

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Jessica Barta
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Texas Department of Insurance
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28 TAC §3.3725

STATUTORY AUTHORITY. TDI proposes the repeal of §3.3725 under Insurance Code §1301.007 and §36.001.

Insurance Code §1301.007 requires that the commissioner adopt rules necessary to implement Chapter 1301 and to ensure reasonably accessibility and availability of preferred provider 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.

CROSS-REFERENCE TO STATUTE. The proposed repeal of §3.3725 implements Insurance Code Chapter 1301.

§3.3725. Payment of Certain Out-of-Network Claims.

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

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CHAPTER 7. CORPORATE AND FINANCIAL REGULATION
SUBCHAPTER B. INSURANCE HOLDING COMPANY SYSTEMS

28 TAC §7.216

The Texas Department of Insurance (TDI) proposes new 28 TAC §7.216, concerning a liquidity stress test framework for certain insurance companies. Section 7.216 implements House Bill 2839, 88th Legislature, 2023.

EXPLANATION. New §7.216 adopts a liquidity stress test framework and reporting requirements for certain insurers. HB 2839 adds new Insurance Code §823.0596, which requires the commissioner to adopt a liquidity stress test framework--including scope criteria and reporting templates--consistent with the framework published by the National Association of Insurance Commissioners (NAIC) and report it to the NAIC to facilitate the aggregation of results from the liquidity stress test filed with this and other states. HB 2839 was a biennial recommendation from TDI.

The liquidity stress test framework simulates large-scale asset sales in response to unexpected liquidity demands and assesses the potential impact of these sales on financial markets.

A secondary goal of the liquidity stress test implementation is to enhance monitoring of large life insurers that might be vulnerable to liquidity stress. Liquidity demands can be placed unexpectedly on an insurer that issues long-term cash-buildup products, particularly when cash and asset surrenders are experienced at greater-than-projected levels during widespread economic shifts. Elevated demand of cash payouts by customers can impact broader financial markets if those insurers are required to sell a significant amount of assets to meet demand.

New §7.216(a) provides the purpose of the section. New §7.216(b) provides that the liquidity stress test framework is adopted as published by the NAIC. New §7.216(c) specifies the scope criteria and thresholds applicable to the liquidity stress test framework. New §7.216(d) specifies that the ultimate controlling person of an insurer must submit the liquidity stress test framework filing using the appropriate reporting template in an electronic format. New §7.216(e) describes the exemption process. After consultation with other state insurance commissioners, the commissioner can exempt from the filing requirement a data year that an insurer would otherwise be required to submit under subsection (d) of this section. New §7.216(f) states that if there was a conflict between the liquidity stress test framework adopted by NAIC and the Insurance Code or TDI rules, including new §7.216, the Insurance Code or TDI rule takes precedence and in all respects controls.

This proposal arises out of rules, regulations, directives, or standards adopted by the NAIC. Under Insurance Code §36.004, TDI must consider whether authority exists to enforce or adopt it. In addition, under Insurance Code §36.007, an agreement that infringes on the authority of this state to regulate the business of insurance in this state has no effect unless the agreement is approved by the Texas Legislature. TDI has determined that neither Insurance Code §36.004 nor §36.007 prohibits the proposed rule because of Insurance Code §823.0596, requiring the adoption by rule of a liquidity stress test framework consistent with the framework published by the NAIC.

FISCAL NOTE AND LOCAL EMPLOYMENT IMPACT STATEMENT. Mike Arendall, assistant chief analyst of the Financial Analysis Section, Financial Regulation Division, has determined that during each year of the first five years the proposed new section is in effect, there will be no measurable fiscal impact on state and local governments as a result of enforcing or administering the new section, other than that imposed by the statute. Mr. Arendall made this determination because the proposed new section does not add to or decrease state revenues or expenditures, and because local governments are not involved in enforcing or complying with the proposed new section.

Mr. Arendall does not anticipate any measurable effect on local employment or the local economy as a result of this proposal.

PUBLIC BENEFIT AND COST NOTE. For each year of the first five years the proposed new section is in effect, Mr. Arendall expects that enforcing the proposed new section will have the public benefit of ensuring that TDI's rules conform to Insurance Code §823.0596 and the rule meets anticipated NAIC accreditation standard requirements. Insurers that meet the liquidity stress test framework scope criteria may incur additional monitoring and reporting costs to comply. However, these costs are attributable to the statute, which requires TDI to adopt a liquidity stress test framework, including scope criteria and reporting templates that are consistent with the framework published by the NAIC.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS. TDI has determined that the proposed new section will not have an adverse economic effect on small or micro businesses, or on rural communities. This is because the amendment does not impose any requirements beyond those required by the statute. As a result, and in accordance with Government Code §2006.002(c), TDI is not required to prepare a regulatory flexibility analysis.

EXAMINATION OF COSTS UNDER GOVERNMENT CODE §2001.0045. TDI has determined that this proposal does not impose a possible cost on regulated persons. Any costs are attributable to the statute, which directs the commissioner to adopt the liquidity stress test framework. In addition, the proposed rule is necessary to implement Insurance Code §823.0596, as added by HB 2839.

GOVERNMENT GROWTH IMPACT STATEMENT. TDI has determined that for each year of the first five years that the proposed new section is in effect, the proposed rule:

- will not create or eliminate a government program;

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

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

- will not require an increase or decrease in fees paid to the agency;

- will create a new regulation;

- will not expand, limit, or repeal an existing regulation;

- will increase or decrease the number of individuals subject to the rule's applicability; and

- may positively affect the Texas economy.

TAKINGS IMPACT ASSESSMENT. TDI has determined that no private real property interests are affected by this proposal and

that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. TDI will consider any written comments on the proposal that are received by TDI no later than 5:00 p.m., central time, on January 8, 2024. Send your comments to ChiefClerk@tdi.texas.gov or to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

To request a public hearing on the proposal, submit a separate request before the end of the comment period to ChiefClerk@tdi.texas.gov or by mail to the Office of the Chief Clerk, MC: GC-CCO, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

STATUTORY AUTHORITY. TDI proposes new §7.216 under Insurance Code §§823.012, 823.0596, and 36.001.

Insurance Code §823.012 states the commissioner may, after notice and opportunity for all interested persons to be heard, adopt rules and issue orders to implement Insurance Code Chapter 823, including the conducting of business and proceedings under Insurance Code Chapter 823.

Insurance Code §823.0596 requires the commissioner to adopt by rule a liquidity stress test framework, including scope criteria and reporting templates, consistent with the framework published by the NAIC to facilitate the aggregation of results from the liquidity stress test filed with this and other states.

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

CROSS-REFERENCE TO STATUTE. Section 7.216 implements Insurance Code §823.0596.

§7.216. Liquidity Stress Test Framework.

(a) Purpose. This section specifies the requirements for the ultimate controlling person of an insurance holding company system to submit a liquidity stress test framework necessary to report information as required by Insurance Code §823.0596.

(b) Liquidity stress test framework. The commissioner adopts by reference the liquidity stress test framework as adopted and published by the National Association of Insurance Commissioners (NAIC). The liquidity stress test framework is available on the department's website.

(c) Scope criteria. The scope criteria are the designated criteria and thresholds described in the liquidity stress test framework as adopted by reference in subsection (b) of this section.

(d) Reporting template. The reporting template an insurer must use is described in the liquidity stress test framework as adopted in subsection (b) of this section.

(d) Filing. Using the reporting template described in the liquidity stress test framework adopted by reference in subsection (b) of this section, the ultimate controlling person of an insurer must submit a liquidity stress test framework filing on or before June 30 of each year, using the appropriate reporting template in an electronic format acceptable to TDI. The electronic filing address is provided on TDI's website at www.tdi.texas.gov.

(e) Exemption. Only after consultation with other state insurance commissioners will the commissioner exempt from the filing requirement a data year that an insurer would otherwise be required to submit under subsection (d) of this section.

(f) Conflicts. In the event of a conflict between the liquidity stress test framework adopted and published by the NAIC and the Insurance Code, any TDI rule, or any specific requirement of this section, the Insurance Code, TDI rule, or specific requirement of this section takes precedence and in all respects controls. The requirements of this section do not repeal, modify, or amend any TDI rule or any Insurance Code provision.

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

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

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

34 TAC §3.1208

The Comptroller of Public Accounts proposes new §3.1208, concerning prohibited e-cigarette products. The new section implements House Bill 4758, 88th Legislature, 2023, which enacted Health and Safety Code, §161.0876 (Prohibited E-Cigarette Products).

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

"Various e-cigarette manufacturers package e-cigarette products to appear nearly identical to popular candy, flavored juice boxes, and other edible treats. The similarity in packaging of e-cigarette products to children's snacks is a direct appeal from manufacturers to children, which entices them to consume these dangerous nicotine products. The CDC reports that 69 percent of youth are exposed to e-cigarette advertisement via retail stores, magazines, TV shows, movies, and the Internet. These mediums also use cartoon-like characters and celebrity imagery to appeal to youths. According to the CDC, in the 10-year period from 2011 to 2021, vaping rates among middle and high school student increased from 1.5 percent of youth to nearly 30 percent of youth using e-cigarettes. These deliberate and ongoing efforts considerably impact the consumption

rates of e-cigarettes among youth and require swift action. In 2018, the Department of State Health Services determined that e-cigarette use has reached epidemic status among teens." House Comm. on Pub. Health, Bill Analysis, Tex. C.S.H.B. 4758, 88th Leg., R.S. (2023).

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

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

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

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

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

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

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

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

Paragraph (8) defines "retailer." The definition is based on the definition given in Health and Safety Code, §161.081(4). The qualifier "coin-operated" is removed from the description of vending machines to better track the language in Tax Code, Chapters 154 (Cigarette Tax) and 155 (Cigars and Tobacco Products Tax), and to eliminate any confusion with coin-operated machines, which are regulated under the Occupations Code. In addition, because the comptroller does not permit e-cigarette vending machines, the term "e-cigarette" is deleted as a descriptor of vending machines.

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

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed new rule is in effect, the rule: will not create or eliminate 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 require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed new rule would benefit the public by conforming the rules to current statute. This rule is proposed under Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses or rural communities. The proposed new rule would have no significant fiscal impact on the state government, units of local government, or individuals. There would be no anticipated significant economic cost to the public.

You may submit comments on the proposal to Jenny Burleson, Director, Tax Policy Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: tp.rule.comments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

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

which provides the comptroller with the authority to adopt rules to implement the section.

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

§3.1208. Prohibited E-Cigarette Products.

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

(1) Cartoon--Any drawing or other depiction of an object, person, animal, creature, or any similar caricature that satisfies any of the following criteria:

(A) the use of comically exaggerated features;

(B) the attribution of human characteristics to animals, plants, or other objects, or the similar use of anthropomorphic technique; or

(C) the attribution of unnatural or extra-human abilities, such as imperviousness to pain or injury, X-ray vision, tunneling at very high speeds, or transformation.

(2) Celebrity--An individual well-known to a significant section of the public.

(3) Container--Any object used to hold an e-cigarette product, including, but not limited to, a pod, bottle, jar, box, wrapper, or other packaging.

(4) E-cigarette--An electronic cigarette or any other device that simulates smoking by using a mechanical heating element, battery, or electronic circuit to deliver nicotine or other substances to the individual inhaling from the device; or a consumable liquid solution or other material aerosolized or vaporized during the use of an electronic cigarette or other device described by this subdivision. The term does not include a prescription medical device unrelated to the cessation of smoking. The term also includes:

(A) a device described in paragraph (1) of this subsection regardless of whether the device is manufactured, distributed, or sold as an e-cigarette, e-cigar, or e-pipe or under another product name or description; and

(B) a component, part, or accessory for the device, regardless of whether the component, part, or accessory is sold separately from the device.

(5) E-cigarette product--Any substance containing nicotine from any source that is intended for use in an e-cigarette.

(6) Food product--A product intended for human consumption that is consumed for taste, aroma, or nutritional value. The term includes, but is not limited to, fruit, juice, candy, cookies, cereal, coffee, ice cream, soft drinks, and mint and other herbs.

(7) Minor--A person under 21 years of age.

(8) Retailer--a person who engages in the practice of selling cigarettes, e-cigarettes, or tobacco products to consumers and includes the owner of a cigarette or tobacco product vending machine. The term includes a retailer as defined by Tax Code, §154.001 (Definitions) or §155.001 (Definitions), and an e-cigarette retailer as defined by Health and Safety Code, §147.0001 (Definitions).

(b) Violations and Penalties.

(1) A person commits an offense if the person markets, advertises, sells, or causes to be sold an e-cigarette product, if the product's container:

(A) depicts a cartoon-like fictional character that mimics a character primarily aimed at entertaining minors, including a superhero, video game character, or character from an animated television show marketed to minors;

(B) imitates or mimics trademarks or trade dress of products that are or have been primarily marketed to minors, including products that are candy, bubble gum, cookies, cereals, juice boxes, or soft drinks;

(C) includes a symbol that is primarily used to market products to minors;

(D) includes an image of a celebrity; or

(E) includes an image that is or resembles a food product.

(2) A retailer is subject to disciplinary action as provided by §3.1204 of this title (relating to Administrative Remedies for Violations of Health and Safety Code, Chapter 161, Subchapter H) if the comptroller finds, after notice and an opportunity for a hearing, that an agent or employee of the retailer marketed, advertised, sold, or caused to be sold an e-cigarette product in violation of this section.

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

Filed with the Office of the Secretary of State on November 27, 2023.

TRD-202304371
Jenny Burleson
Director, Tax Policy Division
Comptroller of Public Accounts
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 475-2220

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CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER I. VALUATION PROCEDURES

34 TAC §9.4038

The Comptroller of Public Accounts proposes new §9.4038, concerning definition of petroleum products. The new section replaces existing §9.4201, concerning definition of petroleum products, which the comptroller is proposing for repeal to improve the clarity and organization of Subchapter I. The section is also updated to better reflect the list of products that fall under this definition.

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

The comptroller provides the definition of petroleum products to assist appraisal districts in the administration and implementation of Tax Code, §11.251 (Tangible Personal Property Exempt).

The products defined by this section are not exempt under the "freeport" exemption provided by Tax Code, §11.251 and Texas Constitution, Article VIII, Section 1-j.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed new rule is in effect, the rule: will not create or eliminate 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 require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed new rule would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed new rule would benefit the public by improving the organization and clarity of Subchapter I (Valuation Procedures.) There would be no anticipated significant economic cost to the public. The proposed new rule would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528, Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

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

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

§9.4038. Definition of Petroleum Products.

For the purposes of administration and operation of appraisal districts, the term "liquid or gaseous materials that are the immediate derivatives of the refining of oil or natural gas," as used in the Tax Code, §11.251, means the following products:

(1) ethane;

(2) propane;

(3) butane;

(4) normal butane;

(5) isobutane;

(6) butane-propane;

(7) motor gasoline;

(8) natural gasoline;

(9) kerosene;

(10) home heating oil;

(11) diesel fuel;

(12) other middle distillates;

(13) aviation gasoline;

(14) kerosene-type jet fuel;

(15) naphtha-type jet fuel;

(16) fuel oil #4 for utility use;

(17) fuel oils #5, #6 for utility use;

(18) fuel oil #4 for nonutility use;

(19) fuel oils #5, #6 for nonutility use;

(20) bunker C;

(21) navy special;

(22) lubricants;

(23) special naphtha;

(24) solvent products; and

(25) crude oil.

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

Filed with the Office of the Secretary of State on November 27, 2023.

TRD-202304369
Victoria North
General Counsel for Fiscal and Agency Affairs
Comptroller of Public Accounts
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 475-2220

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34 TAC §9.4201

The Comptroller of Public Accounts proposes the repeal of §9.4201, concerning definition of petroleum products. The comptroller repeals existing §9.4201 in order to propose the adoption of a replacement §9.4038 to improve the organization of Subchapter I. The repeal of §9.4201 will be effective as of the date the new §9.4038 takes effect.

Brad Reynolds, Chief Revenue Estimator, has determined that during the first five years that the proposed rule repeal is in effect, the repeal: will not create or eliminate 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 require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rules' applicability; and will not positively or adversely affect this state's economy.

Mr. Reynolds also has determined that the proposed rule repeal would have no significant fiscal impact on the state government, units of local government, or individuals. The proposed rule repeal would benefit the public by improving the clarity and organization of Subchapter I (Valuation Procedures.) There would be no anticipated significant economic cost to the public. The proposed rule repeal would have no significant fiscal impact on small businesses or rural communities.

You may submit comments on the proposal to Shannon Murphy, Director, Property Tax Assistance Division, P.O. Box 13528 Austin, Texas 78711 or to the email address: ptad.rulecomments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

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

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

§9.4201. Definition of Petroleum Products.

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

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Comptroller of Public Accounts
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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 3. RESPONSIBILITIES OF STATE FACILITIES

SUBCHAPTER D. TRAINING

40 TAC §§3.401 - 3.404

As required by Texas Government Code §531.0202(b), the Department of Aging and Disability Services (DADS) was abolished effective September 1, 2017, after all its functions were transferred to the Texas Health and Human Services Commission (HHSC) in accordance with Texas Government Code §531.0201 and §531.02011. Rules of the former DADS are codified in Title 40, Part 1, and will be repealed or administratively transferred to Title 26, Health and Human Services, as appropriate. Until such action is taken, the rules in Title 40, Part 1 govern functions previously performed by DADS that have transferred to HHSC. Texas Government Code §531.0055, requires the Executive Commissioner of HHSC to adopt rules for the operation and provision of services by the health and human services system, including rules in Title 40, Part 1. Therefore, the Executive Commissioner of HHSC proposes the repeal of rules in Title 40, Part 1, Chapter 3, Subchapter D, Training, comprising of §3.401, concerning Training for New Employees; §3.402, concerning Additional Training for Direct Support Professionals; §3.403, Refresher Training; and §3.404, Specialized Training for of a Forensic Facility Employee.

BACKGROUND AND PURPOSE

The purpose of the proposed repeals is to reflect the move of the state supported living centers from DADS to HHSC by moving HHSC rules from Texas Administrative Code (TAC) Title 40, Chapter 3, Subchapter D to 26 TAC Chapter 926 and consolidate HHSC rules. The new rules are proposed simultaneously elsewhere in this issue of the *Texas Register.*

SECTION-BY-SECTION SUMMARY

The repeal of 40 TAC Chapter 3, Subchapter D rules will delete the rules from 40 TAC and place updated rules in 26 TAC to reflect the transfer of functions from DADS to HHSC.

FISCAL NOTE

Trey Wood, Chief Financial Officer, has determined that for each year of the first five years that the repeals will be in effect, enforcing or administering the repeals does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

(6) the proposed repeals will repeal existing rules;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities because the repeals do not apply to small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed repeals will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these repeals because the repeals do not impose a cost on regulated persons.

PUBLIC BENEFIT AND COSTS

Scott Schalchlin, Deputy Executive Commissioner of Health and Specialty Care System, has determined that for each year of the first five years the repeals are in effect, the public benefit will be the removal of rules no longer associated with DADS from 40 TAC.

Trey Wood has also determined that for the first five years the repeals are in effect, there are no anticipated economic costs to persons who are required to comply with the repeals because the repeals do not impose a cost.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to HHSC, Mail Code E619, P.O. Box 13247, Austin, Texas 78711-3247, or by email to HealthandSpecialtyCare@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R006" in the subject line.

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §555.024, which requires HHSC to provide certain training for employees of SSLCs and requires the Executive Commissioner to adopt rules for SSLCs to provide refresher trainings to direct care employees.

The repeals affect Texas Government Code §531.0055 and Texas Health and Safety Code §555.024.

§3.401. Training for New Employees.

§3.402 Additional Training for Direct Support Professionals.

§3.403 Refresher Training.

§3.404 Specialized Training for of a Forensic Facility Employee.

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304330
Karen Ray
Chief Counsel
Department of Aging and Disability Services
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 438-3049

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PART 19. DEPARTMENT OF FAMILY AND PROTECTIVE SERVICES

CHAPTER 700. CHILD PROTECTIVE SERVICES

SUBCHAPTER I. PURCHASED PROTECTIVE SERVICES TO PREVENT REMOVAL OR TO REUNIFY FAMILIES

40 TAC §700.905

The Department of Family and Protective Services (DFPS) proposes new §700.905 in Title 40, Texas Administrative Code (TAC), Chapter 700, Subchapter I, relating to Purchased Protective Services to Prevent Removal or to Reunify Families.

BACKGROUND AND PURPOSE

The Texas 88th Regular legislative session enacted House Bill 793 which requires DFPS to promulgate a rule requiring DFPS to reimburse a licensed or qualified provider in an amount equal to the average cost for the specific service from department contractors providing the service in the region the parent resides, from existing DFPS resources. This provision is codified at Texas Family Code §263.1021.

Chapter 263, Subchapter B of the Texas Family Code pertains to when the Department of Family and Protective Services (DFPS) has been court ordered the temporary managing conservator of a minor, and the parent, as a client is required to obtain services under a family service plan. A parent seeking services under a family service plan will be permitted to choose a licensed or qualified service provider that is not under contract with DFPS or an SSCC. Services obtained from a service provider selected by the parent must be designed to achieve the stated goals of the Family Plan of Service for a child in DFPS conservatorship and the service provider must certify whether the parent has satisfactorily completed the required service that is being sought for reimbursement.

SECTION-BY-SECTION SUMMARY

Proposed new §700.905: gives a summary of the rule, including that this rule relating to the reimbursement of noncontracted service providers are intended to further supplement and clarify Texas Family Code §263.1021; (a) defines words used in the bill and in the rule to clarify family plan of service, qualified and license providers; (b) requires Single Source Continuum Contract/Contractors (SSCC) to adopt their own reimbursement requirements; (c) requires the service provider, as opposed to the parent to seek reimbursement for the services; (d) allows services to be provided in-person or via electronic communication platform; (e) requires a service provider to bill Medicaid if the parent is a Medicaid beneficiary; and (f) lays out the basic requirements for a non-contracted service provider to be reimbursed, such as a licensed provider maintaining licensure, the timeline in which DFPS can reimburse, and that the service provider cannot be related by consanguinity or affinity to the parent receiving services.

FISCAL NOTE

Lea Ann Biggar, Chief Financial Officer of DFPS, has determined that for each year of the first five years that the section(s) will be in effect, there will not be fiscal implications to state and local governments as a result of enforcing and administering the section(s) as proposed. Implementation of this statute and rule would require DFPS to process payments manually within existing resources and without IT modifications at this time.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

(3) implementation of the proposed rule will not require an increase or decrease in future legislative appropriations to the agency;

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

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

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

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

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

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

Ms. Biggar has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rule will provide additional revenue for small, micro businesses or rural communities by allowing them to provide services to DFPS clients without having to go through the contracting process to become a certified vendor for the agency.

ECONOMIC COSTS TO PERSONS AND IMPACT ON LOCAL EMPLOYMENT

There are no anticipated economic costs to persons who are required to comply with the section(s) as proposed.

There is no anticipated negative impact on local employment.

COSTS TO REGULATED PERSONS

Pursuant to subsection (c)(7) of Texas Government Code §2001.0045, the statute does not apply to a rule that is adopted by the Department of Family and Protective Services

PUBLIC BENEFIT

Ms. Biggar has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the section(s). The public benefit anticipated will be a positive effect on small, or micro-businesses or rural communities because the proposed changes will provide additional revenue for small, micro businesses or rural communities by allowing them to provide services to DFPS clients without having to go through the contracting process to become a certified vendor for the agency. There is no anticipated economic cost to persons who are required to comply with the proposed sections.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Comments and questions on this proposal must be submitted within 30 days of publication of the proposal in the *Texas Register.* Electronic comments and questions may be submitted to RULES@dfps.state.tx.us. Hard copy comments may be submitted to the DFPS Rules Coordinator, Legal Services Sanjuanita Maltos, Department of Family and Protective Services E-611, P.O. Box 149030, Austin, Texas 78714-9030.

STATUTORY AUTHORITY

The new rule section 700.905 is authorized by Human Resources Code (HRC) §40.027, which provides that the Department of Family and Protective Services Commissioner shall adopt rules for the operation and provision of services by the department.

CROSS REFERENCE TO STATUTES

The new rule implements Texas Family Code §263.1021.

§700.905. Reimbursement of Noncontracted Service Providers.

(a) A parent who is required to complete a Family Service Plan may obtain services from a qualified or licensed noncontracted service provider, and this provider may be reimbursed by DFPS in an amount equal to the average cost for the specific service from DFPS contractors providing the service in the region, where the parent resides. Only services where the parent is the direct client of the service provider are eligible for reimbursement. In addition, the rules relating to the reimbursement of noncontracted service providers are intended to further supplement and clarify Texas Family Code §263.1021. This rule is operable to the extent that DFPS has existing resources to implement Texas Family Code §263.1021.

(b) Definitions:

(1) Case Plan: a Case Plan, as defined by 42 U.S.C. 675, is a written document which meets the requirements 42 U.S.C. 675a. Texas has divided the federal requirement of a Case Plan into two separate plans, the Family Service Plan as defined in Texas Family Code §263.101 and the Child's Plan of Service as defined in Texas Family Code §264.128. For the purpose of this Rule, a Child's Plan (also referred to as a Child's Plan of Service) is not a Family Service Plan.

(2) Family Service Plan (also referred to as a "Family Plan of Service," "Family Plan" or "Individual Family Service Plan") is a written plan in which DFPS and a child's parents identify the actions, specific skills, knowledge, steps, and/or responsibilities that are necessary for the parents to achieve the Family Service Plan's goal during this Plan's service period and the assistance to be provided to the parents by the DFPS or other agency toward meeting that goal.

(3) Single Source Continuum Contract/Contractor (SSCC) is an entity, as described in Texas Family Code §264.154, with whom DFPS enters into a contract for the provision of the full continuum of substitute care, case management, and reunification services in a Designated Community Area.

(4) Licensed Provider is an individual who is required by the State of Texas to be licensed to provide the professional service that the parent is receiving and DFPS is reimbursing.

(5) Qualified Provider is an individual who has completed certification or other training programs and has two (2) years of verified full-time experience in the professional service in which they are providing to the parent and DFPS is reimbursing.

(6) Noncontracted Service Provider is one who is not under a current contract with DFPS or SSCC for the service that they are seeking reimbursement. They also cannot be an employee of DFPS or SSCC.

(c) SSCCs must adopt similar requirements relating to the manner in which noncontracted service providers are reimbursed that do not conflict with this Section.

(d) Only the noncontracted service provider may seek reimbursement from DFPS for services and must not have already been paid by the parent or a third party.

(e) To be reimbursed, services may be provided in-person or through an electronic communication platform.

(f) DFPS cannot use state funds to reimburse a noncontracted service provider for Medicaid services to a parent who is a Medicaid beneficiary, as described in Texas Human Resources Code Chapter 32. If the parent has Texas Medicaid, the noncontracted service provider must bill Medicaid and not seek reimbursement through DFPS.

(g) All the following requirements/conditions must be met in order for a noncontracted service provider to be reimbursed:

(1) Must be qualified or licensed provider and comply with the DFPS's guidelines and requirements for reimbursement pursuant to Texas Family Code §263.1021.

(2) If a license is required, the service provider must maintain licensure and the license must remain in good standing while providing services that they are seeking reimbursement.

(3) Services obtained from a service provider selected must be designed to achieve the stated goals of the Family Plan of Service for a child in DFPS conservatorship and the noncontracted service provider must certify whether the parent has satisfactorily completed the required service that is being sought for reimbursement.

(4) DFPS cannot reimburse for services that occur after DFPS is dismissed from the case, or the parental rights have been terminated (earlier of two). If a Family Service is reinstated, then the service provider would have to seek reimbursement though a new claim under the reinstated Family Service Plan.

(5) The noncontracted service provider must be able to receive reimbursement from state or federal funds and not be debarred from receiving these funds.

(6) The noncontracted service provider cannot have had a prior DFPS contract to provide the specific service that they are seeking reimbursement which DFPS terminated for cause.

(7) The noncontracted service provider cannot be related by consanguinity or affinity to the parent receiving services.

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

Filed with the Office of the Secretary of State on November 20, 2023.

TRD-202304341
Katharine McLaughlin
Policy Attorney
Department of Family and Protective Services
Earliest possible date of adoption: January 7, 2024
For further information, please call: (512) 915-1729

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