

# ADOPTED RULES

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

## TITLE 1. ADMINISTRATION

### PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

#### CHAPTER 353. MEDICAID MANAGED CARE

The Texas Health and Human Services Commission (HHSC) adopts amendments to Chapter 353, Subchapter A, General Provisions, §353.2, concerning Definitions; Subchapter G, STAR+PLUS, §353.601, concerning General Provisions; and §353.603, concerning Member Participation; and Subchapter H, STAR Health, §353.701, concerning General Provisions; and §353.702, concerning Member Participation. HHSC adopts new Subchapter M, concerning Home and Community Based Services in Managed Care, including new §353.1151, concerning General Provisions; §353.1153, concerning STAR+PLUS Home and Community Based Services (HCBS) Program; and §353.1155, concerning Medically Dependent Children Program. HHSC also adopts new Subchapter N, concerning STAR Kids, including new §353.1201, concerning General Provisions; §353.1203, concerning Member Participation; §353.1205, concerning Service Coordination; §353.1207, concerning Participating Providers; and §353.1209, concerning STAR Kids Handbook. Sections 353.2, 353.603, 353.1153 and 353.1155 are adopted with changes to the proposed text as published in the July 22, 2016, issue of the *Texas Register* (41 TexReg 5287). The text of the rules will be republished. Sections 353.601, 353.701, 353.702, 353.1151, 353.1201, 353.1203, 353.1205, 353.1207 and 353.1209 are adopted without changes to the proposed text as published in the July 22, 2016, issue of the *Texas Register* (41 TexReg 5287) and the text of the rules will not be republished.

#### BACKGROUND AND JUSTIFICATION

The Texas Health and Human Services Commission (HHSC) adopts amendments to Subchapter A to update the definitions rule for Chapter 353, §353.2, concerning Definitions. HHSC also adopts amendments to Subchapters G (relating to STAR+PLUS) and H (relating to STAR Health) to make changes resulting from the STAR Kids implementation. These primarily include changes to the list of client populations who are now mandatory, voluntary, or excluded for STAR+PLUS and STAR Health.

Additionally, HHSC adopts amendments to STAR+PLUS eligibility and program rules under Subchapter G to implement Senate Bill 169 (84th Legislature, Regular Session, 2015), which enacted new Texas Government Code §531.0931 regarding military members and their dependents who are on interest or waiting lists for services.

HHSC adopts new Subchapter M, concerning Home and Community Based Services in Managed Care, which describes the

eligibility and assessment requirements for the STAR+PLUS Home and Community Based Services (HCBS) program offered to qualified members in the STAR+PLUS managed care program and the Medically Dependent Children Program (MDCP).

HHSC adopts new Subchapter N, concerning STAR Kids, implementing Texas Government Code §533.00253, which directs HHSC to establish a mandatory, capitated STAR Kids managed care program tailored to provide Medicaid benefits to individuals with disabilities under the age of 21. HHSC intends for the STAR Kids program to improve coordination of care, access to care, health outcomes, and quality of care with an operational start date of November 1, 2016.

#### COMMENTS

The 30-day comment period ended on August 21, 2016. During the 30-day comment period, HHSC received written comments from PSA Healthcare and the Texas Association of Home Care and Hospice. Neither commenter was opposed to the proposed rules.

Summaries of each comment and HHSC's response follow:

Comment: One commenter noted that in §353.2(45) "based on the individual's person-centered service plan" is omitted from the definition of "habilitation."

Response: HHSC agrees with the comment and has amended the definition as suggested.

Comment: One commenter noted that §353.2(52) provided a citation for 42 CFR 431.923, but the commenter could not locate this reference.

Response: HHSC agrees and has corrected the citation to reflect the correct reference of 42 CFR 435.923.

Comment: Regarding §353.2(65)(B)(iv), one commenter questioned whether or not the individual's functional need is assessed to determine medical need.

Response: HHSC thanks the commenter for this feedback. HHSC believes the definition of functional necessity in §353.2(44) addresses the commenter's concern, and no changes were made as a result of this comment.

Comment: One commenter noted that in §353.2(80) "significant level of care" is vague in the definition of "significant traditional provider."

Response: HHSC thanks the commenter for this feedback. HHSC declines to make a change to this definition at this time, because the definition of "significant level of care" is specific to each program and cannot be generalized here. HHSC will consider addressing this comment in future rule projects, as the definition applies to all managed care programs and has impact

beyond the primary reason for this rule change, implementation of STAR Kids.

Comment: One commenter noted that that §353.2(83) "long-term services and supports" is vague in the definition of "STAR Kids."

Response: HHSC thanks the commenter for this feedback. The type of long-term service and support provided by the managed care organization (MCO) varies considerably depending on the child or young adult, their enrollment in a waiver program, their residence in an institution, and a number of other factors. The definition as written is meant to be broad enough to account for all of the different scenarios and factors. Therefore, HHSC declines to make a change to this definition at this time.

Comment: One commenter requested a definition for "person centered care services."

Response: HHSC declines to make the suggested change at this time. HHSC will address the requested definition in a future rule project to ensure the public has the opportunity to comment on the proposed definition.

Comment: One commenter requested that the definition of "STAR+PLUS Home and Community-Based Services Program" in §353.2(85) only state the program is for individuals over 21 years old.

Response: HHSC agrees with the comment and, therefore, deleted "who are age 65 or over" and "are blind or have a disability" from the definition and added "Medicaid eligible." The individual over the age of 21 will still have to be otherwise qualified for the program.

Comment: One commenter noted that §353.603(e)(2) uses the term "client," but "individual" and "member" are used elsewhere.

Response: HHSC agrees with the comment and has changed the term "clients" to "individuals" to reduce the number of terms used to describe individuals. Member is used to describe an individual who is enrolled with a managed care organization.

Comment: One commenter noted that that §353.1153(a) is missing a subsection (G)(1).

Response: HHSC disagrees with this comment. Paragraph (2) is not a subpart of subparagraph (G). Rather, subparagraph (G) is a subpart of paragraph (1). Therefore, HHSC declines to make a change to the rule at this time.

Comment: One commenter noted that §353.1153(b)(1)(A) and §353.1155(c)(1)(A) did not note that calls are toll-free or provide a phone number.

Response: HHSC agrees with the comment and has corrected §353.1153(b)(1)(A) and §353.1155(c)(1)(A) to note the toll-free numbers.

Comment: One commenter requested that §353.1153(c)(1)(F) and corresponding §353.1155(d)(1)(F) reflect that service plans may be reviewed and revised at the request of the individual or legally authorized representative.

Response: HHSC agrees with the comment and updated §353.1153(c)(1)(F) and §353.1155(d)(1)(F) to reflect that a service plan may be reviewed and revised at the request of an individual or their legally authorized representative.

Comment: One commenter requested clarity about the terms "residing" and "immediate" in §353.1155(b)(2).

Response: HHSC thanks the commenter for this feedback. HHSC declines to define these terms at this time, as the terms are sufficiently clear in their current context. HHSC will consider addressing this in future rule projects to ensure the public has the opportunity to comment on the proposed language.

Comment: One commenter requested clarity about whether the term "provider" in §353.1155(f) referred to in-network providers.

Response: HHSC thanks the commenter for this feedback. The term "provider" in §353.1155(f) refers to a provider as defined in §353.2(74) who has a contract with the managed care organization. Therefore, HHSC declines to make a change to the rule based on this comment.

Comment: One commenter requested clarity about whether §353.1155(h) refers to HHSC conducting utilization reviews of providers or MCOs.

Response: HHSC thanks the commenter for this feedback. This section of rule pertains to utilization reviews of MCOs. Rules pertaining to HHSC utilization reviews of providers can be found in Texas Administrative Code Title 1, Part 15, Chapter 371, Subchapter C.

## SUBCHAPTER A. GENERAL PROVISIONS

### 1 TAC §353.2

#### STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.00253, which directs HHSC to create the STAR Kids 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 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) Agreement or Contract--The formal, written, and legally enforceable contract and amendments thereto between HHSC and an MCO.

(5) 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.

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

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

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

(9) 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.

(10) CFR--Code of Federal Regulations.

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

(12) 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.

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

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

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

(16) 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.

(17) 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.

(18) 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.

(19) 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.

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

(21) 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.

(22) 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.

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

(24) 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.

(25) 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.

(26) 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.

(27) 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.

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

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

(30) 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.

(31) 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.

(32) 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.

(33) 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.

(34) 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.

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

(36) 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).

(37) 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.

(38) 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.

(39) 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.

(40) 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.

(41) 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.

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

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

(44) 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.

(45) 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.

(46) 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.

(47) 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.

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

(49) 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.

(50) 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.

(51) 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)).

(52) 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.

(53) 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.

(54) Main dental home provider--See definition of "dental home" in this section.

(55) Main dentist--See definition of "dental home" in this section.

(56) 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.

(57) Managed care organization (MCO)--A dental MCO or a health care MCO.

(58) 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.

(59) 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.

(60) 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.

(61) 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.

(62) 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).

(63) Medicaid for transitioning foster care youth (MTFCY) program--The Medicaid program for young adults who aged out of the conservatorship of Texas Department of Family and Protective Services (DFPS), administered in accordance with Chapter 366, Subchapter F of this title (relating to Medicaid for Transitioning Foster Care Youth).

(64) 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.

(65) 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 treat-

ments 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.

(66) 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.

(67) 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.

(68) 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.

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

(70) 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.

(71) Participating MCO--An MCO that has a contract with HHSC to provide services to members.

(72) 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.

(73) 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.

(74) 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.

(75) 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.

(76) Provider network or Network--All providers that have contracted with the MCO for the applicable managed care program.

(77) Quality improvement--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(78) 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.

(79) Service area--The counties included in any HHSC-defined service area as applicable to each MCO.

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

(81) 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.

(82) STAR Health--The managed care program that operates under the Medicaid state plan and primarily serves:

(A) children and youth in Texas Department of Family and Protective Services (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.

(83) STAR Kids--The program that operates under a federal waiver and primarily provides, arranges, and coordinates preven-

tative, primary, acute care, and long-term services and supports to persons with disabilities under the age of 21 who qualify for Medicaid.

(84) 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.

(85) 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.

(86) 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.

(87) 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).

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

(89) 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.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605176

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Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 424-6900



## SUBCHAPTER G. STAR+PLUS

### 1 TAC §353.601, §353.603

#### STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government

Code §531.00253, which directs HHSC to create the STAR Kids managed care program.

§353.603. *Member Participation.*

(a) Except as provided in subsections (b) and (d) of this section, enrollment in the STAR+PLUS program is *mandatory* for Medicaid recipients who meet one or more of the following criteria:

(1) have a physical or mental disability, are age 21 or older, and receive Supplemental Security Income (SSI) benefits or Medicaid due to low income;

(2) qualify for the STAR+PLUS Home and Community-Based Services Program, as described in §353.1153 of this title (relating to STAR+PLUS Home and Community Based Services (HCBS) Program);

(3) are age 21 or older and receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for STAR+PLUS Home and Community-Based Services Program; or

(4) are age 21 or older and reside in a nursing facility.

(b) In addition to the Medicaid recipients who must enroll in the STAR+PLUS program under subsection (a) of this section, recipients age 21 or older residing in a community-based ICF-IID or receiving services under the following Medicaid 1915(c) waivers and not enrolled in Medicare must enroll in STAR+PLUS to receive acute care services:

(1) Home and Community-based Services (HCS);

(2) Community Living Assistance and Support Services (CLASS);

(3) Texas Home Living (TxHmL); and

(4) Deaf Blind with Multiple Disabilities (DBMD).

(c) Medicaid recipients have a choice among at least two MCOs.

(d) The following Medicaid recipients *cannot* participate in the STAR+PLUS program:

(1) persons under age 21;

(2) residents of state supported living centers;

(3) persons not eligible for full Medicaid benefits; and

(4) persons enrolled in Programs of All-Inclusive Care for Elderly (PACE).

(e) Dual eligible individuals.

(1) Enrollment in Medicare does not affect eligibility for the STAR+PLUS program, except as specified in subsection (b) of this section.

(2) Dual eligible individuals who participate in the STAR+PLUS program receive most acute care services through their Medicare provider, and STAR+PLUS Home and Community-Based Services Program through the STAR+PLUS MCO. Dual eligible individuals who participate in the STAR+PLUS program receive most acute care services through their Medicare provider, but may receive additional services through their STAR+PLUS MCO. The STAR+PLUS program does not change the way dual eligibles receive Medicare services.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605178

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Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 424-6900



## SUBCHAPTER H. STAR HEALTH

### 1 TAC §353.701, §353.702

#### STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.00253, which directs HHSC to create the STAR Kids managed care program.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605179

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 424-6900



## SUBCHAPTER M. HOME AND COMMUNITY BASED SERVICES IN MANAGED CARE

### 1 TAC §§353.1151, 353.1153, 353.1155

#### STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.00253, which directs HHSC to create the STAR Kids managed care program.

§353.1153. *STAR+PLUS Home and Community Based Services (HCBS) Program.*

(a) The MCO assesses an individual's eligibility for STAR+PLUS HCBS.

(1) To be eligible for the STAR+PLUS HCBS program, an individual must:

- (A) be 21 years of age or older;
- (B) reside in Texas;
- (C) meet the level-of-care criteria for medical necessity for nursing facility care as determined by HHSC;
- (D) have an unmet need for support in the community that can be met through one or more of the STAR+PLUS HCBS program services;
- (E) choose the STAR+PLUS HCBS program as an alternative to nursing facility services, as described in 42 CFR §441.302(d);
- (F) not be enrolled in another Medicaid HCBS waiver program approved by CMS; and
- (G) be determined by HHSC to be financially eligible for Medicaid, as described in Chapter 358 of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities) and Chapter 360 of this title (relating to Medicaid Buy-In Program).

(2) An individual receiving Medicaid nursing facility services is approved for the STAR+PLUS HCBS program if the individual requests services while residing in the nursing facility and meets eligibility criteria listed in paragraph (1) of this subsection. If the individual is voluntarily discharged from the nursing facility into a community setting before being determined eligible for Medicaid nursing facility services and the STAR+PLUS program, the individual is denied immediate enrollment in the program.

(b) HHSC maintains a statewide interest list of individuals not enrolled in STAR+PLUS interested in receiving services through the STAR+PLUS HCBS program. There is no interest list for individuals currently enrolled in STAR+PLUS who are eligible to receive services through the STAR+PLUS HCBS program. Individuals enrolled in STAR+PLUS may contact their MCO for more information about STAR+PLUS HCBS.

(1) A person may request an individual's name be added to the STAR+PLUS HCBS interest list by:

- (A) calling HHSC toll-free at 1-855-937-2372;
- (B) submitting a written request to HHSC; or
- (C) generating a referral through YourTexasBenefits.com, Find Support Services screening and referral tool.

(2) HHSC removes an individual's name from the STAR+PLUS HCBS interest list if:

- (A) the individual is deceased;
- (B) the individual is assessed for the program and determined to be ineligible;
- (C) the individual or LAR requests in writing that the individual's name be removed from the interest list; or
- (D) the individual is no longer a Texas resident, unless the individual is a military family member living outside of Texas as described in Texas Government Code §531.0931:

- (i) while the military member is on active duty; or
- (ii) for less than one year after the former military member's active duty ends.

(c) The MCO develops a person-centered individual service plan (ISP) for each member, and all applicable documentation, as described in the STAR+PLUS Handbook.

(1) The ISP must:

(A) include services described in the Texas Healthcare Transformation and Quality Improvement Program Waiver, governed by §1115(a) of the Social Security Act.

(B) include services necessary to protect the individual's health and welfare in the community;

(C) include services that supplement rather than supplant the individual's natural supports and other non-STAR+PLUS HCBS supports and services for which the individual may be eligible;

(D) include services designed to prevent the individual's admission to an institution;

(E) include the most appropriate type and amount of services to meet the individual's needs in the community;

(F) be reviewed and revised if an individual's needs or natural supports change or at the request of the individual or their legally authorized representative;

(G) be approved by HHSC; and

(H) be cost effective.

(2) If an individual's ISP exceeds 202 percent of the cost of the individual's level-of-care in a nursing facility to safely serve the individual's needs in the community, the MCO must submit a request for a clinical assessment for general revenue funds to HHSC.

(d) MCOs are responsible for conducting reassessments and ISP development for their enrollees' continued eligibility for STAR+PLUS HCBS, in accordance with the policies and procedures outlined in the STAR+PLUS Handbook and in accordance with the timeframes outlined in the managed care contracts governing STAR+PLUS.

(e) MCOs are responsible for authorizing a network provider of the individual's choosing to deliver services outlined in an individual's ISP.

(f) Individuals participating in STAR+PLUS HCBS have the same rights and responsibilities as any individual enrolled in managed care, as described in Subchapter C of this chapter (relating to Member Bill of Rights and Responsibilities), including the right to appeal a decision made by HHSC or an MCO and the right to a fair hearing, as described in Chapter 357, Subchapter A, of this title (relating to Uniform Fair Hearing Rules).

(g) HHSC conducts utilization reviews of STAR+PLUS MCOs as described in Texas Government Code §533.00281.

§353.1155. *Medically Dependent Children Program.*

(a) This section applies to the Medically Dependent Children Program (MDCP) services provided under a Medicaid managed care program. The rules under 40 TAC, Chapter 51 (relating to Medically Dependent Children Program) do not apply to MDCP services provided under a Medicaid managed care program.

(b) The MCO assesses an individual's eligibility for MDCP.

(1) To be eligible for MDCP, an individual must:

- (A) be under 21 years of age;
- (B) reside in Texas;
- (C) meet the level-of-care criteria for medical necessity for nursing facility care as determined by HHSC;
- (D) have an unmet need for support in the community that can be met through one or more MDCP service;

(E) choose MDCP as an alternative to nursing facility services, as described in 42 CFR §441.302(d);

(F) not be enrolled in another Medicaid HCBS waiver program approved by CMS;

(G) if the individual is under 18 years of age, reside:

(i) with a family member; or

(ii) in a foster home that includes no more than four children unrelated to the individual; and

(H) be determined by HHSC to be financially eligible for Medicaid under Chapter 358 of this title (relating to Medicaid Eligibility for the Elderly and People with Disabilities), Chapter 360 of this title (relating to Medicaid Buy-In Program), or Chapter 361 of this title (relating to Medicaid Buy-In for Children Program).

(2) An individual receiving Medicaid nursing facility services is approved for MDCP if the individual requests services while residing in the nursing facility and meets eligibility criteria listed in paragraph (1) of this subsection. If the individual is discharged from the nursing facility for a community setting before being determined eligible for Medicaid nursing facility services and MDCP, the individual is denied immediate enrollment in the program.

(c) HHSC maintains a statewide interest list of individuals interested in receiving services through MDCP.

(1) A person may request an individual's name be added to the MDCP interest list by:

(A) calling HHSC toll-free 1-877-438-5658;

(B) submitting a written request to HHSC; or

(C) generating a referral through the YourTexasBenefits.com, Find Support Services screening and referral tool.

(2) HHSC removes an individual's name from the MDCP interest list if:

(A) the individual is deceased;

(B) the individual is assessed for the program and determined to be ineligible;

(C) the individual, medical consentor, or LAR requests in writing that the individual's name be removed from the interest list; or

(D) the individual moves out of Texas, unless the individual is a military family member living outside of Texas as described in Texas Government Code §531.0931:

(i) while the military member is on active duty; or

(ii) for less than one year after the former military member's active duty ends.

(3) An individual may request to be placed at the end of the interest list immediately following a determination of ineligibility.

(d) The MCO develops a person-centered individual service plan (ISP) for each individual, and all applicable documentation, as described in the STAR Kids Handbook and the Uniform Managed Care Manual (UMCM).

(1) The ISP must:

(A) include services described in the waiver approved by CMS;

(B) include services necessary to protect the individual's health and welfare in the community;

(C) include services that supplement rather than supplant the individual's natural supports and other non-Medicaid supports and services for which the individual may be eligible;

(D) include services designed to prevent the individual's admission to an institution;

(E) include the most appropriate type and amount of services to meet the individual's needs in the community;

(F) be reviewed and revised if an individual's needs or natural supports change or at the request of the individual or their legally authorized representative; and

(G) be cost effective.

(2) If an individual's ISP exceeds 50 percent of the cost of the individual's level of care in a nursing facility to safely serve the individual's needs in the community, HHSC must review the circumstances and, when approved, provide funds through general revenue.

(e) MCOs are responsible for conducting reassessments and ISP development for their enrollees' continued eligibility for MDCP, in accordance with the policies and procedures outlined in the STAR Kids Handbook, UMCM, or materials designated by HHSC and in accordance with the timeframes outlined in the MCO's contract.

(f) MCOs are responsible for authorizing a provider of the individual's choosing to deliver services outlined in an individual's ISP.

(g) Individuals participating in MDCP have the same rights and responsibilities as any individual enrolled in managed care, as described in Subchapter C of this title (relating to Member Bill of Rights and Responsibilities), including the right to appeal a decision made by HHSC or an MCO and the right to a fair hearing, as described in Chapter 357 of this title (relating to Hearings).

(h) HHSC conducts utilization reviews of MCOs providing MDCP services.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605181

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Texas Health and Human Services Commission

Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 424-6900



## SUBCHAPTER N. STAR KIDS

### 1 TAC §§353.1201, 353.1203, 353.1205, 353.1207, 353.1209

#### STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.00253, which directs HHSC to create the STAR Kids managed care program.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605182

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 424-6900



## CHAPTER 354. MEDICAID HEALTH SERVICES

### SUBCHAPTER D. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM

The Texas Health and Human Services Commission (HHSC) adopts amendments to §354.1624, concerning Independent Assessment of DSRIP Projects, without changes to the proposed text as published in the July 29, 2016, issue of the *Texas Register* (41 TexReg 5486) and will not be republished. HHSC also adopts new Division 6, concerning DSRIP Program Demonstration Year 6, and within the division, HHSC adopts new §354.1661, concerning Definitions; and §354.1667, concerning Requirements for Continuing DSRIP Projects with changes to the proposed as text published in the July 29, 2016, issue of the *Texas Register* (41 TexReg 5486). The text of the rules will be republished. HHSC also adopts new §354.1663, concerning Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI); §354.1665, concerning Demonstration Year 6 DSRIP Pool Funding and Distribution; §354.1669, concerning Requirements for Combining Certain DSRIP Projects; §354.1671, concerning DSRIP Requirements for Uncompensated Care Hospitals; §354.1673, concerning Remaining DSRIP Funds; and §354.1675, concerning Anchor Requirements without changes to the proposed text as published in the July 29, 2016, issue of the *Texas Register* (41 TexReg 5486) and will not be republished.

#### BACKGROUND AND JUSTIFICATION

The Texas Healthcare Transformation and Quality Improvement Program, a Section 1115 Waiver (the waiver), authorizes Texas to operate managed care statewide, the Uncompensated Care (UC) pool, and the Delivery System Reform Incentive Payment (DSRIP) pool. DSRIP is a program for hospitals and certain other performing providers (or "performers" as used in the DSRIP rules) to propose and implement transformative projects that increase access to care and quality of care.

The waiver was initially effective from December 12, 2011, through September 30, 2016. However, HHSC and the Centers for Medicare & Medicaid Services (CMS) have agreed to extend the waiver. The 15-month period is considered DY6 (October 1, 2016 to December 31, 2017). DY6 is divided into DY6A and DY6B. DY6A is federal fiscal year 2017, or the first 12 months of DY6 (October 1, 2016 to September 30, 2017). DY6B is the

last three months of DY6 (October 1, 2017 to December 31, 2017). The adopted rules describe the policies for DY6A.

The Program Funding and Mechanics (PFM) protocol outlines the requirements for DSRIP performers. CMS approved the proposed PFM protocol language for DY6A on June 23, 2016. The adopted rules closely mirror the approved DY6A PFM protocol language.

The DY6A PFM protocol language and adopted rules provide that in DY6A, HHSC will simplify the structure and administration of the DSRIP program while maintaining the overall level of funding to performers. To that end, HHSC will focus payments more directly on the impact to patients.

The DY6A PFM protocol language and adopted rules also clarify that compliance monitoring is an ongoing process that will continue in DY6A, and that performers are responsible for providing any requested documentation to the independent assessor and HHSC. In addition, they clarify that HHSC can initiate recoupments based on the findings of the independent assessor.

HHSC received comments regarding the proposed rules, and made changes to the rules based on those comments. HHSC revised §354.1661 and §354.1667 to allow performers of projects with a DY6A MLIU QPI milestone that is pay-for-reporting (P4R) to report on, and receive payment for, the milestone during the first DY6A reporting period if they have done the following by the first DY6A reporting period: 1) achieved or forfeited a DY5 QPI metric; and 2) provided at least one encounter or served at least one individual toward the DY6A MLIU QPI milestone goal.

HHSC also corrected errors in the proposed rules. HHSC revised the figure in §354.1667(e)(10)(B) to correct errors in the methodology for calculating the program year (PY) 3 goal for a Category 3 pay-for-performance (P4P) outcome designated as Quality Improvement System for Managed Care (QISMC) in DY5. First, HHSC corrected the formula for calculating the PY3 goal if the outcome direction is positive (meaning that higher rates indicate improvement) and the baseline is below the minimum performance level (MPL). The revised formula is as follows:  $MPL + .15*(HPL - MPL)$ . HHSC also corrected the formula for calculating the PY3 goal if the outcome direction is negative (meaning that lower rates indicate improvement) and the baseline is above the MPL. The revised formula is as follows:  $MPL - .15*(MPL - HPL)$ .

In addition, HHSC revised §354.1667(d)(4) to change the title of the Category 1 and 2 "core component reporting" milestone to "project summary and core components," to more accurately reflect the types of questions performers will need to respond to in order to achieve this milestone. HHSC also added to §354.1667(d)(4) the requirement for performers to attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting during DY6A in order to be eligible for payment for the two Category 1 and 2 non-QPI milestones.

Further, HHSC added language to §354.1667(e)(10)(D) describing the methodology recently approved by CMS for calculating the PY3 goal for a Category 3 P4P survey-based outcome in outcome domain 10 or 11 that is designated as improvement over self (IOS)-survey in DY5. In addition, HHSC clarified language describing how partial payment will be measured for IOS-survey outcomes.

#### COMMENTS

The 30-day comment period ended August 29, 2016. During this period, HHSC received comments regarding the proposed

rules from several commenters: CHRISTUS Health, Harris Health System, HCA Gulf Coast Division, Memorial Hermann, Midland Memorial Hospital, Nueces County Hospital District, OakBend Medical Center, Odessa Regional Hospital, Regional Healthcare Partnership (RHP) 2, RHP 8, RHP 17, Rice Medical Center, Southwest General Hospital, St. Joseph Medical Center, Tenet Healthcare, Texas Council of Community Centers, and Yoakum Community Hospital. A summary of comments and HHSC's responses follows.

*Comment:* One commenter requested that §354.1624 be revised to provide for a process that guarantees performers the right to appeal the independent assessor's findings.

*Response:* HHSC disagrees and declines to revise the rule as the commenter suggests. The current process, established by the independent assessor and HHSC, gives performers sufficient time to request and review the independent assessor's findings, understand the methodology, and provide additional data, if necessary. HHSC is not involved in this part of the review, as the independent assessor is guided by auditing standards and quality measure steward guidelines. The independent assessor informs HHSC if a performer disagrees with the findings, and HHSC provides the independent assessor with its input. The independent assessor then considers HHSC's input in finalizing its findings. HHSC does not believe it is necessary to change this process.

*Comment:* Multiple commenters recommended revising §354.1667(b) to include a provision that encourages governmental entities to continue providing intergovernmental transfers (IGTs) on behalf of affiliated private hospitals during DY6A. The commenters suggested that one way to do this would be to proportionately reduce a governmental entity's additional DSRIP funding over and above their original Pass 1 DY5 DSRIP allocation if the governmental entity reduces or ends IGT funding for affiliated private hospitals.

*Response:* HHSC disagrees and declines to revise the rule as the commenter suggests. HHSC does not believe it necessary to add a provision encouraging governmental entities to continue providing IGTs on behalf of affiliated private hospitals for DY6A. Also, HHSC does not have a way to implement such a requirement. In addition, there is already a requirement in §355.8203(h)(2)(B), that if a governmental entity does not transfer, on behalf of each performer owned by or affiliated with that governmental entity, the maximum IGT amount necessary for the performer to receive the maximum payment amount for the payment period, each performer owned by or affiliated with that governmental entity will receive a portion of the value associated with that milestone or quality measure (as specified in the RHP plan) that is proportionate to the total value of all milestones that are completed and eligible for payment for that period by all performers owned by or affiliated with that governmental entity. However, HHSC will take this comment under consideration for the longer term negotiations with CMS.

*Comment:* One commenter requested additional detail regarding the methodology that HHSC used to determine which DSRIP projects would be eligible for an adjustment to the DY6A total QPI milestone goal as referenced in §354.1667(d)(2). The commenter also requested additional detail regarding the process HHSC used to notify performers of projects determined eligible for such an adjustment.

*Response:* HHSC found that there were projects with low Category 1 and 2 values relative to other projects that had significantly

overestimated their QPI metric goals during the initial demonstration period. The general policy for DY6A is that projects maintain their DY5 QPI metric goal in DY6A. To avoid further penalizing those projects that were disproportionately challenged to meet their DY4 QPI metric goal, and would therefore likely be disproportionately challenged to meet their DY5 QPI metric goal, HHSC determined that certain projects would be eligible for an adjustment to their DY6A total QPI milestone goal. HHSC established a methodology to determine which projects were eligible for such an adjustment.

The DSRIP projects eligible for an adjustment include projects for which the performer reported 66 percent achievement or less of the DY4 QPI metric as of April DY5 reporting, and for which: 1) The value per MLIU individual is less than or equal to \$1,000; or 2) The value per MLIU encounter is less than or equal to \$500.

The exact formula for calculating value per MLIU individual or encounter is as follows:

$$\frac{(DY4 + DY5 \text{ Category 1 or 2 value})}{[DYs 4 \text{ and } 5 \text{ total MLIU } \% * (DY4 \text{ total QPI goal} + DY5 \text{ total QPI goal})]}$$

In addition, performers of projects with multiple, and potentially overlapping, DY5 QPI metrics that were combined into a single DY6A total QPI milestone were eligible for an adjustment to the DY6A total QPI milestone goal. For example, if a project had one DY5 QPI metric that measured the number of individuals screened for substance abuse, and a second DY5 QPI metric that measured the number of individuals treated for depression and substance abuse, these metrics were likely overlapping, and adding the two DY5 QPI metric goals together would result in an unattainable goal. Therefore, HHSC determined that these projects would be eligible for an adjustment to the DY6A total QPI milestone goal.

Performers were required to complete the DSRIP Participation Form during summer 2016. This form specified project characteristics, including milestone goals, for DY6A. It also allowed for performers to request certain adjustments. Performers that were determined eligible for an adjustment to their DY6A total QPI goal based on the criteria above were notified of their eligibility through this form, and could request an adjustment through this form.

HHSC only evaluated DY4 QPI metrics (and not DY3 or DY5 QPI metrics) because the DY4 data was the most recent data available at the time of the evaluation. HHSC assumes that projects with QPI metrics in DY5 only will have had sufficient ramp-up time to achieve their DY5 QPI metric goals during DY5 or the DY5 carry-forward period (DY6A). Many of the projects that have been disproportionately challenged to achieve their DY4 QPI metric goals were delayed in implementing the projects or seriously overstated their goals (as indicated by the combination of achievement and valuation elements included in the methodology for evaluating eligibility for adjustment). For these reasons, no rule changes were made in response to this comment.

*Comment:* One commenter requested clarification on the circumstances under which a performer is eligible to report on, and receive payment for, each DY6A Category 1 and 2 milestone during the first reporting period of DY6A.

*Response:* Each project has four Category 1 or 2 milestones in DY6A: total QPI, MLIU QPI, project summary and core components, and sustainability planning. A performer is eligible to report on, and receive payment for, a project's DY6A total QPI milestone during the first reporting period of DY6A only if the per-

former has achieved or forfeited a DY5 QPI metric and achieved the DY6A total QPI milestone by the first DY6A reporting period.

If a DSRIP project's DY6A MLIU QPI milestone is P4R, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

- (1) achieved or forfeited a DSRIP project's DY5 QPI metric; and
- (2) provided at least one encounter or served at least one individual toward the DSRIP project's DY6A MLIU QPI milestone goal.

If a DSRIP project's DY6A MLIU QPI milestone is P4P, and the project does not have a DY5 MLIU-specific QPI metric, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

- (1) achieved or forfeited a DSRIP project's DY5 QPI metric; and
- (2) achieved the DSRIP project's DY6A MLIU QPI milestone goal.

If a DSRIP project's DY6A MLIU QPI milestone is P4P, and the project has a DY5 MLIU-specific QPI metric, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

- (1) achieved or forfeited the DSRIP project's DY5 MLIU-specific QPI metric; and
- (2) achieved the DSRIP project's DY6A MLIU QPI milestone goal.

A performer may only begin to count individuals served or encounters provided toward a DSRIP project's DY6A MLIU QPI milestone goal after they have achieved or forfeited a DY5 QPI metric or a DY5 MLIU-specific QPI metric.

A performer is only eligible to report on, and receive payment for, a DSRIP project's DY6A MLIU QPI milestone during DY6A or the DY6A carry forward period.

HHSC added §354.1667(d)(3)(H)-(L) to clarify when performers may report on, and receive payment for, the DY6A MLIU QPI milestone.

Performers cannot report on, or receive payment for, the project's two DY6A non-QPI Category 1 and 2 milestones (the project summary and core components milestone and the sustainability planning milestone) during the first reporting period of DY6A. Performers can only report on, and receive payment for, these two milestones during the second reporting period of DY6A.

*Comment:* Multiple commenters recommended that §354.1667(d)(4) be revised to allow performers to report on, and receive payment for, the core component reporting and sustainability planning milestones during the first reporting period of DY6A. One commenter stated that performers should be able to earn at least half of the value of each of these milestones during the first reporting period of DY6A (i.e., that there should be partial payment for these two milestones).

*Response:* In the adopted version of this rule, HHSC has revised the name of the core component reporting milestone to project summary and core components. HHSC does not agree that a revision should be made to allow performers to report on, and receive payment for, the project summary and core components and sustainability planning milestones during the first reporting period of DY6A. First, the project summary and core components milestone and the sustainability planning milestone are annual milestones that should reflect the activities that the performers

are conducting throughout DY6A, some of which cannot be conducted by the first reporting period of DY6A. Second, performers have reported relatively few metrics for achievement during the first reporting period of the same DY for Categories 1 and 2. For example, in DY5 Round 1 reporting, of the 1,451 Category 1 and 2 projects, only 293 (20 percent) had a DY5 metric approved, representing only 11 percent of the total DY5 value for all Category 1 and 2 projects. Third, HHSC revised §354.1661 and §354.1667 to allow performers of projects with a DY6A MLIU QPI milestone that is pay-for-reporting (P4R) to report on, and receive payment for, the milestone during the first DY6A reporting period if they have done the following by the first DY6A reporting period: 1) achieved or forfeited a DY5 QPI metric; and 2) provided at least one encounter or served at least one individual toward the DY6A MLIU QPI milestone goal. Fourth, performers still have the opportunity to report on, and receive payment for, Category 3 and Category 4 during the first reporting period of DY6A. Fifth, DSRIP process metrics have not historically been eligible for partial payment because payment for these metrics has been based on completion of the metric rather than reported progress. For these reasons, HHSC did not revise this rule to allow performers to report on, and receive payment for, these two non-QPI milestones during the first reporting period of DY6A.

*Comment:* One commenter requested that the template for reporting on the sustainability planning milestone referenced in §354.1667(d)(4) be made available to performers to ensure expectations are met.

*Response:* HHSC plans to post the draft questions to be included in the sustainability planning milestone reporting template to the HHSC website by October 2016. No rule changes were made in response to this comment.

*Comment:* Multiple commenters requested changes to §354.1667(e)(5). This section specifies that if a Category 3 outcome is designated as P4R or maintenance with a Population Focused Priority Measure (PFPM) in DY5, 100 percent of the outcome's value is P4P of the PFPM. The commenters stated that this approach weighs funds towards outcomes that are even further removed from the intervention population and that it is inconsistent with the approach for Category 3 outcomes designated as P4R with an associated stretch activity in DY5. The commenters also stated that performers would have little experience improving this outcome. The commenters proposed the following alternatives: 1) 50 percent P4P of the PFPM and 50 percent P4R for the Category 3 outcome or another P4P Category 3 outcome; and 2) 100 percent P4P of the PFPM with an allowance for subsets currently in use for Category 3 outcomes.

*Response:* CMS has expressed interest in significantly increasing the percentage of a performer's total value that is in Category 3 for DY6A. As an alternative, to the extent possible, HHSC has attempted to replace Category 3 P4R milestones with milestones tied to achievement without increasing the volume of measures reported, and with only a modest increase in goals for DY6A. PFPM measures are not substantially different from Category 3 outcomes, as a majority of standard Category 3 outcomes report on a broad population and performers reporting on PFPM outcomes in DY5 are reporting with similar success rates to performers reporting primary P4P Category 3 outcomes. HHSC has worked with performers in extenuating circumstances to approve reporting variances for PFPMs related to data access (similar to facility and payer subsets). Performers with a newly selected PFPM in DY6A have the option to establish a DY4 or DY5 base-

line, with some exceptions to be confirmed by HHSC prior to reporting a PFFM baseline. The first opportunity to report performance of the PFFM will be PY3, which aligns with DY6A. PY3 will be used to report achievement of the DY6 milestone, AM-3.x. A DY4 or DY5 baseline allows for sufficient time to achieve the DY6A goal. Additionally, the DSRIP program has mitigated some of the risk associated with P4P outcomes, including PFFMs, by allowing for partial payment and carry forward. For these reasons, no rule changes were made in response to this comment.

*Comment:* Multiple commenters requested changes to §354.1667(e)(6). This section specifies that if a Category 3 outcome is designated as P4R with an associated stretch activity in DY5, the performer must choose one of the following options: 1) maintain the P4R outcome from DY5 and select a new stretch activity that does not duplicate the DY5 stretch activity from an HHSC-approved list of stretch activities; or 2) select a PFFM. The HHSC-approved stretch activities under Option #1 include: 1) program evaluation (alternate approaches to program and outcome linkages); 2) new participation in health information exchange (HIE) or improvement of existing HIE infrastructure; and 3) cost analysis and value based purchasing planning. The commenters stated that these approved stretch activities may not be feasible for performers to complete for DY6A, and requested that HHSC add additional stretch activity options for DY6A. The commenters also requested that HHSC revise this section to allow performers with a P4R outcome and associated stretch activity of program evaluation in DY5 to continue that same stretch activity of program evaluation in DY6A in a modified form. In addition, commenters requested that Option 2 be revised to maintain the P4R outcome from DY5 in addition to selecting a PFFM, and that the payment methodology be 50 percent P4R of the outcome and 50 percent P4P of the PFFM.

*Response:* Following CMS direction to keep Category 3 as P4P, HHSC initially proposed milestone structures for all Category 3 outcomes that did not include a stretch activity. In response, CMS requested that HHSC require stretch activities in DY6A for P4R outcomes with no PFFM in DY5. Outcomes that are P4R with a stretch activity had 100 percent of DY4 and DY5 Category 3 valuation as P4R. Performers with a P4R outcome and stretch activity in DY4 are eligible to receive a median value of \$472,000 for Category 3 P4R activities in DY5, with a median 30 percent of Category 3 valuation in outcomes that are P4R with a stretch activity. Where possible, performers should be moving towards outcomes or more challenging stretch activities.

The new cost analysis and value-based purchasing (VBP) planning stretch activity is applicable to all provider types, is not specific to payer type, and builds on any program evaluations conducted in DY6A. This stretch activity does not require that performers enter into a VBP contract with a specific payer, but rather that performers create a business case for a VBP arrangement through evaluation of the costs and benefits of a DSRIP intervention or portions of a DSRIP intervention. Performers would submit a cost-benefit analysis (CBA) or return-on-investment (ROI) analysis of the project. Costs could include, but would not be limited to, costs associated with ongoing overhead needs, staff/labor, supplies, and equipment costs. Savings/benefits could include, but would not be limited to, reduced utilization of health-care services and improved health outcomes. The CBA or ROI would function as a way to demonstrate that a project is a worthwhile investment to payers (managed care organizations, community, health systems, etc.) to include as a value-based service.

Currently, 77 DSRIP performers are required to select either a new stretch activity or a replacement PFFM for DY6A for one or more Category 3 outcomes. Thirty-nine of the 77 performers reported a PFFM or measure that is identical to a PFFM in DY5 indicating that for the majority of performers, measurement of a PFFM is feasible in DY6A. For performers that opt to select a PFFM to replace a P4R outcome with an associated stretch activity, the approved PFFM menu includes measures that performers with and without subsets have been able to improve dramatically in a short period of time, including BMI Assessment (90 percent success rate in PY1 with a median improvement of 42 percent, reported by all provider types), Follow-Up After Hospitalization for Mental Illness (100 percent success rate in PY1 with a median improvement of 12 percent for 7 day follow up), and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (100 percent success rate, 68 percent median improvement for rate 1, and 69 percent improvement for rate 2).

HHSC believes that all performers will be able to complete the new cost analysis and VBP planning stretch activity or report on a PFFM in DY6A. For these reasons, no rule changes were made in response to this comment.

*Comment:* Multiple commenters recommended changing §354.1667(e)(10), to make the DY6A goal for Category 3 P4P outcomes equal to, instead of greater than, the DY5 goal. The commenters state that this approach would be consistent with the approach for establishing DY6A QPI goals in DY6A.

*Response:* HHSC recognizes the inherent risk in P4P outcomes, but sees the value in providing an incentive for performers to continue to improve on performance goals and improve health outcomes in Texas. HHSC was able to negotiate with CMS a modest increase in goals for Category 3 outcomes in DY6A rather than increased funding in Category 3. Unlike QPI, Category 3 goals were not increased prior to DY6A to account for early achievement. Category 3 DY6A goals were set taking into consideration the magnitude of improvement reported in the first year of Category 3 performance reporting. Furthermore, the Category 3 allocations for P4P outcomes were 100 percent P4R in DY3 and 50 percent P4R in DY4. The DSRIP program has mitigated some of the risk associated with P4P outcomes by allowing for partial payment and carry forward. For these reasons, no rule changes were made in response to this comment.

*Comment:* One commenter indicated that §354.1667(e)(10) references a figure for calculating QISMC PY3 goals, but the commenter was unable to determine the methodology for determining the goal if the baseline was below the MPL.

*Response:* PY3 goal calculation for QISMC outcomes with a baseline below the MPL can be found in §354.1667(e)(10)(B). The standard PY3 goal calculation for QISMC outcomes with a baseline below the MPL is as follows:

Positive Directionality:  $MPL + .15 * (HPL - MPL)$  and

Negative Directionality:  $MPL - .15 * (MPL - HPL)$

The PY3 goal calculation is also included in the approved DY6A PFM protocol language, and the draft Category 3 Operational Details document sent to DSRIP anchors.

This methodology for DY6A is consistent with the approved goal setting methodology for DY4 and DY5 for outcomes with a baseline below the MPL, where in PY1 the goal is equal to the MPL, and the PY goal is calculated as the MPL plus or minus 10 per-

cent of the difference between the MPL and HPL, depending on directionality.

In addition to the above methodology, QISMC outcomes with a baseline below the MPL are eligible to submit an alternate achievement request for DY6A goals as stated in §354.1667(e)(10)(F).

*Comment:* Multiple commenters recommended changing §354.1667(e)(11) to measure partial achievement from the baseline rather than from the DY4 goal, as measuring it from the DY4 goal effectively establishes a new, higher baseline that does not recognize improvements made or maintained between baseline and the DY4 goal.

*Response:* Measuring partial payment in DY6A over DY4 goals supports continued improvement. For most P4P outcomes, performers had the opportunity to earn payment for closing the gap between their baseline and DY4 goals in two prior reporting years. In DY4, performers who exceeded their DY4 goal were eligible for full payment. In DY5, performers who maintained their DY4 goal but did not reach their DY5 goal earned partial payment. Similarly, in DY6A performers who maintain their DY5 goal but do not reach their DY6A goal will be eligible for partial payment. For these reasons, no rule changes were made in response to this comment.

*Comment:* One commenter stated that §354.1669 should be revised to allow projects that are combining in DY6A to combine their Category 3 outcome goals to reduce the burden of tracking these outcomes separately.

*Response:* HHSC disagrees and declines to revise the rule as the commenter suggests. Where possible, HHSC has combined identical P4R outcomes and PFPMs that are under the same Category 1 or 2 project ID in DY6A. HHSC has also combined P4P outcomes that have reported identical rates for baseline and PY1. HHSC cannot combine P4P outcomes that have reported unique baselines and performance as they have unique goals and achievement levels.

*Comment:* One commenter asked by which date the anchors would receive their one-time anchor payment referenced in §354.1673 and §354.1675.

*Response:* Anchors can report for their one-time anchor payment during the second reporting period of DY6A in October 2017. If an anchor submits documentation during the second reporting period of DY6A in October 2017 that demonstrates that the anchor met all of the requirements by September 30, 2017, for receiving the DY6A anchor payment, the anchor will receive the anchor payment in January 2018. No rule changes were made in response to this comment.

*Comment:* One commenter requested that a portion of the one-time anchor payment referenced in §353.1673 and §354.1675 be available prior to the current payment date of January 2018.

*Response:* It would not be possible for performers to meet the requirements associated with this payment by the first reporting period of DY6A. Similar to the DY1 anchor payments that were based on submission of RHP Plans and used the Medicaid FMAP rather than the 50/50 administrative match, HHSC does not plan to make payments prior to the completion of all requirements. No rule changes were made in response to this comment.

*Comment:* One commenter requested an estimated timeline for the one-time anchor payment requirements referenced in §353.1673 and §354.1675.

*Response:* Because requirements for the longer-term extension have not yet been negotiated with CMS, it is difficult to give timelines for the requirements related to DY6B and beyond. The DY6A learning collaborative plan will be due by December 15, 2016. The updated community needs assessment is estimated to be due by June 2017. However, at this time it is unclear by when the extension stakeholder engagement forum will need to be completed, or by when the updated RHP plan for DY6B and beyond will be due. No rule changes were made in response to this comment.

*Comment:* Multiple commenters recommended changes to §354.1667(f), relating to Category 4. Proposed §354.1667(f) states that if a performer's Category 4 value is greater than ten percent of the performer's total value, the funds in excess of the ten percent will be redistributed to Category 3. For most performers who selected Reporting Domain (RD) 6 in the initial demonstration period, their Category 4 value is greater than ten percent of their total value. The commenters argued that HHSC should give performers who had RD 6 in the initial demonstration period the opportunity to reallocate the funds in excess of the ten percent to Category 1 or 2 for DY6A as long as the allocation comports with the DSRIP category funding distribution described in paragraph 38 of the PFM protocol and proposed §354.1665. They stated that the original source of the RD 6 funds was Categories 1 and 2, so performers that selected RD 6 thought that they were shifting payment risk from Categories 1 and 2 to Category 4. Therefore, the commenters would like the opportunity to shift the risk back to Categories 1 and 2.

*Response:* One of CMS's goals for 1115 demonstration waivers is to focus more on outcomes-based payments. As part of the negotiations with CMS for the 15-month waiver extension, HHSC proposed to move the RD 6 pay-for-reporting funds to Category 3 outcomes. This allowed HHSC to maintain the previously CMS-approved valuations for Category 1 and 2 projects and the Category 3 minimum at 33 percent of the performer's total value. There may be an opportunity to change performer values for DY7 onward depending on the outcome of negotiations with CMS for the first 15 months of the waiver extension. No rule changes were made in response to this comment.

## DIVISION 3. RHP PLAN CONTENTS AND APPROVAL

### 1 TAC §354.1624

#### STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605136

Karen Ray

Chief Counsel

Texas Health and Human Services Commission

Effective date: October 30, 2016

Proposal publication date: July 29, 2016

For further information, please call: (512) 424-6900



## DIVISION 6. DSRIP PROGRAM DEMONSTRATION YEAR 6

**1 TAC §§354.1661, 354.1663, 354.1665, 354.1667, 354.1669,  
354.1671, 354.1673, 354.1675**

### STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

#### §354.1661. *Definitions.*

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

(1) **Alternate improvement activity**--An activity that must be selected in conjunction with a Category 3 outcome designated as pay-for-reporting (P4R) or maintenance. There are two types of alternate improvement activities: stretch activities and Population-Focused Priority Measures (PFPMs).

(2) **Baseline**--The baseline that HHSC has on record for a Category 3 outcome, typically the baseline that the performer most recently submitted to HHSC.

(3) **Baseline measurement period**--The time period used to set the baseline for a Category 3 outcome.

(4) **Category 3 outcome**--An outcome measure for which a performer can earn Category 3 payments.

(5) **Demonstration Year (DY) 6**--The initial 15-month time period, as approved by CMS, for which the waiver is extended beyond the initial demonstration period, or October 1, 2016 - December 31, 2017.

(A) **DY6A**--Federal fiscal year (FFY) 2017, or the first 12 months of DY6 (October 1, 2016 to September 30, 2017).

(B) **DY6B**--The last three months of DY6 (October 1, 2017 to December 31, 2017).

(6) **Extension period**--The entire time period, as approved by CMS, for which the waiver is extended beyond the initial demonstration period.

(7) **Federal poverty level**--The household income guidelines issued annually and published in the *Federal Register* by the United States Department of Health and Human Services.

(8) **Improvement floor**--A fixed value equal to ten percent of the difference between the minimum performance level (MPL) and the high performance level (HPL) for a Category 3 outcome. It is used to set the performance year (PY) goal for certain Category 3 outcomes designated as pay-for-performance (P4P) and Quality Improvement System for Managed Care (QISMC) that have a baseline that is either close to the HPL or above the HPL.

(9) **Improvement over self (IOS)**--A goal-setting methodology for certain Category 3 outcomes designated as pay-for-performance (P4P). Under IOS, an outcome's goal is set as closing the gap between the baseline and the perfect rate.

(10) **Initial demonstration period**--The first five DYs of the waiver, or December 12, 2011, through September 30, 2016.

(11) **Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI)**--The number of MLIU individuals served, or encounters provided to MLIU individuals, during an applicable DY that are attributable to the DSRIP project.

(12) **Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI) Goal**--The number of MLIU individuals that a performer intends to serve, or the number of MLIU encounters that a performer intends to provide, during an applicable DY that are attributable to the DSRIP project.

(13) **Medicaid and Low-income or Uninsured (MLIU) Quantifiable Patient Impact (QPI) - Specific Metric**--A QPI metric in the initial demonstration period that is specific to counting the MLIU population. This metric usually represents a subpopulation of another QPI metric and has a metric ID of I-34.1.

(14) **Performance level**--The benchmark level used to determine a Category 3 outcome's performance year (PY) goal relative to the baseline under the Quality Improvement System for Managed Care (QISMC) goal-setting methodology. There is a high performance level (HPL) and minimum performance level (MPL) for each outcome, as described in the RHP Planning Protocol.

(15) **Performance Year (PY)**--The 12-month measurement period that follows the baseline measurement period for a Category 3 outcome. For most outcomes, PY1 is the 12-month period that immediately follows the baseline measurement period, and PY2 is the 12-month period that immediately follows PY1.

(16) **Population-Focused Priority Measure (PFPM)**--A Category 3 outcome designated as pay-for-performance (P4P) that is an alternate improvement activity.

(17) **Pre-DSRIP baseline**--The service volume prior to the implementation of a DSRIP project, as measured by the number of individuals served or encounters provided during the 12-month period preceding the implementation of the DSRIP project. There is a pre-DSRIP baseline for total QPI and a pre-DSRIP baseline for MLIU QPI.

(18) **Quality Improvement System for Managed Care (QISMC)**--A goal-setting methodology for certain Category 3 outcomes designated as pay-for-performance (P4P). Under QISMC, an outcome's goal is set as closing the gap relative to the baseline and a high performance level (HPL) and minimum performance level (MPL) benchmark.

(19) **Quantifiable Patient Impact (QPI) Grouping**--The category of the QPI measurement. The category may be either individuals served or encounters provided.

(20) **Reporting Domain (RD)**--Category 4 contains five domains upon which hospital performers must report, as specified in the Program Funding and Mechanics (PFM) Protocol.

(21) Stretch activity--A pay-for-reporting (P4R) activity that is an alternate improvement activity.

(22) Total Quantifiable Patient Impact (QPI)--The total number of individuals served or encounters provided during an applicable DY that are attributable to the DSRIP project.

(23) Total Quantifiable Patient Impact (QPI) Goal--The total number of individuals that a performer intends to serve, or the total number of encounters that a performer intends to provide, during an applicable DY that are attributable to the DSRIP project.

(24) Uncompensated Care (UC) Hospital--A hospital eligible to be a performer that is not a performer, but receives UC payments.

§354.1667. *Requirements for Continuing DSRIP Projects.*

(a) A performer's total value for demonstration year (DY) 6A is equal to the performer's total value for DY5 with the following exceptions:

(1) HHSC notifies a performer that a DSRIP project's value may be reduced if the DSRIP project fails to complete DSRIP project or metric goals by the end of DY5.

(2) Performers with a total value less than \$250,000 for DY5 may increase their total value to up to \$250,000 per each subsequent DY beginning in DY6A. The increase in value is contingent on funds availability as described in §354.1673 of this division (relating to Remaining DSRIP Funds). Categories 1-4 will each be increased proportionately. However, any funds in excess of the 10 percent maximum for Category 4 will be allocated to Category 3. A performer may need to increase a DSRIP project's MLIU QPI goal for DY6A and beyond in order to obtain the increased value. Performers eligible for this option must make this choice by a date to be determined by HHSC.

(b) The DY5 IGT process, payment calculations, and monitoring IGT are continued in the extension period. IGT entities from DY5 will continue to provide funding for the extension period unless a performer submits changes during the reporting period. No new certifications (RHP Plan Section VI) are required for continuing RHP participants.

(c) If a performer participated in Category 4 in DY5, the performer will continue to participate in Category 4 in DY6A. The performer's Category 4 value for DY6A will be equal to the performer's Category 4 value for DY5, unless the performer's DY5 Category 4 value is greater than 10 percent of the performer's total DY5 value. In such a situation, the performer's DY6A Category 4 value will be reduced to 10 percent of the performer's total DY5 value, and the funds above the 10 percent threshold will be allocated to Category 3 in DY6A.

(d) The following Category 1 and 2 requirements must be met in DY6A:

(1) Each DSRIP project must have the following four milestones:

(A) a total Quantifiable Patient Impact (QPI) milestone valued at 25 percent of each DSRIP project's Category 1 or 2 value;

(B) a Medicaid and Low-income or Uninsured (MLIU) QPI milestone valued at 25 percent of each DSRIP project's Category 1 or 2 value;

(C) a core component reporting milestone valued at 25 percent of each DSRIP project's Category 1 or 2 value; and

(D) a sustainability planning milestone valued at 25 percent of each DSRIP project's Category 1 or 2 value.

(2) Total Quantitative Patient Impact (QPI) Milestone.

(A) HHSC will convert each total QPI metric to a total QPI milestone with standardized language. However, if a DSRIP project has multiple QPI metrics in DY5, that project may be exempted from this conversion, based on criteria determined by HHSC and CMS.

(B) The total QPI goal is equal to the DY5 total QPI goal.

(i) Certain DSRIP projects are eligible for an adjustment to the total QPI goal. These DSRIP projects include projects for which the provider reported 66 percent achievement or less of their DY4 total QPI metric as of April DY5 reporting, and for which:

(I) the value per MLIU individual is less than or equal to \$1,000; or

(II) the value per MLIU encounter is less than or equal to \$500.

(ii) Performers of a DSRIP project described in clause (i) of this subparagraph may, by a date determined by HHSC in a form determined by HHSC, request an adjustment to the DSRIP project's total QPI goal.

(C) DSRIP projects must retain the same QPI grouping from the initial demonstration period for total QPI.

(D) DSRIP projects must retain the same pre-DSRIP baseline for total QPI from the initial demonstration period. If multiple metrics are combined to form one total QPI milestone, the pre-DSRIP baselines will also be combined.

(E) DSRIP projects may carry forward total QPI milestones from DY6A to DY6B and DY7.

(3) MLIU QPI Milestone.

(A) Beginning in DY6A, there is an MLIU QPI milestone.

(B) For DSRIP projects that have an MLIU QPI requirement in DY5:

(i) The MLIU QPI goal is equal to the DY5 MLIU QPI goal. If, based on a determination pursuant to paragraph (2)(B) of this subsection, the total QPI goal is changed, the MLIU QPI goal will also be changed in proportion to the total QPI goal.

(ii) If the DSRIP project has an MLIU QPI metric in DY5, it retains the same pre-DSRIP baseline for MLIU QPI used in the initial demonstration period.

(iii) If the DSRIP project does not have an MLIU QPI metric in DY5, the pre-DSRIP baseline for MLIU QPI is equal to the pre-DSRIP baseline for total QPI multiplied by the earliest MLIU percentage goal on record with HHSC.

(iv) The MLIU QPI milestone must be pay-for-performance (P4P).

(C) For DSRIP projects that do not have an MLIU QPI requirement in DY5:

(i) The MLIU QPI goal is equal to the DY5 MLIU percentage goal multiplied by the DY5 total QPI goal, or as indicated in the DY5 goal language. If, based on a determination pursuant to paragraph (2)(B) of this subsection, the total QPI goal is changed, the MLIU QPI goal will also be changed in proportion to the total QPI goal.

(ii) The pre-DSRIP baseline for MLIU QPI is equal to the pre-DSRIP baseline for total QPI multiplied by the earliest MLIU percentage goal on record with HHSC.

(iii) Although all DSRIP projects must include an MLIU QPI goal, DSRIP projects under this subparagraph, with the exception of projects subject to clause (iv) of this subparagraph, must include an MLIU QPI milestone that is pay-for-reporting (P4R). This means that the performer is eligible to receive payment for the project's MLIU QPI milestone by reporting their actual MLIU QPI achievement, regardless of whether the performer achieved the MLIU QPI goal.

(iv) HHSC may determine that some of these DSRIP projects must include an MLIU QPI milestone that is P4P, meaning that the performer must demonstrate achievement of the project's MLIU QPI goal in order to receive payment for the MLIU QPI milestone.

(I) These DSRIP projects include the following:

(-a-) all Project Area 1.9 DSRIP projects, as described by the RHP Planning Protocol;

(-b-) DSRIP projects that did not achieve the estimated MLIU percentage in DY3, DY4, or DY5, and that caused them to have a higher than expected value per MLIU individual/ encounter;

(-c-) DSRIP projects for which HHSC notified the performer that the project was eligible to continue with changes, but the project's MLIU QPI milestone must be P4P; and

(-d-) DSRIP projects that included an MLIU goal in their QPI metric Baseline/Goal statement (an embedded goal) of the performer's own choosing or that were required to include MLIU to receive CMS initial DSRIP project approval.

(II) A performer of a DSRIP project with an MLIU QPI milestone that is P4P under this section may request to adjust the pre-DSRIP baseline for MLIU QPI by a date determined by HHSC in a form determined by HHSC. HHSC will consider requests to adjust the pre-DSRIP baseline for MLIU QPI and may approve those requests with a strong justification.

(D) Certain DSRIP projects are eligible for an adjustment to the MLIU QPI goal. These DSRIP projects include:

(i) a DSRIP project that HHSC identifies as underperforming on MLIU QPI estimates in the initial demonstration period;

(ii) a DSRIP project that is reporting on individuals or encounters that meet the MLIU definition for the initial demonstration period, but will not meet the MLIU definition for the extension period; and

(iii) any other DSRIP project that HHSC determines has a strong justification for an adjustment.

(E) Performers of a DSRIP project described in subparagraph (D) of this paragraph may, by a date to be determined by HHSC, request an adjustment to the DSRIP project's MLIU QPI goal.

(F) DSRIP projects must retain the same total QPI grouping from the initial demonstration period for MLIU QPI.

(G) DSRIP projects may carry forward MLIU QPI milestones from DY6A to DY6B and DY7.

(H) If a DSRIP project's DY6A MLIU QPI milestone is P4R, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

(i) achieved or forfeited a DSRIP project's DY5 QPI metric; and

(ii) provided at least one encounter or served at least one individual toward the DSRIP project's DY6A MLIU QPI milestone goal.

(I) If a DSRIP project's DY6A MLIU QPI milestone is P4P, and the project does not have a DY5 MLIU-specific QPI metric, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

(i) achieved or forfeited a DSRIP project's DY5 QPI metric; and

(ii) achieved the DSRIP project's DY6A MLIU QPI milestone goal.

(J) If a DSRIP project's DY6A MLIU QPI milestone is P4P, and the project has a DY5 MLIU-specific QPI metric, the performer is eligible to report on, and receive payment for, the DY6A MLIU QPI milestone once the performer has done the following:

(i) achieved or forfeited the DSRIP project's DY5 MLIU-specific QPI metric; and

(ii) achieved the DSRIP project's DY6A MLIU QPI milestone goal.

(K) A performer may only begin to count individuals served or encounters provided toward a DSRIP project's DY6A MLIU QPI milestone goal after the performer has achieved or forfeited a DY5 QPI metric or a DY5 MLIU-specific QPI metric.

(L) A performer is only eligible to report on, and receive payment for, a DSRIP project's DY6A MLIU QPI milestone during DY6A or the DY6A carry forward period.

(4) Non-QPI Milestones.

(A) DSRIP projects must include the following non-QPI milestones:

(i) project summary and core components, which may include continuous quality improvement (CQI); and

(ii) sustainability planning, which may include activities toward furthering the exchange of health information, integration into managed care, collaboration with other community partners, or a project level-evaluation.

(B) Performers must attend at least one learning collaborative, stakeholder forum, or other stakeholder meeting during DY6A and report on their activities for these milestones in order to be eligible for milestone payment.

(C) DSRIP projects may report on DY6A non-QPI milestones only during the second reporting period of DY6A.

(D) DSRIP projects may not carry forward non-QPI milestones from DY6A to DY6B or DY7.

(e) The following Category 3 requirements must be met in DY6A:

(1) The Category 3 outcome values are equal to the Category 3 outcome values for DY5. However, if a performer's Category 4 value is greater than 10 percent of the performer's total value, the Category 4 funds in excess of the 10 percent will be redistributed to the performer's Category 3 outcomes proportionately.

(2) If a Category 3 outcome has multiple parts, the Category 3 outcome's value is equally divided among the parts.

(3) Each Category 3 outcome is designated as pay-for-performance (P4P), pay-for-reporting (P4R), or maintenance. The direction of an outcome (positive or negative) necessary to demonstrate improvement is described in the Category 3 Compendium. An outcome designated as maintenance was high performing at baseline with no

reasonable room for improvement and was approved to use a milestone structure for DYs 3-5 that includes an alternate improvement activity.

(4) If a Category 3 outcome is designated as pay-for-performance (P4P) in DY5, 100 percent of the Category 3 outcome's value is P4P.

(5) If a Category 3 outcome is designated as pay-for-reporting (P4R) or maintenance with a population focused priority measure (PFPM) in DY5, 100 percent of the Category 3 outcome's value is P4P of the PFPM.

(6) If a Category 3 outcome is designated as P4R with an associated stretch activity in DY5, the performer must choose one of the following options by a date determined by HHSC in a form determined by HHSC:

(A) Maintain the Category 3 outcome designated as P4R from DY5 and select a new stretch activity that does not duplicate the DY5 stretch activity.

(i) The performer must select a new stretch activity from the following:

(I) program evaluation (alternate approaches to program and outcome linkages);

(II) new participation in health information exchange (HIE) or improvement of existing HIE infrastructure; or

(III) cost analysis and value-based purchasing planning.

(ii) Under this option, 50 percent of the Category 3 outcome's value is P4R of the Category 3 outcome and 50 percent is for completion of the stretch activity.

(B) Select a PFPM. Under this option, 100 percent of the Category 3 outcome's value is P4P of the selected PFPM.

(7) If a Category 3 outcome is designated as maintenance with an associated stretch activity in DY5, 100 percent of the Category 3 outcome's value is for statistically significant maintenance of the baseline.

(8) If a Category 3 outcome is designated as P4P in DY5, performance year (PY) 3 is the 12-month period immediately following the PY2 approved for use in DYs 3-5, or a performer may request, by a date to be determined by HHSC, to use DY6A as PY3. PY4 is the 12-month period immediately following PY3.

(9) If a Category 3 outcome is designated as P4R in DY5, PY3 is the 12-month period immediately following the PY2 approved for use in DYs 3-5.

(10) If a Category 3 outcome is designated as P4P in DY5, the outcome's goal is set as an improvement over the baseline from DYs 3-5 to be achieved in PY3, or PY4 if not fully achieved in PY3.

(A) One of the following methodologies is used to set the outcome's goal, as described in the RHP Planning Protocol:

(i) Quality Improvement System for Managed Care (QISMC);

(ii) Improvement over self (IOS); or

(iii) IOS - Survey.

(B) If an outcome is designated as QISMC in DY5, the outcome's PY3 goal is calculated as follows, using the baseline, minimum performance level (MPL), and high performance level (HPL) that were used for goal setting in DYs 3-5:

Figure: 1 TAC §354.1667(e)(10)(B)

(C) If an outcome is designated as IOS in DY5, the outcome's PY3 goal is a 12.5 percent gap closure towards perfect over the baseline.

(D) If an outcome is a P4P survey-based outcome in outcome domain 10 or 11 as defined in the RHP Planning Protocol, and is designated as IOS-survey in DY5, the outcome's PY3 goal is calculated as follows, using the reporting scenario approved for goal setting in DY5:

Figure: 1 TAC §354.1667(e)(10)(D)

(E) If an outcome has an HHSC approved alternate achievement request in DY5, the performer must submit to HHSC, by a date determined by HHSC in a form determined by HHSC, a request to use a PY3 goal that is a continuation of the goals approved in DYs 4-5. Such requests will be approved by HHSC on a case-by-case basis.

(F) If an outcome is designated as QISMC in DY5, with a baseline that is below the MPL, and the performer is measuring a population substantially dissimilar from the population used to establish the MPL benchmark, the performer may submit, by a date determined by HHSC in a form determined by HHSC, an alternate achievement request to set the PY3 goal as a 12.5 percent gap closure towards perfect over the baseline.

(11) Partial payment for a Category 3 P4P outcome is available in quartiles as defined in the RHP Planning Protocol, measured between the outcome's PY1 goal and PY3 goal.

(A) Each Category 3 P4P outcome has an associated achievement milestone that is assigned an achievement value based on the performer's achievement of the outcome's goal as follows:

(i) if 100 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 1.0;

(ii) if at least 75 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.75;

(iii) if at least 50 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.5;

(iv) if at least 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.25; or

(v) if less than 25 percent of the goal is achieved, the achievement milestone is assigned an achievement value of 0.

(B) The percent of the goal achieved is determined as follows:

Figure: 1 TAC §354.1667(e)(11)(B)

(i) If an outcome is approved to use a baseline established in DY4, partial payment will be measured over a PY1 equivalent goal. The PY1 equivalent goal will follow the QISMC or IOS goal calculations for PY1 as approved in the RHP Planning Protocol.

(ii) If a QISMC outcome has a PY3 goal that was determined using the improvement floor, partial payment will be measured over the PY1 equivalent goal. If a higher rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus 40 percent of the improvement floor. If a lower rate indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus 40 percent of the improvement floor.

(iii) If an IOS - Survey outcome is approved to use goal setting Scenario 2 or Scenario 3, partial payment will be measured over a PY1 equivalent goal. The PY1 equivalent goal will follow the IOS goal calculations for PY1 as approved in the RHP Planning Protocol.

(12) Performers may carry forward Category 3 milestones from DY6A to DY6B and DY7.

(f) The following Category 4 requirements must be met in DY6A:

(1) Requirements for Category 4 are the same as the requirements for Category 4 Reporting Domains (RDs) 1-5 in DY5.

(2) If a performer's Category 4 value is greater than 10 percent of the performer's total value, the funds in excess of the 10 percent will be redistributed to Category 3.

(3) The optional RD6 will be removed as it was required to value Category 4 at the 15 percent maximum in DYs 3-5.

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605137

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Texas Health and Human Services Commission

Effective date: October 30, 2016

Proposal publication date: July 29, 2016

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## CHAPTER 355. REIMBURSEMENT RATES SUBCHAPTER E. COMMUNITY CARE FOR AGED AND DISABLED

### 1 TAC §355.501

The Texas Health and Human Services Commission (HHSC) adopts amendments to §355.501, concerning Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE), with changes to the proposed text as published in the July 22, 2016, issue of the *Texas Register* (41 TexReg 5298). The text of the rule will be republished.

#### BACKGROUND AND JUSTIFICATION

Federal law (42 U.S.C. §1396u-4) permits a state to operate a PACE program to provide comprehensive health care services to eligible individuals; providers are to be paid a capitated amount that is "less than the amount" the State would otherwise have paid under Medicaid "if the individuals were not" PACE-enrollees. Texas has elected to operate PACE since 2003.

The purpose of the amendments is three-fold. First, the amendments align the rule with the shift from a fee-for-service payment system to a managed care payment system. The amendments thus adjust the underlying methodology and the data sources for determining PACE reimbursement. Second, the amendments reflect the termination of the Community-Based Alternatives (CBA) 1915(c) waiver. And third, the amendments implement Texas Human Resources Code §§32.0532 - 32.0534, adopted by House Bill 3823, 84th Legislature, Regular Session, 2015, which outline new requirements for reimbursement methodology. On the whole, the statutes link PACE reimbursement rates to those of the STAR+PLUS Medicaid program, modify the methods for collecting PACE and STAR+PLUS Medicaid

program data, and require a comparison of PACE costs and care outcomes to STAR+PLUS Medicaid costs and outcomes.

#### COMMENTS

The 30-day comment period ended August 22, 2016. During this period, HHSC did not receive any comments regarding the amended rule.

HHSC revised subsection (c)(4) of the rule to correctly cross reference paragraph (3)(B) of subsection (c).

#### STATUTORY AUTHORITY

The amendment is adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements. The amended rules implement Texas Human Resources Code §§32.0532 - 32.0534.

§355.501. *Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE).*

(a) General specifications. The Texas Health and Human Services Commission (HHSC) determines the upper payment limits and reimbursement rates for each PACE contractor. HHSC applies the general principles of cost determination as specified in §355.101 of this title (relating to Introduction).

(b) Frequency of reimbursement determination. The upper payment limits and reimbursement rates are determined coincident with the state's biennium.

(c) Upper payment limit determination. There are three upper payment limits calculated for each PACE contract: one for clients eligible only for Medicaid services (Medicaid-only clients), one for clients eligible for both Medicare and Medicaid services (dual-eligible clients), and one for clients eligible for only Medicare services as Qualified Medicare Beneficiaries (QMBs). An average monthly historical cost per client receiving nursing facility services and Home and Community Based Services (HCBS) under either the fee-for-service payment system or the managed care program is calculated for the counties served by each PACE contract for the upper payment limits for Medicaid-only clients and for dual-eligible clients.

(1) The upper payment limits for Medicaid-only and for dual-eligible clients for the biennium are calculated for the base period using historical claims and encounter data and member-month data from the most recent state fiscal year of complete claims available prior to the state's biennium.

(2) The historical costs are derived from claims data for clients age 55 and older receiving nursing facility services or HCBS in the counties served by each PACE contract.

(3) The historical costs include:

- (A) acute care services, including inpatient, outpatient, professional, and other acute care services;
- (B) prescriptions;
- (C) medical transportation;
- (D) nursing facility services;
- (E) hospice services;

(F) long-term care specialized services, such as physical therapy, occupational therapy, and speech therapy;

(G) HCBS;

(H) Primary Home Care (including Family Care) services; and

(I) Day Activity and Health Services.

(4) Effective on and after January 1, 2006, the historical prescription costs from paragraph (3)(B) of this subsection that are used in the calculation of the upper payment limit, and as such the associated payment rate, for dual-eligible clients for each PACE contract will exclude the costs of any drug that is in a category covered by Medicare Part D.

(5) To determine an average monthly historical cost for the counties served by each PACE contract, the total historical claims data for the counties served by each PACE contract are divided by the number of member months for the counties served by each PACE contract.

(6) An adjustment for administrative costs is added to the average monthly historical cost per client. The per member month amount is added for:

(A) processing claims, based on the state's cost to process claims under the managed care payment system; and

(B) case management, based on the state's cost to provide case management under the managed care payment system for HCBS clients.

(7) The sum of the average monthly historical cost per client for each PACE contract and the amounts from paragraph (5) of this subsection are projected from the claims data base period identified in paragraph (1) of this subsection to the rate period to account for anticipated changes in costs for each PACE contract. The methodology used for trending historical costs for calculating PACE Upper Payment Limits (UPLs) and rates is comparable to that used for trending costs in the managed care program.

(8) The PACE Upper Payment Limit (UPL) method may be adjusted to account for statistical outliers, small populations, programmatic changes, catastrophic events, or other economic changes, as determined by HHSC to be actuarially appropriate. Data from sources other than those described in paragraphs (1) and (2) of this subsection may be used, if deemed by HHSC necessary to calculate an appropriate UPL. For example, HHSC may consider comparable data from other time periods.

(d) HHSC determines the UPL for Qualified Medicaid Beneficiaries (QMBs) on a statewide basis using the average cost incurred by Medicaid for Medicare co-insurance and deductibles.

(e) Payment rate determination. HHSC calculates three reimbursement rates for each PACE contract: one for clients eligible for Medicaid services (Medicaid Only rate), one for clients eligible for both Medicare and Medicaid services (Dual Eligible rate), and one for clients eligible for only Medicare services as QMBs. The payment rates for the three client categories for each PACE contract are determined by multiplying the UPLs calculated for each PACE contract by a factor less than 1.0. HHSC may reduce the factor as necessary to establish a rate consistent with available funds.

(1) In setting the reimbursement rates under the PACE program, HHSC complies with Texas Human Resources Code §32.0532(b).

(2) The PACE payment rate is less than the amount that would otherwise have been paid under the Texas State Plan if the participants were not enrolled under the PACE program.

(f) Reporting of cost. HHSC may require the PACE contractor to submit financial and statistical information on a cost report or in a survey format designated by HHSC. Cost report completion is governed by the requirements specified in Subchapter A of this chapter (relating to Cost Determination Process). HHSC may also require the PACE contractor to submit audited financial statements.

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

Filed with the Office of the Secretary of State on October 7, 2016.

TRD-201605134

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Effective date: October 27, 2016

Proposal publication date: July 22, 2016

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## CHAPTER 363. TEXAS HEALTH STEPS COMPREHENSIVE CARE PROGRAM SUBCHAPTER B. PRESCRIBED PEDIATRIC EXTENDED CARE CENTER SERVICES

### **1 TAC §§363.201, 363.203, 363.205, 363.207, 363.209, 363.211, 363.213, 363.215**

The Texas Health and Human Service Commission (HHSC) adopts new Chapter 363, Subchapter B, concerning Prescribed Pediatric Extended Care Center Services. New §363.201, concerning Purpose, is adopted without changes to the proposed text as published in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5842) and will not be republished. New §363.203, concerning Definitions; §363.205, concerning Provider Participation Requirements; §363.207, concerning Participant Eligibility Criteria; §363.209, concerning Benefits and Limitations; §363.211, concerning Service Authorization; §363.213, concerning Ordering Physician Responsibilities; and §363.215, concerning Termination, Reduction, or Denial of Authorization for Prescribed Pediatric Extended Care Center Services are adopted with changes to the proposed text as published in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5842). The text of the rules will be republished.

#### BACKGROUND AND JUSTIFICATION

Senate Bill 492, 83rd Legislature, Regular Session, 2013, enacted Texas Health and Safety Code Chapter 248A to establish Prescribed Pediatric Extended Care Centers (PPECCs) in Texas and provide for their licensure; enacted Texas Human Resources Code §32.024(jj) to require HHSC to establish PPECCs as a separate Medicaid provider type; and, in an uncodified portion, limited the HHSC-established reimbursement rate to no more than 70 percent of the average hourly private duty nursing (PDN) rate. See Act of May 22, 2013, 83rd Leg., R.S., ch. 1168, §§1, 6, 8(c), 2013 Tex. Gen. Laws 2898.

In the next legislative session, the Texas Legislature adopted House Bill 2340, 84th Legislature, Regular Session, 2015, which enacted amendments to Texas Health and Safety Code Chapter 248A. While this bill primarily impacted licensure requirements, some amendments affected the Medicaid program. In particular, the bill clarified that parental accompaniment is not required for services rendered at a PPECC or for transportation to and from a PPECC, and clarified that PPECC services are intended to be a one-to-one replacement of authorized PDN hours unless additional hours are medically necessary. See Act of May 23, 2015, 84th Leg., R.S., ch. 557, §§8, 9, 2015 Tex. Gen. Laws 1943.

A PPECC provides non-residential, center-based care as an alternative to PDN for individuals under the age of 21 with complex medical needs. PPECC services, which include ongoing skilled nursing, personal care services, nutritional counseling, functional developmental services, responsible adult/caregiver training, and psychosocial services, will be made available in traditional fee-for-service Medicaid and Medicaid managed care.

PPECC services may be provided only to individuals who are medically dependent or technologically dependent. The term "medically dependent or technologically dependent" is defined as an individual who, because of an acute, chronic, or intermittent medically complex or fragile condition or disability, requires ongoing, technology-based skilled nursing care prescribed by the individual's physician to avert death or further disability or the routine use of a medical device to compensate for a deficit in a life-sustaining body function. The term does not, however, include minor or occasional medical conditions that do not require continuous nursing care. Services received in a PPECC must be prescribed by the individual's physician.

Receiving services in a PPECC setting does not supplant an individual's right to PDN services when they are determined medically necessary, but the PDN and PPECC services cannot be provided at exactly the same time (concurrently). Rather, PDN services may be rendered before and after PPECC services in the same day. Under the terms of its license, a PPECC may provide services to a participant for no more than 12 hours in a 24-hour period.

The provisions of the PPECC rate rule, §355.9080, were adopted to be effective January 1, 2016, (40 TexReg 8885).

#### COMMENTS

The 30-day comment period ended September 12, 2016. During this period, HHSC received comments regarding the new proposed rules from two commenters, the Texas Medical Association and Disability Rights Texas. A summary of comments relating to the rules and HHSC's responses follows.

Comment: A commenter questions whether there is a demand for PPECCs, given that Texas provides PDN and Personal Care Services to Texans younger than 21 years of age in their homes.

Response: HHSC declines to revise the rules in response to this comment. As we have discussed above, the Texas Legislature has directed HHSC to establish PPECCs as a separate provider type. See Tex. Hum. Res. Code §32.024(jj).

Comment: A commenter notes that the proposed rules use the term "client" rather than "individual" and suggests replacing the "outdated" term "client" with "individual" or "participant."

Response: HHSC concurs and has replaced references to "client" with "participant."

Comment: A commenter recommends that §363.203 be amended to define the terms "functional developmental services" and "educational developmental services," consistent with the terms' definitions in the PPECC licensure rules. See 40 Tex. Admin. Code §15.507, §15.508. The commenter urges HHSC to include these definitions to ensure that the PPECC "does not act as the primary education provider for a minor or accept a delegation of responsibility for the provision of a minor's education from an education provider." Without such definitions, the commenter is concerned that there will be confusion about "developmental" services and educational services the school is required to provide in the least restrictive setting.

Response: HHSC disagrees and declines to revise the rules based on this comment. Medicaid does not cover educational services in the PPECC benefit, and the federal Centers for Medicare and Medicaid (CMS) has directed HHSC to remove any references to educational services in the PPECC State Plan Amendment. Consistent with the Medicaid State Plan Amendment for PPECC, HHSC has no references to educational services in the PPECC rules.

The Medicaid covered functional developmental services are described in the Medicaid State Plan pages. Functional developmental services are provided in accordance with 42 CFR §440.130(d) and assist a recipient in maintaining or restoring functional abilities, such as adaptive, motor, and speech. Functional developmental services are provided by a Registered Nurse (RN) or Licensed Vocational Nurse (LVN) licensed under state authority or a direct care staff person under the supervision of an RN. Functional developmental services are based on the needs of the recipient, in accordance with the recipient's plan of care and physician order. Functional services respond to needs identified in a functional assessment.

Comment: A commenter is concerned that the rules--in particular §363.207(a)(6) and §363.213--exceed HHSC's authority. In the commenter's view, by requiring that a minor have a prescription for each authorization period that is "signed and dated by the ordering physician who has personally examined the within 30 days prior to admission and reviewed all appropriate medical records," HHSC restricts a physician's ability to delegate tasks to other health care professionals, imposes an expiration date on a physician's diagnosis, and defines standard of care and valid prescriptions. The commenter recommends that the rules should rely more on established regulations for standards of care and the physician's judgment.

Response: HHSC disagrees and declines to revise the rules based on this comment. These rules are not beyond HHSC's authority to administer the Medicaid program and to determine limitations on covered Medicaid services. The Legislature has given HHSC ultimate authority over Texas Medicaid. Texas Gov't Code §531.0055(b). These rules impact only the operations of PPECCs as a medical assistance program insofar as the PPECCs provide services to Medicaid participants. In addition, the rules are consistent with legislative direction in Senate Bill 492 (2013) and House Bill 2340 (2015) and PPECC licensing regulations. See 40 Tex. Admin. Code ch. 15. Finally, the PPECC examination and prescription requirements (30 days before initial start of care) are similar to the existing PDN benefit, in keeping with the intention that PPECC services be a one-to-one replacement for PDN services.

Comment: A commenter suggests that the requirement in §363.207(a)(6) directing that the physician's personal examination of the occur within 30 days prior to admission to the

PPECC will create "the possibility of needless visits or other additional services." The commenter continues, "Physicians and families alike would not want go through an additional visit, for example, if the physician had recently seen a patient, just so the physician can be within the proposed rules' required 30-day window." The commenter thus recommends that HHSC amend these proposed rules to state only that the physician be subject to already existing standards of care, including the Texas Medical Board's regulations, the physician's professional judgment, or best practices advocated by physician specialty societies. In the commenter's view, this ensures that HHSC's rules are legally sound and also will not create unnecessary administrative burdens on families or on physicians.

Response: HHSC disagrees and declines to revise the rules based on this comment. The physical examination requirement (30 days before the start of care) ensures a current diagnosis and prescription for authorization purposes. Additionally, the requirement is similar to the examination requirement for PDN, in keeping with the intention that PPECC services be a one-to-one replacement for PDN services. HHSC also disagrees that the rule will necessitate needless visits to a physician's office to the extent the commenter suggests. After the initial start of care, a physical examination is required by rule once a year. A physician's signature on a plan of care will continue to suffice as a physician order. These requirements also are similar to the PDN requirements.

Comment: A commenter urges HHSC to maintain the language in §363.207(c) that admissions are voluntary, based on the individual's, or the individual's responsible adult's choice for PPECC services.

Response: HHSC concurs and will maintain the proposed rule text.

Comment: A commenter agrees with §363.209(a)(2), which requires PPECCs to provide transportation between the individual's residence and the PPECC when there is a stated need or prescription for such transportation, an RN or LVN is on board and parents are not required to accompany the individual.

Response: HHSC will maintain this requirement in the adopted PPECC rules.

Comment: A commenter requests that HHSC insert the word "integrated" between the words "most" and "appropriate" in §363.209(a)(3)(B)(ii) so that it reads "providing cost-effective quality care in the most integrated, appropriate environment."

Response: HHSC disagrees and declines to revise the rule based on this comment. HHSC believes the current language in §363.209(a)(3)(B)--"promoting and supporting family-centered, community-based care as a component of an array of service options"--coupled with an emphasis on participant choice throughout the rules, captures the intent of an integrated environment.

Comment: A commenter indicates that, in the commenter's view, §363.209(c)(3) is "overreaching" the legislative direction, which the commenter suggests did not indicate that PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary. While the commenter agrees that PDN and PPECC cannot be billed at the same time, the commenter does not understand how HHSC will operationalize the requirement.

Response: HHSC disagrees and declines to revise the rule based on this comment. The one-to-one replacement reference

aligns with the plain language of Texas Health and Safety Code §248A.158: "Nursing services provided by a [PPECC] must be a one-to-one replacement of private duty nursing or other skilled nursing services unless additional nursing services are medically necessary." PPECC and PDN cannot be billed simultaneously, as Medicaid does not allow for duplication of services. The PDN can occur in the same day before or after PPECC, but not at the same time. A participant is approved for a specific number of ongoing skilled nursing hours (e.g., currently through PDN). The total number of authorized hours (between PDN and PPECC) are not expected to increase with PPECC services unless the participant's medical condition changes or the approved hours are not commensurate with the participant's needs. When a participant chooses PPECC, the approved hours are shifted from PDN to the PPECC, but the total number of skilled nursing hours authorized would not be impacted. For example, if a participant currently has ten hours of approved PDN a day, and chooses to have six hours a day in a PPECC, six hours would shift to the PPECC and the PDN would retain four hours. For PPECC authorizations, HHSC or its contractors will look at both the current PDN authorization, where applicable, and the PPECC authorization request.

Comment: A commenter suggests that the text of §363.211(g)(5) be modified to be more specific about services other than private duty nursing that might be reduced as a result of accepting PPECC services. In the commenter's view, if the rule is referring to PDN, home health skilled nursing, home health aide services, or any therapies that are medically necessary, the rule could be misleading or inaccurate when the service is medically necessary outside the hours in which PPECC is provided.

Response: HHSC disagrees and declines to revise the rule based on this comment. HHSC believes the rule is sufficiently clear. Services that may be impacted include PDN, personal care services, and home health aide and skilled nursing. Therapies would not be impacted. Approved service hours for PDN, personal care services, and home health aide or skilled nursing would be reduced only in an effort to avoid duplication, as the participant shifts these service hours from the home to the PPECC. To clarify, the total number of hours will not be reduced for these services, as the services are based on a medical necessity.

Comment: A commenter asks who will be trained to and responsible for sharing information about the hours of services provided in a non-PPECC setting that may be reduced before a responsible adult signs the acknowledgement required by the text of §363.211(g)(5).

Response: HHSC does not interpret this comment as a request to modify the rule. In large part, HHSC believes that the providers serving the families and participants will provide this information to them. Medicaid managed care organizations (MCOs) also have contractual obligations to conduct service coordination or service management and inform participants of their service options. MCOs are subject to the PPECC rules.

Comment: Regarding §363.213, concerning Ordering Physician Responsibilities, a commenter is concerned that about situations in which a PPECC-ordering physician gains financially from ordering a child to receive PPECC services. The commenter requests that the rule expressly prevent such a conflict of interest by prohibiting a physician with an employment or contractual relationship with the PPECC from being the ordering physician.

Response: HHSC disagrees and declines to revise the rule based on this comment. Due to the scarcity of certain medical specialists who treat conditions and rare diseases, it is possible for such a specialist to be involved with a PPECC. HHSC does not wish to prevent an individual from receiving either PPECC services or specialty treatment from the individual's provider of choice. However, HHSC acknowledges the concern and will monitor for conflict of interest, and HHSC will take action as necessary if there is a systemic problem.

In addition to the amendments to the proposed rules stated in the responses to comments, HHSC made the following revisions primarily to align the rules with the PPECC state plan amendment, PPECC medical policy and to ensure consistency between fee-for-service Medicaid and Medicaid managed care.

§363.207, Participant Eligibility Criteria: A minor editorial change was made to paragraph (a)(7) to clarify the rule without substantively changing the requirements.

§363.209, Benefits and Limitations: A minor editorial change was made to clause (a)(1)(C)(iii) to clarify the rule without substantively changing the requirements. In addition, HHSC added paragraph (a)(5), related to daily documentation in the 's medical record of the specific person providing services, the type of services performed, and the start and end times of services performed. This language has been added to be consistent with language the federal Centers for Medicare and Medicaid (CMS) has required HHSC to add to the Medicaid State Plan Amendment for PPECC. Finally, HHSC clarified subparagraph (b)(2)(A) related to re-evaluations to include when "authorized services are not commensurate with the 's medical needs and additional authorized hours are medically necessary." This ensures consistent application across fee-for-service and Medicaid managed care.

§363.211, Service Authorizations: HHSC clarified in paragraph (g)(1) that the physician signature on the PPECC plan of care serves as a physician order for authorization purposes. This ensures consistent application between fee-for-service and Medicaid managed care. HHSC clarified that both recertifications, in subsection (h), and revisions, in subsection (i), require the same documentation as an initial authorization. This consolidates the requirements in subsection (g) and minimizes repetition in the rule. To ensure consistent application across fee-for-service Medicaid and Medicaid managed care, HHSC also removed from paragraph (g)(4), (h)(4), and (i)(2) the RN assessment from the list of documents required for an initial, revision, or recertification authorization request, respectively. HHSC further added a new subsection (m) without substantively changing the requirements related to nursing assessments. A nursing assessment is required before initiating services, recertification, and when changes in the 's condition impacts the amount and duration of services (e.g., revisions). A nursing assessment must be performed in these circumstances, but is not required documentation for authorization purposes.

§363.213, Ordering Physician Responsibilities: HHSC revised paragraphs (b)(6) and (7) to clarify text that appeared vague on further review. Specifically, HHSC revised paragraph (b)(6) from the physician "providing a statement" to "affirming in writing" that PPECC services are medically necessary. Similarly, HHSC revised paragraph (b)(7) from "providing a statement" to "affirming in writing" that a "participant's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the plan of care." Note that these acknowledgements are built into state-developed Medicaid fee-for-service authorization forms for PPECCs. Managed care organizations may use

these forms or develop their own if the MCO-developed forms contain similar elements.

## STATUTORY AUTHORITY

The new rules are adopted under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Human Resources Code §32.024(jj), which requires HHSC to establish PPECCs as a separate provider type in the Medicaid program.

### §363.203. Definitions.

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

(1) Activities of daily living (ADLs)--Activities that include eating, toileting, personal hygiene, dressing, bathing, transferring, positioning, and locomotion or mobility.

(2) Basic services--Basic services include:

(A) the development, implementation, and monitoring of a comprehensive protocol of care that:

(i) is provided to a medically dependent or technologically dependent participant;

(ii) is developed in conjunction with the participant's responsible adult; and

(iii) specifies the medical, nursing, psychosocial, therapeutic, and developmental services required by the participant; and

(B) the caregiver training needs of a medically dependent or technologically dependent participant's parent or responsible adult.

(3) Correct or ameliorate--To improve, maintain, or slow the deterioration of the participant's health status.

(4) Fair hearing--The process HHSC has adopted and implemented in Chapter 357, Subchapter A, of this title (relating to Uniform Fair Hearing Rules) in compliance with federal and state regulations governing Medicaid Fair Hearings.

(5) HHSC--The Texas Health and Human Services Commission or its designee, including a contractor or MCO. HHSC is the single state agency charged with administration and oversight of the Texas Medicaid program. HHSC's authority is established in Texas Government Code Chapter 531.

(6) Licensed Vocational Nurse (LVN)--A person licensed by the Texas Board of Nursing to practice vocational nursing in Texas at the time and place the service is provided, in accordance with Texas Occupations Code Chapter 301.

(7) Medicaid Managed Care Organization (MCO)--Any entity with which HHSC contracts to provide Medicaid services and that complies with Chapter 353 of this title (relating to Medicaid Managed Care).

(8) Medically or technologically dependent participant--

(A) An individual 20 years of age or younger:

(i) who has an acute or chronic medically complex or fragile condition or disability; and

(ii) whose condition or disability, as stated in clause (i) of this subparagraph, requires:

(I) ongoing skilled nursing care beyond the level of skilled nursing visits normally authorized under Texas Medicaid home health skilled nursing and health aide services, prescribed by a physician to avert death or further disability; or

(II) the routine use of a medical device to compensate for a deficit in a life-sustaining bodily function.

(B) The term does not include a participant with a controlled or occasional medical condition that does not require ongoing nursing care.

(9) Notice (or notification)--A letter provided by HHSC or an MCO to a participant informing the participant of any reduction, denial, or termination of a requested service, as described in the Code of Federal Regulations, Title 42, §§431.206 and 431.210.

(10) Ordering physician--A doctor of medicine or doctor of osteopathy (M.D. or D.O.), legally authorized to practice medicine or osteopathy at the time and place the service is provided, who provides ongoing medical care for the participant and continuing medical supervision of the participant's plan of care.

(11) Participant--An individual who is eligible to receive PPECC services under Texas Health Steps Comprehensive Care Program (THSteps-CCP) from a provider enrolled in the Texas Medicaid program.

(12) Plan of care--A comprehensive, interdisciplinary protocol of care that includes the physician's order for needed services, nursing care plan, and protocols establishing delegated tasks, plans to address functional developmental needs, plans to address psychosocial needs, personal care services for assistance with activities of daily living, and therapeutic service needs required by a participant and family served.

(13) Prescribed Pediatric Extended Care Center (PPECC)--A center operated on a for-profit or nonprofit basis that provides non-residential basic services to four or more medically dependent or technologically dependent participants who require the services of the center and who are not related by blood, marriage, or adoption to the owner or operator of the center.

(14) Private Duty Nursing (PDN)--Nursing, as described by Texas Occupations Code Chapter 301, and its implementing regulations at 22 TAC Part 11 (relating to the Texas Board of Nursing), that provides a participant with more individual and ongoing care than is available from a visiting nurse or than is routinely provided by the nursing staff of a hospital or skilled nursing facility. PDN services include observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings for a participant who has a disability or chronic health condition or who is experiencing a change in normal health processes.

(15) Registered Nurse (RN)--A person who is licensed by the Texas Board of Nursing to practice professional nursing in Texas at the time and place the service is provided, in accordance with Texas Occupations Code Chapter 301.

(16) Respite--Services provided to relieve a participant's primary care giver.

(17) Responsible adult--An adult, as defined by Texas Family Code §101.003, who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for a participant. Responsible adults include biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage. If the participant is 18 years of age or older, the responsible adult must be the participant's managing conservator or legal guardian.

(18) Skilled nursing--Services provided by a registered nurse or by a licensed vocational nurse, as authorized by Texas Occupations Code Chapter 301 and 22 TAC §217.11 (relating to Standards of Nursing Practice) and §217.12 (relating to Unprofessional Conduct).

(19) Stable--Status determined by the participant's ordering physician that the participant's health condition does not prohibit utilizing transportation to access outpatient medical services and does not present significant risk to other participants or personnel at the center, as defined at 40 TAC §15.601 (relating to Admission Criteria). The participant must be able to use transportation services offered by the PPECC with the assistance of a PPECC nurse to and from the PPECC, whether or not the participant uses the PPECC's transportation service.

(20) Texas Health Steps Comprehensive Care Program (THSteps-CCP)--A federal program, required by Medicaid and known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), for children under 21 years of age who meet certain criteria for eligibility. Services are defined in the United States Code, Title 42, §1396d(r), and the Code of Federal Regulations, Title 42, §440.40(b).

§363.205. *Provider Participation Requirements.*

(a) A PPECC service provider must be independently enrolled in the Texas Medicaid program to be eligible to receive Medicaid reimbursement for providing PPECC services through THSteps-CCP.

(b) To participate in THSteps-CCP, a PPECC service provider must:

(1) be currently licensed under and comply with 40 TAC Chapter 15 (relating to Licensing Standards for Prescribed Pediatric Extended Care Centers);

(2) be enrolled and approved for participation in the Texas Medicaid program;

(3) agree to provide services in compliance with all applicable federal, state, and local laws and regulations, including Texas Occupations Code Chapter 301;

(4) comply with the terms of the Texas Medicaid Provider Agreement;

(5) comply with all state and federal regulations and rules relating to the Texas Medicaid program;

(6) comply with the requirements of the Texas Medicaid Provider Procedures Manual, including all published updates and revisions and all handbooks, standards, and guidelines published by HHSC or an MCO with which they contract;

(7) comply with accepted professional standards and principles of nursing practice;

(8) comply with Texas Family Code Chapter 261, and Texas Health and Safety Code Chapter 260A, concerning mandatory reporting of suspected abuse or neglect of children and adults with disabilities; and

(9) maintain written policies and procedures for obtaining consent for medical treatment for participants in the absence of the responsible adult that meet the standards of Texas Family Code §32.001.

§363.207. *Participant Eligibility Criteria.*

(a) All requests for PPECC services must be based on the current medical needs of a participant who meets the following admission criteria for a PPECC:

(1) is eligible for THSteps-CCP;

(2) is age 20 or younger;

(3) requires ongoing skilled nursing care and supervision and skilled observations, judgments, and therapeutic interventions all or part of the day to correct or ameliorate his or her health status, such that delayed skilled intervention is expected to result in:

- (A) deterioration of a chronic condition;
- (B) loss of function;
- (C) imminent risk to health status due to medical fragility; or
- (D) risk of death;

(4) is considered to be a medically dependent or technologically dependent participant;

(5) is stable and eligible for outpatient medical services in accordance with 40 TAC §15.601 (relating to Admission Criteria);

(6) has a prescription for each authorization period for PPECC services signed and dated by the ordering physician who has examined the participant within 30 days prior to admission and reviewed all appropriate medical records;

(7) resides with the responsible adult and does not reside in a 24-hour inpatient facility, including a:

- (A) general acute hospital;
- (B) skilled nursing facility;
- (C) intermediate care facility; or
- (D) special care facility, including sub-acute units or facilities for the treatment of acquired immune deficiency syndrome; and

(8) has a consent to the participant's admission to the PPECC signed and dated by the participant or by the participant's responsible adult.

(b) THSteps-CCP participants are eligible for all medically necessary PPECC services that are required to meet the participant's documented needs.

(c) Admission must be voluntary, based on the participant's, or the participant's responsible adult's choice for PPECC services.

(d) An authorized admission for PPECC services is not intended to supplant the right to a Medicaid PDN benefit, when medically necessary.

#### §363.209. *Benefits and Limitations.*

(a) Comprehensive plan of care; permissible PPECC services.

(1) The PPECC must develop, implement, and monitor a comprehensive plan of care that:

(A) is provided to a medically dependent or technologically dependent participant;

(B) is developed in collaboration with the participant's ordering physician, responsible adult, and interdisciplinary team, as well as the participant's existing service providers as needed to coordinate care;

(C) specifies the following prescribed services needed to address the medical, nursing, psychosocial, therapeutic, dietary, functional, and developmental needs of the participant and the training needs of the participant's responsible adult:

- (i) skilled nursing;
- (ii) personal care services to assist with activities of daily living while in the PPECC;

(iii) functional developmental services;

(iv) nutritional and dietary services, including nutritional counseling;

(v) occupational, physical and speech therapy;

(vi) respiratory care;

(vii) psychosocial services; and

(viii) training for the participant's responsible adult associated with caring for a medically or technologically dependent participant;

(D) specifies if transportation is needed;

(E) is reviewed and revised for each authorization of services per subsection (d) of this section or more frequently as the ordering physician deems necessary;

(F) is signed and dated by the participant's ordering physician;

(G) is signed and dated by the participant or the participant's responsible adult;

(H) meets additional requirements prescribed in 40 TAC §15.607 (relating to Initial and Updated Plan of Care); and

(I) meets requirements contained in the Texas Medicaid Provider Procedures Manual.

(2) Transportation Services.

(A) The PPECC must provide transportation between the participant's residence and the PPECC when a participant has a stated need or prescription for such transportation.

(B) When a PPECC provides transportation to a PPECC participant, an RN or LVN employed by the PPECC must be on board the transport vehicle.

(C) The PPECC must:

(i) sign, date, and indicate the time the participant is put on the transport vehicle to deliver the participant to the PPECC;

(ii) sign, date, and indicate the arrival time of the participant at the PPECC;

(iii) sign, date, and indicate the time the participant is put on the transport vehicle to return the participant to their place of residence; and

(iv) sign, date, and indicate the arrival time at the participant's residence.

(D) A responsible adult is not required to accompany a participant when the participant receives transportation services to and from the PPECC.

(E) A participant or participant's responsible adult may decline a PPECC's transportation and choose to be transported by other means.

(F) A non-emergency ambulance may not be used for transport to and from a PPECC.

(3) PPECC services, including training provided to the participant's responsible adult associated with caring for a medically or technologically dependent participant, must be provided by the PPECC with the following intended outcomes:

(A) optimizing the participant's health status and outcomes; and

(B) promoting and supporting family-centered, community-based care as a component of an array of service options by:

- (i) preventing prolonged or frequent hospitalizations or institutionalization;
- (ii) providing cost-effective, quality care in the most appropriate environment; and
- (iii) providing training and education of caregivers.

(4) The PPECC must provide written documentation about the participant's care each day to the participant's responsible adult, including documentation of medication given, services provided, and other relevant health-related information. The documentation must be provided each day following service delivery when the responsible adult picks up the participant or when the PPECC transports the participant to his or her residence.

(5) For each day that PPECC services are provided, the participant's medical record must identify the specific person (e.g., nursing, direct care staff, therapist) providing services, the type of services performed, and the start and end times of services performed. The PPECC must be able to calculate the cost by practitioner and type of service provided as requested by HHSC.

(b) Amount and duration.

(1) HHSC evaluates the amount and duration of PPECC services requested upon review of:

- (A) a physician order;
- (B) a PPECC plan of care;
- (C) a completed request for authorization, including all required documentation, as indicated in the Texas Medicaid Provider Procedures Manual; and
- (D) the full array of Medicaid services the participant is receiving at the time the plan of care is developed.

(2) HHSC re-evaluates the amount of PPECC services when:

(A) there is a change in the frequency of skilled nursing interventions, other PPECC medical services, or the complexity and intensity of the participant's care, or the authorized services are not commensurate with the 's medical needs and additional authorized hours are medically necessary;

(B) the participant or the participant's responsible adult chooses alternate resources for comparable care; or

(C) the responsible adult becomes available and is willing to provide appropriate care for the participant.

(c) PPECC service limitations.

(1) The Medicaid rate for PPECC services does not include the following PPECC services:

(A) services intended to provide mainly respite care or child care, or services not directly related to the participant's medical needs or disability;

(B) services that are the legal responsibility of a local school district, including transportation;

(C) services covered separately by Texas Medicaid, such as:

(i) speech therapy, occupational therapy, physical therapy, respiratory care practitioner services, and early childhood intervention services;

(ii) durable medical equipment (DME), medical supplies, and nutritional products provided to the participant by Medicaid's DME and medical supply service providers; and

(iii) private duty nursing, skilled nursing, and aide services provided in the home setting when medically needed in addition to the PPECC services authorized;

(D) baby food or formula;

(E) services to participants related to the PPECC owner by blood, marriage, or adoption;

(F) services rendered to a participant who does not meet the definition of a medically or technologically dependent participant; and

(G) individualized comprehensive case management beyond the service coordination required by the Texas Occupations Code Chapter 301.

(2) PPECC services are limited to 12 hours per day. Services begin when the PPECC assumes responsibility for the care of the participant (the point the participant is boarded onto PPECC transportation or when the participant is brought to the PPECC) and ends when the care is relinquished to the participant's responsible adult.

(3) A participant who is eligible may receive both PDN and PPECC services on the same day. However, PPECC services are intended to be a one-to-one replacement of PDN hours unless additional hours are medically necessary. The following medically necessary services may be billed on the same day as PPECC services, but they may not be billed simultaneously with PPECC services. These services may be billed before or after PPECC services:

(A) private duty nursing;

(B) home health skilled nursing; and

(C) home health aide services.

(d) Parental accompaniment is not required for PPECC services, including therapy services rendered in a PPECC setting.

§363.211. *Service Authorization.*

(a) Authorization is required for payment of services. The provider must submit a complete request for prior authorization in order to be considered by HHSC for reimbursement. Prior authorization is a condition for reimbursement, but not a guarantee of payment.

(b) Only those services that HHSC determines to be medically necessary and appropriate are authorized.

(c) PPECC services are prior authorized with reasonable promptness. Prior authorization determinations are completed by HHSC within three business days of receipt of a complete request.

(d) Initial authorization may not exceed 90 days from the start of care. Following the initial authorization, no authorization for payment of PPECC services may be issued for a single service period exceeding 180 days. In addition, specific authorizations may be limited to a time period less than the established maximum based on factors such as the stability and predictability of the participant's medical condition.

(e) HHSC may deny or reduce the PPECC services when:

(1) the participant does not meet the medical necessity criteria for admission;

(2) the participant does not have an ordering physician;

(3) the participant is not 20 years of age or younger;

(4) the services requested are not covered under this subchapter;

(5) the participant's needs are not beyond the scope of services available through Medicaid Title XIX Home Health Skilled Nursing or Home Health Aide Services, because the needs can be met on a part-time or intermittent basis through a visiting nurse as described by Chapter 354, Subchapter A, Division 3 of this title (relating to Medicaid Home Health Services);

(6) there is a duplication of services;

(7) the services are primarily respite care or child care;

(8) the services are provided for the sole purpose of responsible adult training;

(9) the request is incomplete;

(10) the information in the request is inconsistent; or

(11) the requested services are not nursing services as defined by the Texas Occupations Code Chapter 301 and its implementing regulations.

(f) All authorization requests, including initial authorization and authorization of extensions or revisions to an existing authorization, must be submitted in writing.

(g) Initial authorization requests for PPECC services must include the following documentation, which adheres to requirements in the Texas Medicaid Provider Procedures Manual:

(1) physician order for services (a physician signature on the PPECC plan of care serves as a physician order for authorization purposes);

(2) a plan of care developed by the PPECC in compliance with §363.209(a)(1) of this subchapter (relating to Benefits and Limitations);

(3) all required prior authorization forms listed in the Texas Medicaid Provider Procedures Manual, or MCO forms if they contain comparable content; and

(4) signed consent of the participant or participant's responsible adult documenting the choice of PPECC services. The signed consent must include an acknowledgement by the participant or the participant's responsible adult that he or she has been informed that other services such as private duty nursing might be reduced as a result of accepting PPECC services. Consent to share the participant's personal health information with the participant's other providers, as needed to ensure coordination of care, must also be obtained.

(h) Required documentation for recertification of PPECC service authorization after the initial authorization or after an authorization period ends includes the same documents required for an initial authorization, as set forth in subsection (g) of this section.

(i) Revisions during an existing authorization period may be requested at any time, if medically necessary. Revision requests must include the same documentation required for an initial request, as set forth in subsection (g) of this section.

(j) If inadequate or incomplete information is provided, HHSC requests additional documentation from the provider to enable HHSC to make a decision on the request.

(k) During the authorization process, providers are required to deliver the requested services from the start of care date.

(l) Providers are responsible for a safe transition of services when the authorization decision is a denial or reduction in the PPECC services being delivered.

(m) A nursing assessment must be completed, signed and dated by a PPECC RN no earlier than three business days before the initial start of care. A nursing assessment is also required when there are changes in the participant's medical condition that impact the amount or duration of services, and for recertification. The nursing assessment is used to establish the participant's plan of care, and must contain the elements identified in the Texas Medicaid Provider Procedures Manual.

§363.213. *Ordering Physician Responsibilities.*

(a) An ordering physician in an employment or contractual relationship with a PPECC cannot provide the required physician's order unless the physician has a therapeutic relationship with and ongoing clinical knowledge of the participant.

(b) The ordering physician's responsibilities include:

(1) providing an examination or treatment to the participant within 30 days before the start of PPECC services;

(2) providing a signed prescription or written, dated physician's order for PPECC services within 30 calendar days before the participant's start of services, which is valid through the initial authorization period and complies with requirements contained in the Texas Medicaid Provider Procedures Manual;

(3) providing a signed prescription or written, dated physician's order for each PPECC authorization period, once the initial prescription or order is no longer valid;

(4) performing a face-to-face evaluation of the participant each year;

(5) reviewing, approving, signing, and dating a plan of care, and any other documentation required for service prior authorization, including any updates or changes;

(6) affirming in writing that PPECC services are medically necessary for the participant;

(7) affirming in writing that the participant's medical condition is sufficiently stable to permit safe delivery of PPECC services as described in the plan of care; and

(8) providing continuing care to and medical supervision of the participant.

§363.215. *Termination, Reduction, or Denial of Authorization for Prescribed Pediatric Extended Care Center Services.*

(a) HHSC terminates authorization for PPECC services when:

(1) the participant is no longer eligible for THSteps-CCP;

(2) the participant no longer meets the medical necessity criteria for PPECC services;

(3) the PPECC cannot ensure the health and safety of the participant;

(4) the participant or the participant's responsible adult refuses to comply with the plan of care, and compliance is necessary to assure the health and safety of the participant;

(5) the participant changes PPECC providers, and the change of notification is submitted to HHSC in writing with a prior authorization request from the new PPECC provider; or

(6) after receiving PPECC services, the participant declines PPECC services and receives services at home. The home

health agency or independent provider offering these services must submit and update all required authorization documentation.

(b) Notice to approve, reduce, or deny requested PPECC services.

(1) HHSC notifies the participant and the responsible adult in writing of the approval, reduction, or denial of PPECC services.

(2) HHSC notifies the provider in writing of the approval, reduction, or denial of PPECC services.

(3) The effective date of the service reduction or denial is 30 days after the date on the individual's notification letter.

(4) HHSC notifies the individual in writing of the process to appeal the reduction or denial of services.

(c) All participants of Medicaid-funded services have the right to appeal actions or determinations made by HHSC as described in Chapter 357, Subchapter A of this title (relating to Uniform Fair Hearing Rules).

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

Filed with the Office of the Secretary of State on October 10, 2016.

TRD-201605184

Karen Ray

Chief Counsel

Texas Human Health and Services Commission

Effective date: November 1, 2016

Proposal publication date: August 12, 2016

For further information, please call: (512) 424-6900



## TITLE 16. ECONOMIC REGULATION

### PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

#### CHAPTER 100. GENERAL PROVISIONS FOR HEALTH-RELATED PROGRAMS

##### 16 TAC §§100.1, 100.10, 100.20, 100.30, 100.40

The Texas Commission of Licensing and Regulation (Commission) adopts new rules at 16 Texas Administrative Code (TAC), Chapter 100, §§100.1, 100.10, 100.20, 100.30 and 100.40, regarding the General Provisions for Health-Related Programs, without changes to the proposed text as published in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5875). The rules will not be republished.

The Texas Legislature enacted Senate Bill 202 (S.B. 202), 84th Legislature, Regular Session (2015), which, in part, transferred 13 occupational licensing programs in two phases from the Department of State Health Services (DSHS) to the Texas Commission of Licensing and Regulation (Commission) and the Department. Under Phase 1, the following seven programs are being transferred from DSHS to the Commission and the Department: (1) Midwives, Texas Occupations Code, Chapter 203; (2) Speech-Language Pathologists and Audiologists, Chapter 401; (3) Hearing Instrument Fitters and Dispensers, Chapter 402; (4)

Licensed Dyslexia Practitioners and Licensed Dyslexia Therapists, Chapter 403; (5) Athletic Trainers, Chapter 451; (6) Orthotists and Prosthetists, Chapter 605; and (7) Dietitians, Chapter 701. The statutory amendments transferring regulation of these seven Phase 1 programs from DSHS to the Commission and the Department took effect on September 1, 2015.

In particular, S.B. 202 added a new Section 51.2031, Occupations Code, which applies to the following six programs being transferred from DSHS: Midwives, Speech-Language Pathologists and Audiologists, Hearing Instrument Fitters and Dispensers, Athletic Trainers, Orthotists and Prosthetists, and Dietitians. For these professions the Commission may not adopt a new rule relating to the scope of practice or a health-related standard of care unless the rule has been proposed by the advisory board for the profession, and the Commission must adopt rules prescribing the procedure by which an advisory board may propose such a rule. In addition, Section 51.2031 requires the Commission to adopt rules clearly specifying the manner in which the Department and Commission will solicit input from, and on request provide information to, an advisory board established for one of these professions regarding the general investigative, enforcement, or disciplinary procedures of the Department or Commission. The adopted new rules under 16 TAC Chapter 100 are necessary to implement these provisions of Section 51.2031.

The adopted new §100.1 establishes which health-related programs this chapter applies to.

The adopted new §100.10 creates the definitions to be used in this chapter.

The adopted new §100.20 details the manner in which information will be provided to the advisory boards for these programs.

The adopted new §100.30 prescribes the procedure by which the advisory boards for these programs may propose a new rule relating to the scope of practice or a health-related standard of care.

The adopted new §100.40 directs the Department to develop enforcement procedures for these programs and lists the methods by which the Department may obtain health-related expertise in the investigation and resolution of complaints.

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the August 12, 2016, issue of the *Texas Register* (41 TexReg 5875). The deadline for public comments was September 12, 2016. During the 30-day public comment period the Department received comments from the Texas Medical Association on the proposed rules. The public comments received are summarized below.

**Comment--**The Texas Medical Association (TMA) recommended all of the affected health-related advisory boards to be listed in the rules to clarify who the Department is seeking advice from and recommended some related clarifying amendments. TMA also suggested the opinions and recommendations received from advisory boards regarding enforcement procedures should be binding on the Commission and the Department.

**Department Response--**The Department relies heavily on the input and expertise of the advisory boards and will seek input from the respective boards regarding developing procedures. However, the Department is responsible for its work load and may need to adjust the procedures as the transition occurs to ensure consistency across programs. This comment is also inconsistent

with the statutory framework, which makes the boards advisory. Therefore, the Department believes that the recommendations should not be binding on the Commission or the Department. In addition, the Department does not believe it is necessary to list each advisory board since the rules identify each program this section applies to. The Department did not make any changes to the proposed rules as a result of this comment.

At its meeting on October 5, 2016, the Commission adopted the proposed rules without changes as recommended by the Board, and with a change to remove any bar to online continuing education hours for license renewal.

The new rules are adopted under Texas Occupations Code, Chapters 51 and 451, which authorize the Commission, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the adoption are those set forth in Texas Occupations Code, Chapters 51 and 451. No other statutes, articles, or codes are affected by the adoption.

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

Filed with the Office of the Secretary of State on October 7, 2016.

TRD-201605130

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Effective date: November 1, 2016

Proposal publication date: August 12, 2016

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## TITLE 31. NATURAL RESOURCES AND CONSERVATION

### PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

#### CHAPTER 58. OYSTERS, SHRIMP, AND FINFISH

##### SUBCHAPTER A. STATEWIDE OYSTER FISHERY PROCLAMATION

###### 31 TAC §§58.21 - 58.23

In a duly noticed meeting on August 25, 2016, the Texas Parks and Wildlife Commission adopted amendments to §§58.21 - 58.23, concerning the Statewide Oyster Fishery Proclamation, without changes to the proposed text as published in the July 22, 2016, issue of the *Texas Register* (41 TexReg 5388).

The amendments are intended to maximize oyster production by temporarily closing specified areas for the planting of cultch (material, such as oyster shell, that furnishes a place for larval oysters (spat) to attach and grow to maturity), extending harvest opportunities later into the season by reducing the daily sack limit from 50 to 40, and prohibiting the take of oysters on Sundays during the recreational and commercial seasons.

Under Parks and Wildlife Code, §76.115, the department may close an area to the taking of oysters when the commission finds that the area is being overworked or damaged or the area is to be reseeded or restocked. Oyster reefs in Texas, and Galveston Bay in particular, have been impacted due to hurricanes (such as Hurricane Ike, September 2008), drought, and flooding, as well as high harvest pressure. The department's oyster habitat restoration efforts to date in Galveston Bay have resulted in a total of approximately 1,539 acres of sediment/silt-covered oyster habitat returned to productive habitat within the bay. Part of this restoration effort includes approximately \$10.8 million in grants and other funding that have been secured by the department to conduct cultch planting on approximately 435 acres of sediment/silt-covered oyster habitat in Galveston Bay. As a result, sound biological data indicates that the closure is needed for the periods specified in the rules.

The department received grant funds from the Coastal Impact Assistance Program in 2009 to assist in restoring some of this impacted habitat. The department will be restoring approximately 28 acres of oyster reef habitat in Galveston Bay in the spring of 2016, utilizing the remainder of these grant funds with additional funding coming from the Oyster Shell Recovery and Replacement Program and from the city of Texas City. The amendments will temporarily close these four areas to oyster harvest for a period of two years. Commercial oyster leases and other public oyster reefs will not be affected by the closures.

The Half-Moon Reef complex lies off Palacios Point in Matagorda County between Tres Palacios Bay and the eastern arm of Matagorda Bay and was formerly a highly productive oyster reef within the Lavaca-Matagorda Estuary. The reef had been degraded due to a variety of stressors, and as a result, The Nature Conservancy (TNC) secured funding to restore up to 40 acres within a 54-acre section of the historical reef footprint. The department implemented a temporary closure of this area in 2014 to allow cultch materials to become colonized by oysters and to allow the TNC to conduct post-construction monitoring of the reef recovery. The closure was scheduled to expire on November 1, 2016; however, the amendments extend the closure for an additional two years to further evaluate post-construction monitoring and recolonization of this habitat.

The Nature Conservancy has contracted with Texas A&M University - Corpus Christi to monitor the post-construction performance of the restored Half-Moon Reef over a five-year period at a cost of approximately \$700,000. The four components of this monitoring include ecological, structural, fish usage and assessing recreational angler use of the restored reef. Extending the closure of Half-Moon Reef will allow the continuation of this post-construction monitoring.

The amendment to §58.21(c), concerning Taking or Attempting to Take Oysters from Public Oyster Beds: General Rules, closes approximately 28 acres to oyster harvesting in the Galveston Bay Conditionally Approved Area TX-6 and Galveston Bay Approved Area TX-7. The Texas Department of State Health Services (DSHS) regulates shellfish sanitation and designates specific areas where oysters may be harvested for human consumption. The designation of "Conditionally Approved" or "Approved" is determined by DSHS. The amendment also extends the closure of a 54-acre area encompassing Half-Moon Reef in Matagorda Bay. The extent of the closures would be for two harvest seasons (until November 1, 2018), which will allow for repopulation of oysters in Galveston Bay (and the growth of those oysters to market size) and, in the case of Half-Moon Reef, allow for contin-

ued post-construction monitoring of this restoration project. Areas under certificates of location (sometimes referred to as private oyster leases) in TX-6 and TX-7 would not be affected by the closure. The amendment also eliminates the current closure of Hannah Reef, Middle Reef (CCA), Middle Reef, and Pepper Grove Reef, where restoration efforts have been successful and harvest can resume.

The amendment to §58.22, concerning Commercial Fishing, reduces the commercial possession limit for oysters from 50 sacks per day to 40 and closes Sundays to commercial oyster harvest during the recreational and commercial seasons (November 1 of one year through April 30 of the following year). The goal is to promote efficiency in utilizing oyster resources by providing a more stable price structure for oysters taken throughout the duration of the open season. The proposed amendment is expected to lengthen the productive part of the season, both in terms of sacks per vessel landed and effective days fished.

An analysis of the amendment's sack limit provisions found that the combination of these two measures could result in a total harvest reduction of approximately 17.1%, if fishing effort was equivalent to the 2014-15 season. Additional analysis shows that the average vessel during the 2014-15 season made only 44 trips during the 182-day season, ceased effort by mid-February, and experienced an average daily harvest of 23 sacks. By providing the opportunity to conduct trips further into the season and harvest more sacks per day, the amendments are not expected to result in a reduction in total landings over the season. Reducing the daily sack limit and eliminating harvest for one day per week could extend the effective harvest season during a time when oyster yield (meat-weight to shell-weight) is highest and more valuable to the commercial industry. The department worked closely with the Oyster Advisory Workgroup in developing the amendment.

The amendment to §58.23, concerning Non-commercial (Recreational) Fishing, would close Sunday to recreational harvest during recreational oyster season, for the same reasons discussed earlier in this preamble concerning commercial oyster season.

The department received 26 comments opposing adoption of the proposed amendments. Of those comments, twenty-five provided a reason or rationale for opposing adoption.

Five commenters opposed adoption and stated that the proposed closure of the fishery on Sundays would lead to additional restrictions on opportunity in the future and be problematic for commercial operators trying to compensate for opportunity lost as a result of bad weather. The department disagrees with the comments and responds that implicit in the management of fisheries is necessity to modulate effort based on population data, fishing effort, and other factors; therefore, there is the possibility that additional restriction might be warranted, but also the possibility (given market changes, reductions in effort, successful reintroduction programs, etc.) that harvest regulations could be liberalized in the future, as well. An analysis of the fishery since 2007 found that, in general, individual vessels on average experienced between 100 and 130 days per year of fishing effort during a season that is either 182 or 183 days long, meaning that most licensees currently do not utilize 100 percent of available fishing time. The department also responds that bad weather is an occupational reality for fishermen and that based on fishery data, the Sunday closure of the fishery can easily be offset by transferring effort to unused days; thus, rules as adopted do not affect overall harvest opportunity. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the proposed closure of the fishery on Sundays would be problematic because most marine maintenance and supply businesses are closed on Sundays, which would force licensees to miss harvest opportunities on other days in order to attend to maintenance and repair issues. The department disagrees with the comments and responds that legal fishing hours are from sunrise until 3:30 pm, which the department believes allows sufficient time on a daily basis to permit virtually all maintenance and repair activities. Further, an analysis of the fishery since 2007 found that, in general, individual vessels do not utilize all available days to fish during a season. The department also notes that equipment problems can occur on any day of the week and result in the loss of opportunity while repairs are effected. No changes were made as a result of the comments.

Five commenters opposed adoption and stated fears that proposed reduction in the daily sack limit from 50 to 40 would be permanent. The department agrees that the rules as adopted reduce the daily sack limit from 50 to 40 and that there is no expiration date placed on this change. However, the reduction in the daily sack limit should result in the availability of oysters for harvest for a longer period of time, which in turn should result in higher yields of larger oysters and accordingly higher sale prices. The department also notes that during the 2014-15 season a plurality of vessels fished 98 days of the 182-day season. No changes were made as a result of the comments.

Fourteen commenters opposed adoption and stated that the proposed reductions in fishing hours and sack limits were insufficient. The department disagrees with the comments and responds that the daily sack limit as adopted, in combination with the closure of the fishery on Sundays (in addition to the temporary closures of specific reef areas to all harvest) is believed to be sufficient to accomplish the department's regulatory goal, which is to redistribute harvest over a longer period of time during the season. No changes were made as a result of the comments.

The department received 20 comments supporting adoption of the proposed amendments. No group or association commented in opposition to the rules as proposed.

The Nature Conservancy commented in support of adoption of the proposed rules.

The amendments are adopted under Parks and Wildlife Code, §76.115 and §76.301, which, respectively, authorize the commission to close an area to the taking of oysters when the area is to be reseeded or restocked, and regulate the taking, possession, purchase, and sale of oysters.

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

Filed with the Office of the Secretary of State on October 4, 2016.

TRD-201605100

Ann Bright

General Counsel

Texas Parks and Wildlife Department

Effective date: November 1, 2016

Proposal publication date: July 22, 2016

For further information, please call: (512) 389-4775



## 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 §3.1202

The Comptroller of Public Accounts adopts amendments to §3.1202, concerning warning notice signs, to implement Senate Bill 97, 84th Legislature, 2015, without changes to the proposed text as published in the August 26, 2016, issue of the *Texas Register* (41 TexReg 6408). The section is located in Title 34, Chapter 3, Subchapter JJ, which is currently titled Cigarette and Tobacco Products Regulation, but is being changed to reflect that the scope of regulation has changed to include e-cigarettes. The comptroller has proposed to retitle the subchapter as Cigarette, E-Cigarette, and Tobacco Products Regulation.

Throughout the section, titles are amended to correct formatting.

Subsection (a) is amended to conform with Health and Safety Code, §161.084(e). Subsections (a) and (b) are amended to correct grammatical errors and to make the sections easier to read. Subsections (a), (b), (d)(1)(A), and (2)(A) are amended to add e-cigarettes where appropriate, to implement Senate Bill 97, 84th Legislature, 2015. Subsection (d)(2)(A) is amended to remove the size requirements for the additional warning notice sign for a cash register or check-out stand to promote voluntary compliance. Subsection (d)(2)(A) and (B) are reworded to make them easier to read. Subsection (e) is amended to identify

the parties responsible for posting warning notice signs for cigarettes and tobacco products, and to establish the effective date for posting warning notice signs for e-cigarettes.

No comments were received regarding adoption of the amendment.

The amendments are adopted under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture) and §111.0022 (Application to other Laws Administered by Comptroller), which provide 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, and taxes, fees, or other charges which the comptroller administers under other law.

The amendment implements Health and Safety Code, Chapter 161, Subchapter H (Distribution of Cigarettes or Tobacco Products), as amended by Senate Bill 97.

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

Filed with the Office of the Secretary of State on October 4, 2016.

TRD-201605102

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Comptroller of Public Accounts

Effective date: October 24, 2016

Proposal publication date: August 26, 2016

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