PROPOSED RULES

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

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

TITLE 1. ADMINISTRATION

PART 3. OFFICE OF THE ATTORNEY GENERAL

CHAPTER 56. DISTRICT AND COUNTY ATTORNEY REPORTING REQUIREMENTS

1 TAC §§56.1 - 56.10

The Office of the Attorney General (OAG) proposes new chapter 56 in Title 1 of the Texas Administrative Code (TAC), relating to reporting requirements for district attorneys and county attorneys presiding in a district or county with a population of 500,000 or more persons. Proposed new chapter 56 consists of §§56.1 - 56.10. Proposed new chapter 56 is necessary to implement Government Code §41.006 and is in the public's interest.

EXPLANATION AND JUSTIFICATION OF RULES

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

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

SECTION-BY-SECTION SUMMARY

Proposed new §56.1 specifies that district attorneys and county attorneys presiding in a district or county with a population of 500,000 or more are required to submit an initial, quarterly, and annual reports relating to criminal matters and the interests of the state to the OAG in a manner prescribed by the OAG.

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

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

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

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

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

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

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

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

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

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

Proposed new §56.5(a) sets forth the deadlines for reporting entities to electronically submit each type of report. Quarterly reports must be submitted within 30 days of the beginning of each new reporting quarter. Annual reports must be submitted at the end of each reporting year and not later than September 30. The initial reports must be submitted within 90 days of the effective date of this rule. Proposed new §56.4(a) also provides that the

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

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

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

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

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

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

Proposed new §56.10 specifies that all provisions of new proposed chapter 56 are severable.

FISCAL IMPACT ON STATE AND LOCAL GOVERNMENTS

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

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

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

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

PUBLIC BENEFIT AND COST NOTE

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

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

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

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

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

IMPACT ON LOCAL EMPLOYMENT OR ECONOMY

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

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

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

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

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

TAKINGS IMPACT ASSESSMENT

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

- will not create a government program;

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

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

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

- will create a new regulation;

- will not repeal an existing regulation;

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

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

REQUEST FOR PUBLIC COMMENT

Written comments on the proposed rules may be submitted electronically to the OAG's Criminal Prosecution Division by email to OAGRuleCommentsCh56@oag.texas.gov, or by mail to Josh Reno, Attn: Rule Comments, Office of the Attorney General, P.O. Box 12548, Austin, Texas 78711-2548. Comments will be accepted for 30 days following publication in the *Texas Register.*

To request a public hearing on the proposal, submit a request before the end of the comment period by email to OAGRuleCommentsCh56@oag.texas.gov, or by mail to Josh Reno, Attn Rule Comments, Office of the Attorney General, P.O. Box 12548, Austin, Texas 78711-2548.

STATUTORY AUTHORITY

New 1 TAC chapter 56 is proposed pursuant to Texas Government Code §41.006.

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

§56.1. General Reporting Requirements.

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

§56.2. Definitions.

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

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

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

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

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

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

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

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

§56.3. Quarterly and Initial Reporting Requirements.

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

(1) The number of instances that the Reporting Entity indicted a peace officer;

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

(3) The number of prosecutions involving a defendant's discharge of a firearm where the defendant raised a justification under Chapter 9 of the Penal Code, Subchapters C and/or D;

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

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

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

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

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

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

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

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

(12) Records memorializing assistant district attorney or assistant county attorney resignations or terminations where a complaint was made, formally or informally, by the assistant district attorney or assistant county attorney.

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

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

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

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

(B) is not reflective of the reporting entity's current operations due to a formal change in the office's policies, and the formal change is described in detail and transmitted to the Oversight Advisory Committee; or

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

§56.4. Annual Reports.

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

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

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

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

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

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

§56.5. Report Submission Deadlines and Requirements.

(a) Deadlines.

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

(2) The reporting quarters are as follows:

(A) Quarter one: September through November;

(B) Quarter two: December through February;

(C) Quarter three: March through May; and

(D) Quarter four; June through August.

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

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

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

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

§56.6. Document Retention.

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

§56.7. Overdue Reports.

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

§56.8. Compliance.

If a reporting entity violates this chapter, without limitation:

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

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

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

§56.9. Oversight Advisory Committee.

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

(b) The Oversight Advisory Committee may issue notifications of Overdue Reports under §56.6 of this chapter (relating to Document Retention).

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

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

§56.10. Severability.

(a) All provisions of this chapter are severable.

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

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

Filed with the Office of the Secretary of State on August 30, 2024.

TRD-202404124
Justin Gordon
General Counsel
Office of the Attorney General
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 475-4291

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

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

1 TAC §353.1306

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.1306, concerning Comprehensive Hospital Increase Reimbursement Program for Program Periods on or after September 1, 2021.

BACKGROUND AND PURPOSE

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

Comprehensive Hospital Increase Reimbursement Program (CHIRP)

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

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.1306(g)(3)(A) clarifies that for program periods SFY 2025 and prior, the ACR gap used is the individual ACR gap. The proposed amendment to §353.1306(g)(3)(A) further adds that, beginning in SFY 2026, the ACR gap will be the aggregated ACR gap within a class and SDA.

The proposed amendment to §353.1306(g)(3)(B) updates the maximum ACR UPL percentage. The proposed amendment to §353.1306(g)(3)(B) provides that the maximum ACIA payments beginning in SFY 2027 will not exceed 95 percent of the total estimated ACR UPL; and, beginning in SFY 2028, the maximum ACIA payments will not exceed 100 percent of the total estimated ACR UPL.

The proposed amendment to §353.1306(g)(4)(A) revises clause (ii) so that the APHRIQA payment will use the same maximum ACR UPL amounts specified for ACIA in subsection (g)(3)(B).

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rule is in effect, the public will benefit from the adoption of the rule as it will enable hospitals that have fewer or less advantageous commercial payments to benefit from amount generated by other hospitals that have higher or more advantageous commercial payments.

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

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

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030, delivered to 4601 West Guadalupe Street, Austin, Texas 78751, or by email to pfd_hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R064" in the subject line.

STATUTORY AUTHORITY

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

The amendment affects Texas Government Code Chapter 531 and 533, and Texas Human Resources Code Chapter 32.

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

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

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

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

(A) information from the participants in the SDA (including hospitals, managed-care organizations, and sponsoring governmental entities) on the amount of IGT the sponsoring governmental entities propose to transfer to HHSC to support the non-federal share

of the increased rates for the first six months of a program period, as indicated on the applications described in subsection (c) of this section;

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

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

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

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

(F) hospital market dynamics within the SDA; and

(G) other HHSC goals and priorities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) a percentage of the total estimated ACR UPL, not to exceed the applicable percentage specified in paragraph (3)(B) of this subsection [~~90 percent~~], on a per class basis less what Medicaid paid for the services and any payments received under UHRIP, including hospitals that are not participating in ACIA and less any payments received under ACIA.

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

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

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

(h) - (n) (No change.)

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

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Karen Ray
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CHAPTER 354. MEDICAID HEALTH SERVICES

SUBCHAPTER F. PHARMACY SERVICES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §354.1832, concerning Prior Authorization Procedures; and §354.1921, concerning Addition of Drugs to the Texas Drug Code Index.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement House Bill (H.B.) 3286 and Senate Bill (S.B.) 241, 88th Legislature, Regular Session, 2023.

H.B. 3286 amended the Texas Government Code to add §531.0691, creating a new process for the Medicaid pharmacy benefit in which the Vendor Drug Program (VDP) will add drugs to the formulary on a provisional basis. H.B. 3286 also amended Texas Government Code Chapter 533 to add §533.071 which elaborates on an existing process in the Medicaid managed care program regarding Preferred Drug List (PDL) exceptions and when a non-preferred drug can be used by listing these exceptions. Section 533.071 also added new PDL exceptions.

S.B. 241 amended Texas Health and Safety Code Chapter 439 to add new Subchapter D, §439.102. Texas Health and Safety Code §439.102(a) requires a manufacturer of a brand name insulin prescription drug for which a generic or biosimilar prescription drug is not available and is included in the Medicaid VDP formulary, to submit to HHSC a written verification stating whether or not the unavailability of the generic or biosimilar prescription drug is the result, wholly or partly, (1) of a scheme by the manufacturer to pay a generic or biosimilar prescription drug manufacturer to delay manufacturing or marketing the generic or biosimilar drug; (2) a legal or business strategy to extend the life of a patent on the brand name prescription drug; (3) the manufacturer directly manipulating a patent on the brand name prescription drug; or (4) the manufacturer directly manipulating an action described in reasons (1) - (3) of this sentence on behalf of another entity.

Texas Health and Safety Code §439.102(b) requires HHSC to adopt rules that prescribe the form and manner for submission of the written verification required by §439.102(a).

SECTION-BY-SECTION SUMMARY

The proposed amendment to §354.1832 adds new subsections (f) - (h) to set forth the PDL prior authorization exception criteria. Subsection (f) adds the current PDL prior authorization exception criteria. Subsection (g) adds a reference to Texas Insurance Code §1369.213, which refers to prior authorization exceptions for coverage of stage-four advanced, metastatic cancer. Proposed new subsection (h) lists the PDL prior authorization exception criteria that are added by Texas Government Code §533.071. In proposed subsection (h)(1), the exception criteria is that the drug required under the preferred drug list is contraindicated, will likely cause an adverse reaction in or physical or mental harm to the recipient, or the drug is expected to be ineffective based on the known clinical characteristics of the recipient and the known characteristics of the prescription drug regimen. In proposed subsection (h)(2), the exception criteria is that the recipient previously discontinued taking the preferred drug at any point in the recipient's clinical history and for any length of time because the drug was not effective, had a diminished effect, or resulted in an adverse event. In proposed subsection (h)(3), the exception criteria is that the recipient was prescribed and is taking a nonpreferred drug in the antidepressant or antipsychotic drug class and the recipient was prescribed the nonpreferred drug before being discharged from an inpatient facility, is stable on the nonpreferred drug, and is at risk of experiencing complications from switching from the nonpreferred drug to another drug. In proposed subsection (h)(4), the exception criteria is that the preferred drug is not available for reasons outside of the Medicaid managed care organization's control, including because the drug is in short supply according to the Food and Drug Administration Drug Shortages Database, or the drug manufacturer has placed the drug on backorder or allocation.

The proposed amendment replaces "the Health and Human Services Commission (HHSC) or its designee" with "HHSC" in subsection (a) because "HHSC" is defined in §354.1121 as "The Texas Health and Human Services Commission or its designee." The proposed amendment also replaces "The" with "the" in subsection (e)(1).

The proposed amendment to §354.1921 adds new subsection (d) to require manufacturers of brand-name insulin prescription drugs to submit notification of unavailability of generic or biosimilar insulin drugs to HHSC, stating whether or not the unavailability of the generic or biosimilar prescription drug is the result, wholly or partly of, a scheme by the manufacturer to pay a generic or biosimilar prescription drug manufacturer to delay manufacturing or marketing the generic or biosimilar drug; a legal or business strategy to extend the life of a patent on the brand name prescription drug; the manufacturer directly manipulating a patent on the brand name prescription drug; or the manufacturer facilitating an action described by the previous three bullet points on behalf of another entity.

Proposed subsection (e) includes the method insulin manufacturers must use to submit written verification to HHSC, which is through the submission of a Certificate of Information (COI), and on a yearly basis thereafter through the supplemental rebate solicitation process. The proposed amendment adds a new proposed subsection (g) to set forth that HHSC adds drugs to the Texas Drug Code Index on a provisional basis after HHSC receives a COI that is then approved by HHSC, or is pending review by HHSC, for a determination by HHSC that the drug is appropriate for dispensing through an outpatient pharmacy and meets the additional requirements in Texas Government Code §531.0691.

The proposed amendment replaces "the commission" with "HHSC" in subsections (c)(1), (c)(2), (f), (h), (i), (j)(5), (j)(6), (j)(10), (j)(11), (j)(16), and (j)(18) to use consistent terminology when referring to "HHSC." The proposed amendment replaces

"Certification of Information" with "Certificate of Information" in subsections (b), (c)(2), (f), (h), and (j)(11) to be consistent with the terminology used in Texas Government Code §531.0691 for this form. The proposed amendment renumbers certain subsections in the rule. And in renumbered subsection (i) paragraph (18), replaces "Average Wholesale Price" with "AWP" and "Average Manufacturer Price" with "AMP" because these acronyms are in the definitions of these terms in renumbered subsection (j) paragraphs (2) and (3). The term "pricing information" is also added to subsection (j) paragraph (18).

FISCAL NOTE

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

The effect on state government for each year of the first five years the proposed rules are in effect is an estimated cost of $153,750 in fiscal year (FY) 2025, $28,750 in FY 2026, $28,750 in FY 2027, $28,750 in FY 2028, and $28,750 in FY 2029.

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

(2) implementation of the proposed rules will create a new HHSC employee position;

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

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

(5) the proposed rules will not create new regulations;

(6) the proposed rules will expand existing regulations; and

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Emily Zalkovsky, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit for implementation of H.B. 3286, which adds Texas Government Code §531.0691 and §533.071, will be that members may access drugs more quickly after FDA approval if the drug meets the requirements of the bill and members may have increased access to certain non-preferred drugs if the new criteria listed in the bill are met. Implementation of S.B. 241, which adds Texas Health and Safety Code §439.102, will benefit the public because this will ensure that manufacturers are verifying that they are accurately reporting generic insulin availability. HHSC's mission is to deliver quality, cost-effective services to Texans, including ensuring the availability of generic insulin products when available.

Trey Wood, Chief Financial Officer, has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because Texas Health and Safety Code §439.102, only requires drug manufacturers of a brand-name insulin prescription drug for which a generic or biosimilar prescription drug is not available and that is already on the Texas Medicaid Vendor Drug Program formulary to answer a new question on an existing form. For Texas Government Code §531.0691 and §533.071, the proposed rules are not expected to have any economic costs for persons required to comply because there are no requirements to alter current business practices and there are no new fees or costs imposed on those required to comply.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R055" in the subject line.

DIVISION 2. ADMINISTRATION

1 TAC §354.1832

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021(c), which requires the executive commissioner to adopt rules necessary for the proper and efficient operation of the medical assistance program; and Texas

Government Code §533.071, which requires the commission to adopt rules allowing exceptions to the preferred drug list under certain specified conditions.

The proposed amendment affects Texas Government Code §531.0055, §531.0691, Chapter 533.071, Texas Health and Safety Code §439.102,and Texas Insurance Code §1369.213.

§354.1832. Prior Authorization Procedures.

(a) Requests for prior authorization. Except as provided in subsection (b) of this section, a health care practitioner who prescribes a drug that is not included on the Preferred Drug List (PDL) for a Medicaid recipient must request prior authorization of the drug to HHSC [~~the Health and Human Services Commission (HHSC) or its designee~~]. Specific procedures for the submission of requests for prior authorization are available on HHSC's web site. A health care practitioner may request a printed copy of the procedures and forms from HHSC.

(b) New Medicaid recipients. The PDL-related prior authorization requirement of this section does not apply if the prescription for the non-preferred drug is for a newly enrolled Medicaid recipient, until the 31st calendar day after the date of the recipient's Medicaid eligibility determination.

(c) Special Considerations. When HHSC determines based on clinical considerations, cost considerations, or guidance from the Drug Utilization Review Board that the prior authorization requirement could adversely impact Medicaid recipients' health or safety, it may be administratively more efficient to deem the approved prior authorization for a particular client for a certain period of time, or for an indefinite period.

(d) Disposition of requests for prior authorization. HHSC or its designee will notify the requesting practitioner of the approval or disapproval of the request within 24 hours of the receipt of the request.

(e) Emergency requests for prior authorization. HHSC will authorize up to a 72-hour supply of a product subject to prior authorization if:

(1) the [~~The~~] prescribing practitioner notifies HHSC of an emergency need for the product when submitting the request for prior authorization; and

(2) HHSC or its designee is unable to provide its approval or disapproval within 24 hours following the receipt of the request.

(f) The PDL prior authorization exception criteria are as follows:

(1) treatment failure with preferred drug;

(2) contraindication to preferred drug; and

(3) allergic reaction to preferred drugs.

(g) Additional PDL prior authorization exception criteria that HHSC considers includes Texas Insurance Code §1369.213, concerning prior authorization exceptions for coverage of stage-four advanced, metastatic cancer.

(h) The following PDL prior authorization exception criteria are added by Texas Government Code §533.071:

(1) the drug required under the preferred drug list:

(A) is contraindicated;

(B) will likely cause an adverse reaction in or physical or mental harm to the recipient; or

(C) is expected to be ineffective based on the known clinical characteristics of the recipient and the known characteristics of the prescription drug regimen;

(2) the recipient previously discontinued taking the preferred drug at any point in the recipient's clinical history and for any length of time because the drug:

(A) was not effective;

(B) had a diminished effect; or

(C) resulted in an adverse event;

(3) the recipient was prescribed and is taking a nonpreferred drug in the antidepressant or antipsychotic drug class and the recipient:

(A) was prescribed the nonpreferred drug before being discharged from an inpatient facility;

(B) is stable on the nonpreferred drug; and

(C) is at risk of experiencing complications from switching from the nonpreferred drug to another drug; or

(4) the preferred drug is not available for reasons outside of the Medicaid managed care organization's control, including because:

(A) the drug is in short supply according to the Food and Drug Administration Drug Shortages Database; or

(B) the drug's manufacturer has placed the drug on backorder or allocation.

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

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DIVISION 7. TEXAS DRUG CODE INDEX--ADDITIONS, RETENTIONS, AND DELETIONS

1 TAC §354.1921

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which requires the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties under Chapter 531; Texas Human Resources Code §32.021(c), which requires the executive commissioner to adopt rules necessary for the proper and efficient operation of the medical assistance program; and Texas Government Code §533.071, which requires the commission to adopt rules allowing exceptions to the preferred drug list under certain specified conditions.

The proposed amendment affects Texas Government Code §531.0055, §531.0691, Chapter 533.071, Texas Health and Safety Code §439.102,and Texas Insurance Code §1369.213.

§354.1921. Addition of Drugs to the Texas Drug Code Index.

(a) A drug company that has a valid rebate agreement under 42 U.S.C. §1396r-8 may apply to HHSC [~~the Health and Human Services Commission (Commission)~~] to add a drug to the Texas Drug Code Index (TDCI). The term "drug company" includes any manufacturer, repackager, or private labeler.

(b) To apply for the addition of a drug to the TDCI, a drug company must complete each section of the Certificate [~~Certification~~] of Information for the Addition of a Drug Product to the TDCI provided by HHSC [~~the Commission~~].

(c) A drug company must also:

(1) update HHSC [~~the Commission~~] with changes to formulation, product status, or availability; and

(2) submit changes to the prices requested in the Price Certification section of the Certificate [~~Certification~~] of Information, if requested by HHSC [~~the Commission~~], within 10 calendar days of receiving the request.

(d) When a drug company manufactures a brand-name insulin prescription drug for which a generic or biosimilar prescription drug is not available, but the generic or biosimilar prescription drug is in the VDP formulary, the manufacturer must submit to HHSC a written verification stating whether or not the unavailability of the generic or biosimilar prescription drug is the result, wholly or partly, of:

(1) a scheme by the manufacturer to pay a generic or biosimilar prescription drug manufacturer to delay manufacturing or marketing the generic or biosimilar drug;

(2) a legal or business strategy to extend the life of a patent on the brand name prescription drug;

(3) the manufacturer directly manipulating a patent on the brand name prescription drug; or

(4) the manufacturer facilitating an action described by paragraphs (1) - (3) of this subsection on behalf of another entity.

(e) The written verification as described in subsection (d) of this section must be provided by the manufacturer to HHSC:

(1) by submitting a Certificate of Information; and

(2) on a yearly basis thereafter through the supplemental rebate solicitation process.

(f) [~~(d)~~] Sources other than drug companies may request the addition of a drug not currently listed in the TDCI. If the request is not from a drug company, HHSC [~~the Commission~~] may request that the manufacturer submit a Certificate [~~Certification~~] of Information as described in subsection (b) of this section.

(g) HHSC adds drugs to the TDCI on a provisional basis after HHSC receives a Certificate of Information that is then approved by HHSC, or is pending review by HHSC for a determination by HHSC that the drug is appropriate for dispensing through an outpatient pharmacy and meets the additional requirements in Texas Government Code §531.0691.

(h) [~~(e)~~] The drug company and other sources, if applicable, are entitled to receive notification of approved or denied Certifications [~~Certifications~~] of Information. If a Certificate [~~Certification~~] of Information is denied, HHSC [~~the Commission~~] will state the reasons for the denial.

(i) [~~(f)~~] Notwithstanding any other state law, pricing information reported by a drug company under this subchapter is confidential and must not be disclosed by HHSC [~~the Commission~~], its agents, contractors, or any other State agency in a format that discloses the identity of a specific manufacturer or labeler, or the prices charged by a specific manufacturer or labeler for a specific drug, except as necessary to permit the Attorney General to enforce state and federal law.

(j) [~~(g)~~] Definitions. The following words and terms, when used in this chapter and in Chapter 355 of this title (relating to Reimbursement Rates), have the following meanings unless the context clearly indicates otherwise.

(1) Acquisition Cost (AC)--HHSC's determination of the price pharmacy providers pay to acquire drug products marketed or sold by specific manufacturers. AC is based on NADAC, wholesale acquisition cost (WAC), or pharmacy invoice, in accordance with the Medicaid state plan.

(2) Average Manufacturer Price (AMP)--The average manufacturer price as defined in 42 USC §1396r-8(k)(1).

(3) Average Wholesale Price (AWP)--The average wholesale price for a drug as published in a price reporting compendium such as First DataBank or Medispan.

(4) Customary Prompt Pay Discount--Any discount off the purchase price of a drug routinely offered by the drug company to a wholesaler or distributor for prompt payment of purchased drugs within a specified time frame and consistent with customary business practices for payment.

(5) Direct Price to Long Term Care Pharmacy--The amount paid by a pharmacy servicing a long term care facility, including a nursing facility, assisted living facility, and skilled nursing facility. The price should be net of price concessions. In reporting this price point to HHSC [~~the Commission~~], if the price is reported as a range, the weighted average of these prices, based on unit sales, must be included. The following prices should be excluded from this price point:

(A) prices excluded from the determination of Medicaid Best Price at 42 C.F.R. §447.505; and

(B) prices to entities participating in the Health Resources and Services Administration (HRSA) 340b discount program.

(6) Direct Price to Pharmacy--The amount paid for a product by a pharmacy when purchased directly from a drug company. This price should be net of Price Concessions. In reporting this price point to HHSC [~~the Commission~~], if the price is reported as a range, the weighted average of these prices, based on unit sales, must be included. The following prices should be excluded from this price point:

(A) prices excluded from the determination of Medicaid Best Price at 42 C.F.R. §447.505;

(B) prices to entities participating in the Health Resources and Services Administration (HRSA) 340b discount program; and

(C) Direct Prices to Long Term Care Pharmacy.

(7) Gross Amount Due--Has the meaning as defined by the National Council for Prescription Drug Programs.

(8) Long term care facility--Facility that provides long term care services, such as a nursing home, skilled nursing facility, assisted living facility, group home, hospice facility, or intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID).

(9) Long term care pharmacy--A pharmacy for which the total Medicaid claims for prescription drugs to residents of long term care facilities exceeds 50 percent of the pharmacy's total Medicaid claims per year. Long term care pharmacies are not open to the public for walk-in business.

(10) Long term care pharmacy acquisition cost (LTCPAC)--The acquisition cost determined by HHSC [~~the Commission~~] for a drug product purchased by a long term care pharmacy.

(11) "May apply to HHSC [~~the Commission~~]"--The act of applying to have a drug included on the TDCI. This includes completing the Certificate [~~Certification~~] of Information for the Addition of a New Drug Product to the Texas Drug Code Index, submitting National Drug Code (NDC) changes, submitting price updates, and submitting additional package sizes for a drug that is already included on the TDCI.

(12) NADAC--National Average Drug Acquisition Cost.

(13) National Drug Code (NDC)--The 11-digit numerical code established by the U.S. Food and Drug Administration that indicates the labeler, product, and package size.

(14) Pharmacy--An entity with an approved community pharmacy license or an institutional pharmacy license.

(15) Price concession--An action by a manufacturer (other than a customary prompt-pay discount as defined in this section) that has the effect of reducing the net cost of a product to a purchaser. The term includes discounts, rebates, billbacks, chargebacks, or other adjustments to pricing or payment terms. Lagged price concessions must be accounted for in the Reported Manufacturer Pricing by operation of a 12-month average estimation methodology as described in 42 C.F.R. §414.804. For new, at launch products, if a manufacturer has forecasted price concessions, the initial Reported Manufacturer Pricing should reflect this internal business information.

(16) Price to Wholesaler/Distributor--The amount paid by a wholesaler or a distributor. The price should be net of price concessions. In reporting this price point to HHSC [~~the Commission~~], if the price is reported as a range, the weighted average of these prices, based on unit sales, must be included. The following prices should be excluded from this price point:

(A) prices excluded from the determination of Medicaid Best Price at 42 C.F.R. §447.505; and

(B) prices to entities participating in the Health Resources and Services Administration (HRSA) 340b discount program.

(17) Reliable Sources--Sources including other state or federal agencies and pricing services, as well as verifiable reports by contracted providers and Vendor Drug Program formulary and field staff.

(18) Reported Manufacturer Pricing--Pricing information submitted to HHSC [~~the Commission~~] by a drug company on a Certificate [~~Certification~~] of Information, or in subsequent price updates as described in subsections (b) and (c) of this section. This pricing information includes: AWP [~~Average Wholesale Price~~], AMP [~~Average Manufacturer Price~~], Price to Wholesaler/Distributor, Direct Price to Pharmacy, and Direct Price to Long Term Care Pharmacy. If a drug company does not have a single price for a price point, it must report a range of prices. If a drug company reports a range of prices, it must also provide the weighted average of these prices based on unit sales.

(19) Retail Pharmacy Acquisition Cost (RetailPAC)--HHSC's determination of the price a retail pharmacy pays to acquire drug products marketed or sold by specific manufacturers.

(20) Specialty pharmacy--A pharmacy that meets all of the following criteria:

(A) total Medicaid claims for specialty drugs, as described in §354.1853 of this subchapter (relating to Specialty Drugs), exceeds 10 percent of the pharmacy's total Medicaid claims per year;

(B) obtains volume-based discounts or rebates on specialty drugs from manufacturers or wholesalers; and

(C) delivers at least 80 percent of dispensed prescriptions by shipment through the U.S. Postal Service or other common carrier to customers or healthcare professionals (including physicians and home health providers).

(21) Specialty pharmacy acquisition cost (SPAC)--HHSC's determination of the price a retail pharmacy pays to acquire drug products marketed or sold by specific manufacturers.

(22) Weighted AMP (Average Manufacturer Price)--The Weighted AMP (Average Manufacturer Price) as contemplated in 42 U.S.C. §1396r-8(b)(3) and (e), and as reported by the Centers for Medicare & Medicaid Services.

(23) Wholesaler Cost--The net cost of a product to a wholesaler; equivalent to Price to Wholesaler/Distributor and cost to wholesaler.

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

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CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

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

BACKGROUND AND PURPOSE

The Texas Health and Human Services Commission has been working since September 2022 to evaluate the future of the Medicaid hospital financing system in a post-public health emergency environment. With the combination of new Medicaid fee-for-service and managed care rules, the unwinding of the Medicaid caseload coverage from the public health emergency and the interplay of new supplemental payment programs (e.g. the private graduate medical education (GME) and Hospital Augmented Reimbursement program (HARP)), hospital financing in Medicaid and for the uninsured has been challenging to forecast. With the support of hospitals and their representatives, Medicaid managed care organizations and their representatives, industry sub-

ject matter experts, and the staff at the Centers for Medicare & Medicaid Services (CMS), HHSC has come to final decisions about strategies to ensure stability in the event that the Uncompensated Care (UC) pool is reduced in the future.

Disproportionate Share Hospital Program

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

Uncompensated Care Program

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

Hospital Augmented Reimbursement Program

The proposed rule amendment to §355.8070 adds the Medicare definition used by CMS of nominal charge provider and includes clarifications to the payment methodology that HARP payments will be limited such that inpatient Medicaid payments will not exceed inpatient Medicaid charges for all providers except those who meet the Medicare definition of a nominal charge provider. The proposed rule updates codify the existing practice to increase transparency.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §355.8065(b) adds a definition (for the term "Federal medical assistance percentage (FMAP)" and clause (i) is removed from paragraph (47)(B) to align with current practice in accordance with a change that allowed Managed Care Organizations (MCOS) to pay Institution for mental diseases (IMDs) for this age group under certain authorities.

The proposed amendment to §355.8065(d) adds paragraph (5) which includes rural hospitals to be deemed to qualify beginning in FFY 2025.

The proposed amendment to §355.8065(e)(3)(C) adds rural hospitals to hospital types exempt from the condition of participation described in paragraph (e)(3).

The proposed amendment to §355.8065(g)(3) clarifies that HHSC may set aside a portion of the remaining federal funds for rural private hospitals.

The proposed amendment to §355.8065(h)(2)(C)(iii)(II) adds the description of transferring public hospitals' responsibility to fund a portion of the non-federal share of the rural private pool.

The proposed amendment to §355.8065(h)(4)(H)(ii) adds the clarifying description of rural private payments to be included in the recalculation of total pool two and rural private payments for transferring public hospitals and private hospitals based on the actual intergovernmental transfer provided by transferring public hospitals.

The proposed amendment to §355.8065 updates subsection (h)(5)(B) to accurately describe the calculation of the secondary payment from Pool Three Pass One.

The proposed amendment to §355.8065 updates subsection (h)(7) to accurately describe the rural public pool distribution and payment calculation.

The proposed amendment to §355.8065 updates subsection (h)(8) to accurately describe the rural private pool distribution and payment calculation.

The proposed amendment to §355.8065 updates subsection (k)(3) to include conditions of participation listed in subsection (e)(3)-(9).

The proposed amendment to §355.8065 updates subsections (q)(5)(C) and (q)(5)(D) to describe the advance payment calculation process to be used for 2025 and subsequent program years.

The proposed amendment to §355.8065 includes numbering updates as needed throughout.

The proposed amendment to §355.8070(b) adds a definition for the term "nominal charge provider." The paragraphs are renumbered to account for the addition of a paragraph.

The proposed amendment to §355.8070 updates subsection (d)(3) to describe that total inpatient Medicaid payments will not exceed inpatient Medicaid charges for providers who do not meet the nominal charge provider definition in the non-state government-owned and operated hospitals class.

The proposed amendment to §355.8070 updates subsection (e)(3) to describe that total inpatient Medicaid payments will not exceed inpatient Medicaid charges for providers who do not meet the nominal charge provider definition in the private hospitals class.

The proposed amendment to §355.8070 updates subsection (f)(3) to describe that total inpatient Medicaid payments will not exceed inpatient Medicaid charges for providers who do not meet the nominal charge provider definition in the state government-owned hospitals class.

The proposed amendment to §355.8070 updates subsection (g)(3) to describe that total Medicaid payments will not exceed Medicaid charges for providers who do not meet the nominal charge provider definition in the state government-owned Institutions for Mental Diseases (IMDs) hospitals class.

The proposed amendment to §355.8070 updates subsection (h)(3) to describe that total Medicaid payments will not exceed Medicaid charges for providers who do not meet the nominal charge provider definition in the private IMDs hospitals class.

The proposed amendment to §355.8212(f)(2)(D) adds new clause (ii) to describe that beginning in demonstration year seventeen, the HICH pool payments will occur before the non-state owned provider pool payments. The following clauses are renumbered.

The proposed amendment to §355.8212(f)(2)(D)(iv)-(v) adds the description that beginning in demonstration year seventeen, the HICH pool will be at an amount equal to or less than one billion.

The proposed amendment to §355.8212(g)(6)(B)(i) clarifies that beginning in demonstration year seventeen, the non-state owned hospital pool will consider UC payments allocated in both the state-owned and HICH pools.

Other edits are made to update references.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Victoria Grady, Director of Provider Finance, has determined that for each year of the first five years the rules are in effect, the public will benefit from the adoption of the rules due to increased accuracy in the description of the DSH program methodology and increased transparency in the HARP program.

Another anticipated public benefit is that enabling all rural hospitals to qualify for DSH will increase rural hospitals' access to DSH payments, which is the last possible source of payment for uncompensated Medicaid and uninsured costs. Rural hospitals are critical to Texans in rural communities receiving healthcare, including emergency hospital services.

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

TAKINGS IMPACT ASSESSMENT

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

PUBLIC HEARING

A public hearing to receive comments on the proposal will be held by HHSC through a webinar. The meeting date and time will be posted on the HHSC Communications and Events Website at https://hhs.texas.gov/about-hhs/communications-events and the HHSC Provider Finance communications website at https://pfd.hhs.texas.gov/provider-finance-communications. Please contact the Provider Finance Department Hospital Finance section at pfd_hospitals@hhsc.state.tx.us if you have questions.

PUBLIC COMMENT

Written comments on the proposal may be submitted to the HHSC Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030, delivered to 4601 West Guadalupe Street, Austin, Texas 78751, or by email to pfd_hospitals@hhsc.state.tx.us.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R064" in the subject line.

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8065, §355.8070

STATUTORY AUTHORITY

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

The amendments affect Texas Government Code Chapter 531 and Texas Human Resources Code Chapter 32.

§355.8065. Disproportionate Share Hospital Reimbursement Methodology.

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. The Texas Health and Human Services Commission (HHSC) will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this section beginning with the DSH program year corresponding with federal fiscal year 2024. For program

periods that correspond with federal fiscal year 2023, eligibility and payments will be made in accordance with the rule text as it existed on June 1, 2023.

(b) Definitions.

(1) Adjudicated claim--A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.

(2) Available DSH funds--The total amount of funds that may be distributed to eligible qualifying DSH hospitals for the DSH program year, based on the federal DSH allotment for Texas (as determined by the Centers for Medicare & Medicaid Services) and available non-federal funds. HHSC may divide available DSH funds for a program year into one or more portions of funds to allow for partial payment(s) of total available DSH funds at any one time with remaining funds to be distributed at a later date(s). If HHSC chooses to make a partial payment, the available DSH funds for that partial payment are limited to the portion of funds identified by HHSC for that partial payment.

(3) Available general revenue funds--The total amount of state general revenue funds appropriated to provide a portion of the non-federal share of DSH payments for the DSH program year for non-state-owned hospitals. If HHSC divides available DSH funds for a program year into one or more portions of funds to allow for partial payment(s) of total available DSH funds as described in paragraph (2) of this subsection, the available general revenue funds for that partial payment are limited to the portion of general revenue funds identified by HHSC for that partial payment.

(4) Bad debt--A debt arising when there is nonpayment on behalf of an individual who has third-party coverage.

(5) Centers for Medicare & Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid, or its successor.

(6) Charity care--The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public outpatient clinics, hospitals, or health care organizations. A hospital must set the income level for eligibility for charity care consistent with the criteria established in §311.031, Texas Health and Safety Code.

(7) Charity charges--Total amount of hospital charges for inpatient and outpatient services attributed to charity care in a DSH data year. These charges do not include bad debt charges, contractual allowances, or discounts given to other legally liable third-party payers.

(8) Children's hospital--A hospital that is a Children's hospital as defined in §355.8052 of this division [~~chapter~~] (relating to Inpatient Hospital Reimbursement).

(9) Disproportionate share hospital (DSH)--A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid or indigent patients.

(10) DSH data year--A twelve-month period, two years before the DSH program year, from which HHSC will compile data to determine DSH program qualification and payment.

(11) DSH program year--The twelve-month period beginning October 1 and ending September 30.

(12) Dually eligible patient--A patient who is simultaneously eligible for Medicare and Medicaid.

(13) Federal Medical Assistance Percentage (FMAP)--A percentage used in determining the amount of federal matching funds for state expenditures for assistance payments for certain social services and State medical and medical insurance expenditures. Section 1905(b) of the Social Security Act specifies the formula for calculating Federal Medical Assistance Percentages.

(14) [~~(13)~~] Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

(15) [~~(14)~~] HHSC--The Texas Health and Human Services Commission or its designee.

(16) [~~(15)~~] Hospital-specific limit (HSL)--The maximum payment amount, as applied to payments made during a prior DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The hospital-specific limit is calculated using the methodology described in §355.8066 of this division (relating to State Payment Cap and Hospital-Specific Limit Methodology) using actual cost and payment data from the DSH program year.

(17) [~~(16)~~] Independent certified audit--An audit that is conducted by an auditor that operates independently from the Medicaid agency and the audited hospitals and that is eligible to perform the DSH audit required by CMS.

(18) [~~(17)~~] Indigent individual--An individual classified by a hospital as eligible for charity care.

(19) [~~(18)~~] Inflation update factor--Cost of living index based on annual CMS prospective payment system hospital market basket index.

(20) [~~(19)~~] Inpatient day--Each day that an individual is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term includes observation days, rehabilitation days, psychiatric days, and newborn days. The term does not include swing bed days or skilled nursing facility days.

(21) [~~(20)~~] Inpatient revenue--Amount of gross inpatient revenue derived from the most recent completed Medicaid cost report or reports related to the applicable DSH data year. Gross inpatient revenue excludes revenue related to the professional services of hospital-based physicians, swing bed facilities, skilled nursing facilities, intermediate care facilities, other nonhospital revenue, and revenue not identified by the hospital.

(22) [~~(21)~~] Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this division (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities) and §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Diseases (IMD).

(23) [~~(22)~~] Institution for mental diseases (IMD) cap--An IMD limit determined each fiscal year and as described under Section 1923(h) of the Social Security Act.

(24) [~~(23)~~] Intergovernmental transfer (IGT)--A transfer of public funds from a governmental entity to HHSC.

(25) [~~(24)~~] Low-income days--Number of inpatient days attributed to indigent patients are calculated using the following methodology. Low-income days are equal to the hospitals low-in-

come utilization rate as calculated in subsection (d)(2) of this section multiplied by the hospitals total inpatient days.

(26) [~~(25)~~] Low-income utilization rate--A ratio, calculated as described in subsection (d)(2) of this section, that represents the hospital's volume of inpatient charity care relative to total inpatient services.

(27) [~~(26)~~] Mean Medicaid inpatient utilization rate--The average of Medicaid inpatient utilization rates for all hospitals that have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient, that was adjudicated during the relevant DSH data year.

(28) [~~(27)~~] Medicaid contractor--Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(29) [~~(28)~~] Medicaid cost report--Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

(30) [~~(29)~~] Medicaid hospital--A hospital meeting the qualifications set forth in §354.1077 of this title (relating to Provider Participation Requirements) to participate in the Texas Medicaid program.

(31) [~~(30)~~] Medicaid inpatient utilization rate (MIUR)--A ratio, calculated as described in subsection (d)(1) of this section, that represents a hospital's volume of Medicaid inpatient services relative to total inpatient services.

(32) [~~(31)~~] MSA--Metropolitan Statistical Area as defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 137,000, according to the most recent decennial census, are considered "the largest MSAs."

(33) [~~(32)~~] Non-federal percentage--The non-federal percentage equals one minus the FMAP [~~federal medical assistance percentage (FMAP)~~] for the program year.

(34) [~~(33)~~] Non-rural hospital--Any hospital that does not meet the definition of rural hospital as defined in §355.8052 of this chapter.

(35) [~~(34)~~] Non-urban public hospital--A hospital other than a transferring public hospital that is:

(A) owned and operated by a governmental entity; or

(B) operated under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county, and the hospital and governmental entity have both signed an attestation that they wish the hospital to be treated as a public hospital for all purposes under both this section and §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care).

(36) [~~(35)~~] Obstetrical services--The medical care of a woman during pregnancy, delivery, and the post-partum period provided at the hospital listed on the DSH application.

(37) [~~(36)~~] PMSA--Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(38) [~~(37)~~] Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(39) [~~(38)~~] Public Health Hospital (PHH)--The Texas Center for Infectious Disease or any successor facility operated by the Department of State Health Services.

(40) [~~(39)~~] Ratio of cost-to-charges--A ratio that covers all applicable hospital costs and charges relating to inpatient care and outpatient care. This ratio will be calculated for inpatient and outpatient services and, does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(41) [~~(40)~~] Rural public hospital--A hospital that is a rural hospital as defined in §355.8052 of this chapter and is either:

(A) owned and operated by a governmental entity; or

(B) is under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county and the hospital and governmental entity have both signed an attestation that they wish to be treated as a public hospital for all purposes under this section.

(42) [~~(41)~~] State institution for mental diseases (State IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness defined in §1905(i) of the Social Security Act and that is owned and operated by a state university or other state agency. State IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.761 of this chapter.

(43) [~~(42)~~] State-owned hospital--A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in this section.

(44) [~~(43)~~] State-owned teaching hospital--A hospital that is a state-owned teaching hospital as defined in §355.8052 of this chapter.

(45) [~~(44)~~] State payment cap--The maximum payment amount, as applied to payments that will be made for the DSH program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The state payment cap is calculated using the methodology described in §355.8066 of this division [~~title (relating to Hospital-Specific Limit Methodology)~~] using interim cost and payment data from the DSH data year.

(46) [~~(45)~~] Tax Revenue--Funds derived from local taxes that are assessed and payable to a hospital or a hospital district. For purposes of this section, Tax Revenue does not include mandatory payments received by a local governmental entity that is authorized by a relevant chapter of Subtitle D, Title 4, Texas Health and Safety Code, to operate a Local Provider Participation Fund (LPPF).

(47) [~~(46)~~] Third-party coverage--Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payer.

(48) [~~(47)~~] Total Medicaid inpatient days--Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:

(i) Medicaid-eligible days of care adjudicated by managed care organizations or HHSC;

(ii) days that were denied payment for spell-of-illness limitations;

(iii) days attributable to individuals eligible for Medicaid in other states, including dually eligible patients;

(iv) days with adjudicated dates during the period; and

(v) days for dually eligible patients for purposes of the MIUR calculation described in subsection (d)(1) of this section.

(B) The term excludes:

[~~*(i)* days attributable to Medicaid-eligible patients ages 21 through 64 in an IMD;~~]

(i) [~~(ii)~~] days denied for late filing and other reasons; and

(ii) [~~(iii)~~] days for dually eligible patients for purposes of the following calculations:

(I) Total Medicaid inpatient days, as described in subsection (d)(3) of this section; and

(II) Pass one distribution, as described in subsection (h)(4) of this section.

(49) [~~(48)~~] Total Medicaid inpatient hospital payments--Total amount of Medicaid funds that a hospital received for adjudicated claims for covered inpatient services during the DSH data year. The term includes payments that the hospital received:

(A) for covered inpatient services from managed care organizations and HHSC; and

(B) for patients eligible for Medicaid in other states.

(50) [~~(49)~~] Total state and local subsidies--Total amount of state and local payments that a hospital received for inpatient and outpatient care during the DSH data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds, such as County Indigent Health Care, Children with Special Health Care Needs, and Kidney Health Care. The term excludes payment sources that contain federal dollars such as Medicaid payments, Children's Health Insurance Program (CHIP) payments funded under Title XXI of the Social Security Act, Substance Abuse and Mental Health Services Administration, Ryan White Title I, Ryan White Title II, Ryan White Title III, and contractual discounts and allowances related to TRICARE, Medicare, and Medicaid. The term also includes tax revenue.

(51) [~~(50)~~] Transferring public hospital--A hospital that is owned and operated by one of the following entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, or the University Health System of Bexar County.

(c) Eligibility. To be eligible to participate in the DSH program, a hospital must:

(1) be enrolled as a Medicaid hospital in the State of Texas;

(2) have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient, that was adjudicated during the relevant DSH data year; and

(3) apply annually by completing the application packet received from HHSC by the deadline specified in the packet.

(A) Only a hospital that meets the condition specified in paragraph (2) of this subsection will receive an application packet from HHSC.

(B) The application may request self-reported data that HHSC deems necessary to determine each hospital's eligibility. HHSC may audit self-reported data.

(C) A hospital that fails to submit a completed application by the deadline specified by HHSC will not be eligible to participate in the DSH program in the year being applied for or to appeal HHSC's decision.

(D) For purposes of DSH eligibility, a multi-site hospital is considered one provider unless it submits separate Medicaid cost reports for each site. If a multi-site hospital submits separate Medicaid cost reports for each site, for purposes of DSH eligibility, it must submit a separate DSH application for each site.

(E) Merged Hospitals.

(i) HHSC will consider a merger of two or more hospitals for purposes of determining eligibility and calculating a hospital's DSH program year payments under this section if:

(I) a hospital that was a party to the merger submits to HHSC documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application; and

(II) the hospital submitting the information under subclause (I) assumed all Medicaid-related liabilities of each hospital that is a party to the merger, as determined by HHSC after review of the applicable agreements.

(ii) If the requirements of clause (i) are not met, HHSC will not consider the merger for purposes of determining eligibility or calculating a hospital's DSH program year payments under this section. Until HHSC determines that the hospitals are eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any DSH payments to which it was entitled prior to the merger.

(d) Qualification. For each DSH program year, in addition to meeting the eligibility requirements, applicants must meet at least one of the following qualification criteria, which are determined using information from a hospital's application, from HHSC, or from HHSC's Medicaid contractors, as specified by HHSC.

(1) Medicaid inpatient utilization rate. A hospital's Medicaid inpatient utilization rate is calculated by dividing the hospital's total Medicaid inpatient days by its total inpatient census days for the DSH data year.

(A) A hospital located outside an MSA or PMSA must have a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(B) A hospital located inside an MSA or PMSA must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent. For purposes of [~~paragraph (2) of~~] this paragraph [~~section~~], the term "low-income utilization rate" is calculated using the calculation described in 42 U.S.C. §1396r-4 (b)(3).

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total Medicaid inpatient days for all hospitals participating in the Medicaid program, except a hospital in a county with a population of 290,000 persons or fewer, according to the most recent decennial census, must have total Medicaid inpatient days at least 70 percent of the sum of the mean total Medicaid inpatient days for all hospitals in this subset plus one standard deviation above that mean.

(B) Days for dually eligible patients are not included in the calculation of total Medicaid inpatient days under this paragraph.

(4) State-owned hospitals. State-owned hospitals that do not otherwise qualify as disproportionate share hospitals under this subsection will be deemed to qualify. A hospital deemed to qualify must still meet the eligibility requirements under subsection (c) of this section and the conditions of participation under subsection (e) of this section.

(5) Rural hospitals. Effective Federal Fiscal Year (FFY) 2025, rural hospitals that do not otherwise qualify as disproportionate share hospitals under this subsection are deemed to qualify. A hospital deemed to qualify must still meet the eligibility requirements under subsection (c) of this section and the conditions of participation under subsection (e) of this section.

(6) [(5)] Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. In accordance with requirements in subsection (c)(3)(E) of this section, HHSC will aggregate the data used to determine qualification under this subsection from the merged hospitals to determine whether the single Medicaid provider that results from the merger qualifies as a Medicaid disproportionate share hospital.

(7) [(6)] Hospitals with multiple Medicaid provider numbers. Hospitals that held a single Medicaid provider number during the DSH data year, but later added one or more Medicaid provider numbers. Upon request, HHSC will apportion the Medicaid DSH funding determination attributable to a hospital that held a single Medicaid provider number during the DSH data year (data year hospital), but subsequently added one or more Medicaid provider numbers (new program year hospital(s)) between the data year hospital and its associated new program year hospital(s). In these instances, HHSC will apportion the Medicaid DSH funding determination for the data year hospital between the data year hospital and the new program year hospital(s) based on estimates of the division of Medicaid inpatient and low income utilization between the data year hospital and the new program year hospital(s) for the program year, so long as all affected providers satisfy the Medicaid DSH conditions of participation under subsection (e) of this section and qualify as separate hospitals under this subsection [(d) of this section] based on HHSC's Medicaid DSH qualification criteria in the applicable Medicaid DSH program year. In determining whether the new program year hospital(s) meet the Medicaid DSH conditions of participation and qualification, proxy program year data may be used.

(e) Conditions of participation. HHSC will require each hospital to meet and continue to meet for each DSH program year the following conditions of participation.

(1) Two-physician requirement.

(A) In accordance with Social Security Act §1923(e)(2), a hospital must have at least two licensed physicians (doctor of medicine or osteopathy) who have hospital staff privileges and who have agreed to provide nonemergency obstetrical services to individuals who are entitled to medical assistance for such services.

(B) Subparagraph (A) of this paragraph does not apply if the hospital:

(i) serves inpatients who are predominantly under 18 years of age; or

(ii) was operating but did not offer nonemergency obstetrical services as of December 22, 1987.

(C) A hospital must certify on the DSH application that it meets the conditions of either subparagraph (A) or (B) of this paragraph, as applicable, at the time the DSH application is submitted.

(2) Medicaid inpatient utilization rate. At the time of qualification and during the DSH program year, a hospital must have a Medicaid inpatient utilization rate, as calculated in subsection (d)(1) of this section, of at least one percent.

(3) Trauma system.

(A) The hospital must be in active pursuit of designation or have obtained a trauma facility designation as defined in §780.004 and §§773.111 - 773.120, Texas Health and Safety Code, respectively, and consistent with 25 TAC §157.125 (relating to Requirements for Trauma Facility Designation) and §157.131 (relating to [the] Designated Trauma Facility and Emergency Medical Services Account). A hospital that has obtained its trauma facility designation must maintain that designation for the entire DSH program year.

(B) HHSC will receive an annual report from the Office of EMS/Trauma Systems Coordination regarding hospital participation in regional trauma system development, application for trauma facility designation, and trauma facility designation or active pursuit of designation status before final qualification determination for interim DSH payments. HHSC will use this report to confirm compliance with this condition of participation by a hospital applying for DSH funds.

(C) The following hospital types are exempted from the condition of participation described in this paragraph: Rural Hospitals, Children's Hospitals, IMDs, Public Health Hospitals, and State IMDs. Rural hospitals are exempt from trauma system requirement effective FFY 2025.

(4) Maintenance of local funding effort. A hospital district in one of the state's largest MSAs or in a PMSA must not reduce local tax revenues to its associated hospitals as a result of disproportionate share funds received by the hospital. For this provision to apply, the hospital must have more than 250 licensed beds.

(5) Retention of and access to records. A hospital must retain and make available to HHSC records and accounting systems related to DSH data for at least five years from the end of each DSH program year in which the hospital qualifies, or until an open audit is completed, whichever is later.

(6) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in subsection (o) of this section.

(7) Merged hospitals. Merged hospitals are subject to the application requirement in subsection (c)(3)(E) of this section. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to continue receiving DSH payments for the remainder of the DSH program year.

(8) Changes that may affect DSH participation. A hospital receiving payments under this section must notify HHSC's Provider Finance Department within 30 days of changes in ownership, operation, provider identifier, designation as a trauma facility or as a children's hospital, or any other change that may affect the hospital's continued eligibility, qualification, or compliance with DSH conditions of participation. At the request of HHSC, the hospital must submit any documentation supporting the change.

(9) Participation in all voluntary Medicaid programs. Effective FFY [Beginning in Federal Fiscal Year (FFY)] 2024, [it

~~will be required for~~] all non-rural hospitals, except for state-owned hospitals, are required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in DSH, unless:

(A) a hospital is not required to enroll, participate in, and comply with the requirements:

(i) of a program without multiple components if the hospital's estimated payment from the entire program is less than $25,000; or

(ii) of a program's component for programs that have multiple components if the hospital's estimated payment from the program's component is less than $25,000; and

(B) enrollment for the program concluded after the effective date of this requirement.

(f) State payment cap and hospital-specific limit calculation. HHSC uses the methodology described in §355.8066 of this division [~~title~~] to calculate a state payment cap for each Medicaid hospital that applies and qualifies to receive payments for the DSH program year under this section, and a hospital-specific limit for each hospital that received payments in a prior program year under this section. For payments for each DSH program year beginning before October 1, 2017, the state payment cap calculated as described in §355.8066 of this division will be reduced by the amount of prior payments received by each participating hospital for that DSH program year. These prior payments will not be considered anywhere else in the calculation.

(g) Distribution of available DSH funds. HHSC will distribute the available DSH funds as defined in subsection (b)(2) of this section among eligible, qualifying DSH hospitals using the following priorities.

(1) State-owned hospitals. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and public health hospitals an amount less than or equal to its state payment caps, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

(2) Rural public hospitals. HHSC will set aside an amount for rural public hospitals. While the funds are set aside before the non-state hospital funding, the payments will be calculated for each hospital after the non-state hospital payments are calculated.

(3) Rural private hospitals. If funds remain from the amount set aside in paragraph (2) of this subsection [~~(g)(2) of this section~~] for rural public hospitals after paying all hospitals up to their state payment caps, HHSC may set aside a portion of the remaining federal funds for rural private hospitals.

(4) Non-state hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in subsection (h) of this section, including rural public and rural private hospitals.

(A) The remaining available DSH funds equal the lesser of the funds as defined in subsection (b)(2) of this section less funds expended under paragraph (1), (2), and (3) of this subsection or the sum of remaining qualifying hospitals' state payment caps.

(B) The remaining available general revenue funds equal the funds as defined in subsection (b)(3) of this section.

(h) DSH payment calculation.

(1) Data verification. HHSC uses the methodology described in §355.8066(e) of this division [~~title~~] to verify the data used for the DSH payment calculations described in this subsection. The verification process includes:

(A) data sources for the application will include but not limited to Tax Assessor Receipts/Invoices or other official documentation of tax revenue/statements, Medicare Cost Report, and third-party data sources;

(B) notice to hospitals of the data provided to HHSC by Medicaid contractors; and

(C) an opportunity for hospitals to request HHSC review of disputed data.

(2) Establishment of DSH funding pools for non-state hospitals. From the amount of remaining DSH funds determined in subsection (g)(3) of this section, HHSC will establish three DSH funding pools.

(A) Pool One.

(i) Pool One is equal to the sum of the remaining available general revenue funds and associated federal matching funds.

(ii) Pool One payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(B) Pool Two.

(i) Pool Two is equal to the lesser of:

(I) the amount of remaining DSH funds determined in subsection (g)(3) of this section less the amount determined in paragraph (2)(A) of this subsection multiplied by the FMAP in effect for the program year; or

(II) the federal matching funds associated with the intergovernmental transfers received by HHSC that make up the funds for Pool Three; and

(ii) Pool Two payments are available to all non-state-owned hospitals except for any transferring public hospitals as defined in subsection (b) of this section; or non-urban public hospital as defined in subsection (b) of this section that does not transfer any funds to HHSC for Pool Three as described in subparagraph (C)(iii) of this paragraph.

(C) Pool Three.

(i) Pool Three is equal to the sum of intergovernmental transfers for DSH payments received by HHSC from governmental entities that own and operate transferring public hospitals and non-urban public hospitals.

(ii) Pool Three payments are available to the hospitals that are operated by or under lease contracts with the governmental entities described in clause (i) of this subparagraph that provide intergovernmental transfers.

(iii) HHSC will allocate responsibility for funding Pool Three as follows.

(I) Non-urban public hospitals. Each governmental entity that operates or is under a lease contract with a non-urban public hospital is responsible for funding the non-federal share of the hospital's DSH payments from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to that hospital.

(II) Transferring public hospitals. Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments

from Pool Two (calculated as described in paragraphs (3) and (4) of this subsection) to its affiliated hospital, [~~and a portion of~~] the non-federal share of the DSH payments from Pool Two to private hospitals, and the non-federal share of the rural private pool. For funding payments to private hospitals, HHSC will initially suggest an amount in proportion to each transferring public hospitals' individual state payment cap relative to total state payment caps for all transferring public hospitals. If an entity transfers less than the suggested amount, HHSC will take the steps described in paragraph (4)(H) of this subsection.

(III) Following the calculations described in paragraph (5) of this subsection, HHSC will notify each governmental entity of its allocated intergovernmental transfer amount.

(3) Distribution and payment calculation for Pools One and Two initial payment, Standard DSH payment.

(A) HHSC will first determine the state payment cap for the hospital in accordance with §355.8066 of this division, including any year-to-date uncompensated-care (UC) payments as defined in §355.8212 of this subchapter (relating to Waiver Payments to Hospitals for Uncompensated Charity Care) attributable to the state payment cap.

(B) All hospitals that meet DSH qualification and eligibility criteria will be allocated an initial payment from Pools One and Two. Initial payments will be allocated as follows.

(i) A hospital will receive a payment that is the greater of:

(I) the hospital's Medicaid shortfall; or

(II) a standard DSH payment.

(ii) If the amount calculated in clause (i) of this subparagraph is greater than the hospital's state payment cap after considering the state share required to fund the standard DSH payment, the hospital will receive their state payment cap.

(C) HHSC will determine the standard DSH payment amount described in subparagraph (B)(i)(II) of this paragraph annually in an amount not to exceed $10,000,000 per hospital for hospitals that have reported residents on their Medicare cost report or in an amount not to exceed $10,000,000 per hospital for hospitals that have not reported residents on their Medicare cost report.

(D) For a privately-owned institution of mental disease their minimum payment amount may be reduced to ensure that payments for all IMDs remain below the IMD cap.

(4) Distribution and payment calculation for Pools One and Two secondary payment, percentage of costs covered.

(A) The costs considered for the percentage of costs covered will be the costs included in the state payment cap in paragraph (3)(A) of this subsection.

(B) The payments considered for the percentage of costs covered will be the payments included in the state payment cap in paragraph (3)(A) of this subsection plus the standard DSH payment after considering the state share required to fund the hospital's payment. Transferring hospitals will not have IGT paid for private hospitals for the standard DSH payment included in their percentage of cost covered.

(C) The hospital's percentage of cost covered will be equal to the payments in subparagraph (B) of this paragraph divided by the cost in subparagraph (A) of this paragraph.

(D) HHSC will determine an allocation percentage such that all hospitals receive a uniform percentage of their costs covered to fully utilize Pools One and Two, Pass Two.

(E) If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for a Pool One and Two secondary payment.

(F) If a hospital's percentage of cost covered is lower than the allocation percentage, it will be allocated a projected payment such that its percentage of cost covered is equal to the uniform percentage in subparagraph (D) of this paragraph.

(G) If a governmental entity that operates or is under a lease contract with a non-urban public hospital does not fully fund the amount described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will reduce that portion of the hospital's Pool Two payment to the level supported by the amount of the intergovernmental transfer.

(H) If a governmental entity that owns and operates a transferring public hospital does not fully fund the amount described in paragraph (2)(C)(iii)(II) of this subsection, HHSC will take the following steps.

(i) Provide an opportunity for the governmental entities affiliated with the other transferring public hospitals to transfer additional funds to HHSC.

(ii) Recalculate total Pool Two and rural private payments for transferring public hospitals and private hospitals based on actual IGT provided by each transferring public hospital using a methodology determined by HHSC.

(5) Pass One distribution and payment calculation for Pool Three.

(A) HHSC will calculate the initial payment from Pool Three as follows.

(i) For each transferring public hospital:

(I) divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

(II) multiply the result from subclause (I) of this clause by the non-federal percentage. The result is the Pass One initial payment from Pool Three for these hospitals.

(ii) For each Non-urban public hospital:

(I) divide the Pool Two payments from paragraphs (3) and (4) of this subsection by the FMAP for the program year; and

(II) multiply the result from subclause (I) of this clause by the non-federal percentage. The result is the Pass One initial payment from Pool Three for these hospitals.

(iii) For all other hospitals, the Pass One initial payment from Pool Three is equal to zero.

(B) HHSC will calculate the secondary payment from Pool Three for each transferring public hospital as follows.

(i) Sum the DSH payments from Pool Two to private hospitals.

(ii) Determine the transferring public hospital's state payment cap as a percentage of the total state payment caps for all transferring public hospitals.

(iii) Multiply the result of clause (i) of this subparagraph, the result of clause (ii) of this subparagraph, and the non-federal percentage.

(iv) Divide the result of clause (iii) of this subparagraph by the FMAP. The result is the Pass One secondary payment from Pool Three for that hospital.

[*(i)* Sum the intergovernmental transfers made on behalf of all transferring public hospitals.]

[*(ii)* For each transferring public hospital, divide the intergovernmental transfer made on behalf of that hospital by the sum of the intergovernmental transfers made on behalf of all transferring public hospitals from clause (i) of this subparagraph.]

[*(iii)* Sum all Pass One initial payments from Pool Three from subparagraph (A) of this paragraph.]

[*(iv)* Subtract the sum from clause (iii) of this subparagraph from the total value of Pool Three.]

[*(v)* Multiply the result from clause (ii) of this subparagraph by the result from clause (iv) of this subparagraph for each transferring public hospital. The result is the Pass One secondary payment from Pool Three for that hospital.]

(v) [(vi)] For all other hospitals, the Pass One secondary payment from Pool Three is equal to zero.

(C) HHSC will calculate each hospital's total Pass One payment from Pool Three by adding its Pass One initial payment from Pool Three and its Pass One secondary payment from Pool Three.

(6) Pass Two - Secondary redistribution of amounts in excess of state payment caps for Pool Three. For each hospital that received a Pass One initial or secondary payment from Pool Three, HHSC will sum the result from paragraph (4) of this subsection and the result from paragraph (5) of this subsection to determine the hospital's total projected DSH payment. In the event this sum plus any previous payment amounts for the program year exceeds a hospital's state payment cap, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the state payment cap. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals eligible for payments from Pool Three that have projected payments, including any previous payment amounts for the program year, below its state payment caps. For each such hospital, HHSC will:

(A) subtract the hospital's projected DSH payment plus any previous payment amounts for the program year from its state payment cap;

(B) sum the results of subparagraph (A) of this paragraph for all hospitals; and

(C) compare the sum from subparagraph (B) of this paragraph to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of subparagraph (B) of this paragraph is less than or equal to the total excess funds, HHSC will pay all such hospitals up to the state payment cap.

(ii) If the sum of subparagraph (B) of this paragraph is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows.

(I) Divide the result of subparagraph (A) of this paragraph for each hospital by the sum from subparagraph (B) of this paragraph.

(II) Multiply the ratio from subclause (I) of this clause by the sum of the excess funds from all non-state-owned hospitals.

(III) Add the result of subclause (II) of this clause to the projected total DSH payment for that hospital to calculate a revised projected payment amount from Pools One, Two and Three after Pass Two.

(7) Rural public hospital pool distribution and payment calculation.

(A) For each rural public hospital, HHSC will calculate the Rural Public Hospital Maximum Payment before Limiting to Available Funds as follows. [HHSC will determine an allocation percentage such that all rural public hospitals receive a uniform percentage of the costs covered to fully utilize the rural public all funds allocation. The percentage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.]

(i) Determine the state payment cap in accordance with subsection (h)(3)(A) of this section.

(ii) Subtract the payment amount from Pools One, Two, and Three after Pass Two in paragraph (6)(C)(ii)(III) of this subsection.

(B) The rural public hospital's maximum payment amount from subparagraph (A) of this paragraph is divided by the total rural public hospital maximum payment for all rural public hospitals to calculate the hospital's percentage of the total rural public pool. [If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the rural public hospital pool.]

(C) The percentage from subparagraph (B) of this paragraph will be multiplied by the lesser of the rural public hospitals set-aside described in subsection (g)(2) of this section or the total rural public maximum payment in subparagraph (A) of this paragraph. [If a hospital's percentage of cost covered is lower than the allocation percentage, it will be allocated a projected payment such that the percentage of cost covered is equal to the uniform percentage in subparagraph (A) of this paragraph.]

(D) Each rural public hospital is responsible for funding the rural public payment multiplied by the non-federal percentage. If the hospital does not fully fund the rural public payment, HHSC will reduce the hospital's rural public payment to the level supported by the amount of the intergovernmental transfer.

(8) Rural private hospital pool distribution and payment calculation.

(A) If any funds remain from the rural public pool described in paragraph (7) of this subsection, for each rural private hospital, HHSC will calculate a Private Rural Hospital Maximum Payment before Limiting to Available Funds as follows. [allocate a percentage of the remaining funds to rural private hospitals.]

(i) Determine the state payment cap in accordance with paragraph (3)(A) of this subsection.

(ii) Subtract the payment amount from Pools One, Two, and Three after Pass Two for each rural private hospital.

(B) The rural private hospital's maximum payment amount from subparagraph (A) of this paragraph is divided by the total rural private hospital maximum payment for all rural private hospitals to calculate the hospital's percentage of the total rural private pool. [HHSC will determine an allocation percentage such that all rural private hospitals receive a uniform percentage of the costs covered to

fully utilize the rural public federal funds allocation. The percentage of cost covered will consider all previous DSH payments for the program year, including the funds for the non-state hospitals.]

(C) The percentage from subparagraph (B) of this paragraph will be multiplied by the lesser of the Rural private hospitals pool described in subsection (g)(3) or the total rural private maximum payment in subparagraph (A) of this paragraph. [If a hospital's percentage of cost covered is greater than the allocation percentage, it will not be eligible for any DSH payments from the rural private hospital pool.]

[(D) If a hospital's percentage of cost covered is lower than the allocation percentage, it will be allocated a projected payment such that the percentage of cost covered is equal to the uniform percentage in subparagraph (B) of this paragraph.]

(D) [(E)] Each governmental entity that owns and operates a transferring public hospital is responsible for funding the non-federal share of the DSH payments from the rural private hospital pool to rural private hospitals. If an entity transfers less than the suggested amount, HHSC will reduce the rural private hospitals' payments to the level supported by the amount of the intergovernmental transfer.

(E) [(F)] Any remaining federal funds will be redistributed back into the Pool Two secondary payment as described in paragraph (4) of this subsection. The remaining federal funds are calculated as follows. [from the percentage allocation described in subparagraph (A) of this paragraph and any undistributed funds from this pool will be redistributed back into the pool two secondary payment as described in paragraph (4) of this subsection.]

(i) Determine the federal portion of the funds set aside in subsection (g)(2) of this section by multiplying the amount in subsection (g)(2) of this section by the FMAP.

(ii) From the amount in clause (i) of this subparagraph, subtract the federal portion of the rural public payment calculated in paragraph (7)(C) of this subsection. The federal portion of the rural public payment is the total payments in paragraph (7)(C) of this subsection less the total non-federal share calculated in paragraph (7)(D) of this subsection.

(iii) From the amount remaining in clause (ii) of this subparagraph, subtract the rural private total payments in subparagraph (C) of this paragraph.

(9) Pass Three - If any portion of the non-federal share of the available DSH funds is not fully funded, the remaining allocation will be available to non-urban public hospitals that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection.

(A) For each non-urban public hospital that met the funding requirements described in paragraph (2)(C)(iii)(I) of this subsection, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with paragraphs (4) - (8) of this subsection, as appropriate.

(B) HHSC will subtract each hospital's projected payment amount plus any previous payment amounts for the program year from subparagraph (A) of this paragraph from each hospital's state payment cap to determine the maximum additional DSH allocation.

(C) The governmental entity that owns the hospital or leases the hospital may provide the non-federal share of funding through an intergovernmental transfer to fund up to the maximum additional DSH allocation calculated in subparagraph (B) of this paragraph. These governmental entities will be queried by HHSC as to the amount of funding they intend to provide through an intergovernmental transfer for this additional allocation. The query may be conducted through e-mail, through the various hospital associations or through postings on the HHSC website.

(D) Prior to processing any full or partial DSH payment that includes an additional allocation of DSH funds as described in this paragraph, HHSC will determine if such a payment would cause total DSH payments for the full or partial payment to exceed the available DSH funds for the payment as described in subsection (b)(2) of this section. If HHSC makes such a determination, it will reduce the DSH payment amounts non-urban public hospitals are eligible to receive through the additional allocation as required to remain within the available DSH funds for the payment. This reduction will be applied proportionally to all additional allocations. HHSC will:

(i) determine remaining available funds by subtracting payment amounts for all DSH hospitals calculated in paragraphs (4) - (8) of this subsection from the amount in subsection (g)(3) of this section;

(ii) determine the total additional allocation supported by an intergovernmental transfer by summing the amounts supported by intergovernmental transfers identified in subparagraph (C) of this paragraph;

(iii) determine an available proportion statistic by dividing the remaining available funds from clause (i) of this subparagraph by the total additional allocation supported by an intergovernmental transfer from clause (ii) of this subparagraph; and

(iv) multiply each intergovernmental transfer supported payment from subparagraph (C) of this paragraph by the proportion statistic determined in clause (iii) of this subparagraph. The resulting product will be the additional allowable allocation for the payment.

(E) Non-urban public hospitals that do not meet the funding requirements of paragraph (2)(C)(iii)(I) of this subsection are not eligible for participation on Pass Three.

(10) Reallocating funds if hospital closes, loses its license or eligibility, or files bankruptcy. If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving DSH payments for all or a portion of a DSH program year, HHSC will determine the hospital's eligibility to receive DSH payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the program year and whether it can meet the audit requirements described in subsection (o) of this section. If HHSC determines that the hospital is not eligible to receive DSH payments going forward, HHSC will notify the hospital and reallocate that hospital's disproportionate share funds to state hospitals then amongst all DSH hospitals in the same category that are eligible for additional payments.

(11) HHSC will give notice of the amounts determined in this subsection.

(12) The sum of the annual payment amounts for state owned and non-state owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the non-state owned IMDs are reduced first on a pro-rata basis so that the sum is equal to the federal IMD limit. In the case that the non-state owned IMD payments are eliminated and the payments for the state owned IMD still exceed the federal IMD limit, then the state owned IMD payments will be reduced on a pro-rata basis until they equal the federal IMD limit.

(13) For any DSH program year for which HHSC has calculated the hospital-specific limit described in §355.8066(c)(2)

of this division [~~chapter~~], HHSC will compare the interim DSH payment amount as calculated in subsection (h) of this section to the hospital-specific limit.

(A) HHSC will limit the payment amount to the hospital-specific limit if the payment amount exceeds the hospital's hospital-specific limit.

(B) HHSC will redistribute dollars made available as a result of the capping described in subparagraph (A) of this paragraph to providers eligible for additional payments subject to the hospital-specific limits, as described in subsection (l) of this section.

(i) Hospital located in a state or federal natural disaster area. A hospital that is located in a county that is declared a state or federal natural disaster area and that was participating in the DSH program at the time of the natural disaster may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The following conditions and procedures will apply to all such requests received by HHSC.

(1) The hospital must submit its request in writing to HHSC with its annual DSH application.

(2) If HHSC approves the request, HHSC will determine the hospital's DSH qualification using the hospital's data from the DSH data year prior to the natural disaster. However, HHSC will calculate the one percent Medicaid minimum utilization rate, the state payment cap, and the payment amount using data from the DSH data year. The hospital-specific limit will be computed based on the actual data for the DSH program year.

(3) HHSC will notify the hospital of the qualification and interim reimbursement.

(j) HHSC determination of eligibility or qualification. HHSC uses the methodology described in §355.8066(e) of this division to verify the data and other information used to determine eligibility and qualification under this section. The verification process includes:

(1) notice to hospitals of the data provided to HHSC by Medicaid contractors; and

(2) an opportunity for hospitals to request HHSC review of disputed data and other information the hospital believes is erroneous.

(k) Disproportionate share funds held in reserve.

(1) If HHSC has reason to believe that a hospital is not in compliance with the conditions of participation listed in subsection (e) of this section, HHSC will notify the hospital of possible noncompliance. Upon receipt of such notice, the hospital will have 30 calendar days to demonstrate compliance.

(2) If the hospital demonstrates compliance within 30 calendar days, HHSC will not hold the hospital's DSH payments in reserve.

(3) If the hospital fails to demonstrate compliance within 30 calendar days, HHSC will notify the hospital that HHSC is holding the hospital's DSH payments in reserve. HHSC will release the funds corresponding to any period for which a hospital subsequently demonstrates that it was in compliance. HHSC will not make DSH payments for any period in which the hospital is out of compliance with the conditions of participation listed in subsection (e)(1) and (2) of this section. HHSC may choose not to make DSH payments for any period in which the hospital is out of compliance with the conditions of participation listed in subsection (e)(3) - (9) [~~(7)~~] of this section.

(4) If a hospital's DSH payments are being held in reserve on the date of the last payment in the DSH program year, and no request for review is pending under paragraph (5) of this subsection, the amount of the payments is not restored to the hospital, but is divided proportionately among the hospitals receiving a last payment.

(5) Hospitals that have DSH payments held in reserve may request a review by HHSC.

(A) The hospital's written request for a review must:

(i) be sent to HHSC's Director of Hospital Finance, Provider Finance Department;

(ii) be received by HHSC within 15 calendar days after notification that the hospital's DSH payments are held in reserve; and

(iii) contain specific documentation supporting its contention that it is in compliance with the conditions of participation.

(B) The review is:

(i) limited to allegations of noncompliance with conditions of participation;

(ii) limited to a review of documentation submitted by the hospital or used by HHSC in making its original determination; and

(iii) not conducted as an adversarial hearing.

(C) HHSC will conduct the review and notify the hospital requesting the review of the results.

(l) Recovery and redistribution of DSH funds. As described in subsection (o) of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit. Recovered funds will be redistributed as described in subsection (p) of this section.

(m) Failure to provide supporting documentation. HHSC will exclude data from DSH calculations under this section if a hospital fails to maintain and provide adequate documentation to support that data.

(n) Voluntary withdrawal from the DSH program.

(1) HHSC will recoup all DSH payments made during the same DSH program year to a hospital that voluntarily terminates its participation in the DSH program. HHSC will redistribute the recouped funds according to the distribution methodology described in subsection (l) of this section.

(2) A hospital that voluntarily terminates from the DSH program will be ineligible to receive payments for the next DSH program year after the hospital's termination.

(3) If a hospital does not apply for DSH funding in the DSH program year following a DSH program year in which it received DSH funding, even though it would have qualified for DSH funding in that year, the hospital will be ineligible to receive payments for the next DSH program year after the year in which it did not apply.

(4) The hospital may reapply to receive DSH payments in the second DSH program year after the year in which it did not apply.

(o) Audit process.

(1) Independent certified audit. HHSC is required by the Social Security Act (Act) to annually complete an independent certified audit of each hospital participating in the DSH program in Texas. Audits will comply with all applicable federal law and directives, including the Act, the Omnibus Budget and Reconciliation Act of 1993 (OBRA '93), the Medicare Prescription Drug, Improvement and Mod-

ernization Act of 2003 (MMA), pertinent federal rules, and any amendments to such provisions.

(A) Each audit report will contain the verifications set forth in 42 CFR §455.304(d).

(B) The sources of data utilized by HHSC, the hospitals, and the independent auditors to complete the DSH audit and report include:

(i) The Medicaid cost report;

(ii) Medicaid Management Information System data; and

(iii) Hospital financial statements and other auditable hospital accounting records.

(C) A hospital must provide HHSC or the independent auditor with the necessary information in the time specified by HHSC or the independent auditor. HHSC or the independent auditor will notify hospitals of the required information and provide a reasonable time for each hospital to comply.

(D) A hospital that fails to provide requested information or to otherwise comply with the independent certified audit requirements may be subject to a withholding of Medicaid disproportionate share payments or other appropriate sanctions.

(E) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit as described in this subsection and will redistribute the recouped funds to DSH providers in accordance with subsection (p) that received interim payments, subject to the hospital-specific limits, as described in subsections (q) and (l) of this section.

(F) Review of preliminary audit finding of overpayment.

(i) Before finalizing the audit, HHSC will notify each hospital that has a preliminary audit finding of overpayment.

(ii) A hospital that disputes the finding or the amount of the overpayment may request a review in accordance with the following procedures.

(I) A request for review must be received by the HHSC Provider Finance Department in writing by regular mail, hand delivery or special mail delivery, from the hospital within 30 calendar days of the date the hospital receives the notification described in clause (i) of this subparagraph.

(II) The request must allege the specific factual or calculation errors the hospital contends the auditors made that, if corrected, would change the preliminary audit finding.

(III) All documentation supporting the request for review must accompany the written request for review or the request will be denied.

(IV) The request for review may not dispute the federal audit requirements or the audit methodologies.

(iii) The review is:

(I) limited to the hospital's allegations of factual or calculation errors;

(II) solely a data review based on documentation submitted by the hospital with its request for review or that was used by the auditors in making the preliminary finding; and

(III) not an adversarial hearing.

(iv) HHSC will submit to the auditors all requests for review that meet the procedural requirements described in clause (ii) of this subparagraph.

(I) If the auditors agree that a factual or calculation error occurred and change the preliminary audit finding, HHSC will notify the hospital of the revised finding.

(II) If the auditors do not agree that a factual or calculation error occurred and do not change the preliminary audit finding, HHSC will notify the hospital that the preliminary finding stands and will initiate recoupment proceedings as described in this section.

(2) Additional audits. HHSC may conduct or require additional audits.

(p) Redistribution of Recouped Funds. Following the recoupments described in subsection (o) of this section, HHSC will redistribute the recouped funds to eligible providers. To receive a redistributed payment, the hospital must be in compliance with all requirements during the program year, meet the audit requirements described in subsection (o) of this section, and have already received a DSH payment in that DSH year of at least one dollar. For purposes of this subsection, an eligible provider is a provider that has room remaining in its final remaining Hospital-specific limit (HSL) calculated in the audit findings described in subsection (o) of this section after considering all DSH payments made for that program year. Recouped funds from state providers will be redistributed proportionately to eligible state providers based on the percentage that each eligible state provider's remaining final HSL (calculated in the audit findings as described in subsection (o) of this section) is of the total remaining final HSL (calculated in the audit findings described in subsection (o) of this section) of all eligible state providers. Recouped funds from non-state providers may be redistributed proportionately to state providers or eligible non-state providers as follows.

(1) For DSH program years 2011-2017 (October 1, 2011 - September 30, 2017) and for DSH program years 2020 and after (October 1, 2019 and after), HHSC will use the following methodology to redistribute recouped funds:

(A) the non-federal share will be returned to the governmental entity that provided it during the program year;

(B) the federal share will be distributed proportionately among all non-state providers eligible for additional payments that have a source of the non-federal share of the payments; and

(C) the federal share that does not have a source of non-federal share will be returned to CMS.

(2) For DSH program years 2018-2019 (October 1, 2017 - September 30, 2019), HHSC will use the following methodology to redistribute recouped funds.

(A) To calculate a weight that will be applied to all non-state providers, HHSC will divide the final hospital-specific limit described in §355.8066(c)(2) of this division by the final hospital-specific limit described in §355.8066(c)(2) of this division that has not offset payments for third-party and Medicare claims and encounters where Medicaid was a secondary payer. HHSC will add 1 to the quotient. Any non-state provider that has a resulting weight of less than 1 will receive a weight of 1.

(B) HHSC will make a first pass allocation by multiplying the weight described in subparagraph (A) of this paragraph [~~subsection (p)(2)(A) of this section~~] by the final remaining HSL calculated in the audit findings described in subsection (o) of this section. HHSC will divide the product by the total remaining HSLs for all non-state providers. HHSC will multiply the quotient by the

total amount of recouped dollars available for redistribution described in paragraph (1) of this subsection [(p)(1) of this section].

(C) After the first pass allocation, HHSC will cap non-state providers at its final remaining HSL. A second pass allocation will occur in the event non-state providers were paid over its final remaining HSL after the weight in subparagraph (A) of this paragraph [subsection (p)(2)(A) of this section] was applied. HHSC will calculate the second pass by dividing the final remaining HSL calculated in the audit findings described in subsection (o) of this section by the total remaining HSLs for all non-state providers after accounting for first pass payments. HHSC will multiply the quotient by the total amount of funds in excess of total HSLs for non-state providers capped at its total HSL.

(q) Advance Payments

(1) In a DSH program year in which payments will be delayed pending data submission or for other reasons, HHSC may make advance payments to hospitals that meet the eligibility requirements described in subsection (c) of this section, meet a qualification in subsection (d) of this section, meet the conditions of participation in subsection (e) of this section, and submitted an acceptable disproportionate share hospital application for the preceding DSH program year from which HHSC calculated an annual maximum disproportionate share hospital payment amount for that year.

(2) Advance payments are considered to be prior period payments.

(3) A hospital that did not submit an acceptable disproportionate share hospital application for the preceding DSH program year is not eligible for an advance payment.

(4) If a partial year disproportionate share hospital application was used to determine the preceding DSH program year's payments, data from that application may be annualized for use in computation of an advance payment amount.

(5) The amount of the advance payments:

(A) are divided into three payments prior to a hospital receiving its final DSH payment amount;

(B) in DSH program years 2020 and after a provider that received a payment in the previous DSH program year is eligible to receive an advanced payment, and the calculations for advanced payment 1, 2, and 3 are as follows:

(i) HHSC determines a percentage of the pool to pay out in the advanced payments; and

(ii) the pool amount is fed through the previous DSH program year calculation to determine the advanced payments;

(C) in DSH program year 2024 and 2025, HHSC may [will] run the application data for hospital applications through an updated DSH qualification and calculation file to determine advanced payment eligibility and amount to account for rule changes between program years [year] 2023 and 2024, and 2024 and 2025, to prevent recoupments; and

(D) HHSC will determine the payment allocation for the advances for 2026 [2025] and subsequent years by calculating a percentage based on a hospital's payment in the preceding year divided by the sum of all other hospitals' payment in the preceding year that are eligible for an advance payment.

§355.8070. Hospital Augmented Reimbursement Program.

(a) Introduction. This section establishes the Hospital Augmented Reimbursement (HARP) Program, wherein the Texas Health and Human Services Commission (HHSC) directs payments to certain providers that serve Texas Medicaid fee-for-service patients, including eligible non-state government owned hospitals, private hospitals, state-owned hospitals, state government-owned Institutions for Mental Diseases (IMDs), and private IMDs. This section also describes the methodology used by HHSC to calculate and administer such payments. A provider is eligible for a payment under this section only if HHSC has submitted and CMS has approved a state plan amendment permitting HHSC to make payments under this section to the hospital class to which the provider belongs.

(b) Definitions. The following definitions apply when the terms are used in this section.

(1) Fee-for-Service (FFS)--A system of the health insurance payment in which a health care provider is paid a fee by HHSC through the contracted Medicaid claims administrator directly, for each service rendered. For Texas Medicaid purposes, fee-for-service excludes any service rendered under a managed care program through a managed care organization.

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

(3) Intergovernmental transfer (IGT)--A transfer of public funds from another state agency or a non-state governmental entity to HHSC.

(4) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services from the most recent FFS upper payment limit (UPL) demonstration.

(5) Nominal charge provider--A provider that charges an amount equal to 60 percent or less of the reasonable cost of service or services. Nominal charges mean Medicare charges are at or below a ratio equal to 0.6 of reasonable costs which equates to a Medicare ratio of cost to charge (RCC) that exceeds 1.67. Charges and costs are based on inpatient hospital services only.

(6) [(5)] Non-state government-owned and operated hospital--A hospital that is owned and operated by a local government entity, including but not limited to a city, county, or hospital district.

(7) [(6)] Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to outpatients of a hospital under the direction of a physician or dentist, or a subset of these services identified by HHSC.

(8) [(7)] Private hospital--Any hospital that is not government-owned and operated.

(9) [(8)] Private Institution for Mental Diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment or care of individuals with mental illness and that is not government-owned and operated.

(10) [(9)] Program period--Each program period is equal to a federal fiscal year beginning October 1 and ending September 30 of the following year.

(11) [(10)] Prospective Payment System--A method of reimbursement in which payment is made based on a predetermined, fixed amount.

(12) [~~(11)~~] Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures under this subchapter.

(13) [~~(12)~~] State government-owned hospital--Any hospital owned by the state of Texas that is not considered an IMD.

(14) [~~(13)~~] State government-owned IMD--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment or care of individuals with mental illness and that is owned by the state of Texas that is considered an IMD.

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

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 15 business days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

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

(d) Payments for non-state government-owned and operated hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "non-state government owned and operated hospital" that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

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

(A) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(B) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating non-state government-owned and operated hospital's payment under this section, HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(e) Payments for private hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "private hospital" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

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

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and Centers for Medicare & Medicaid Services (CMS) for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating private hospital's payment under this section, HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(f) Payments for state government-owned hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as "state government-owned hospital" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

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

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a

hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC will publish the IGT deadlines and all associated dates on its Internet website.

(3) Payment Methodology.

(A) To determine payment under this section for each participating state-owned hospital reimbursed through Prospective Payment System (PPS), HHSC will sum the hospital's inpatient FFS Medicare payment gap and the hospital's outpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(B) To determine payment under this section for each participating state-owned hospital not reimbursed through Prospective Payment System (PPS), HHSC will use the hospital's FFS outpatient Medicare payment gap.

(g) Payments for state government-owned IMDs.

(1) Eligible hospitals.

(A) Payments under this subsection will be limited to hospitals defined as "state government-owned IMD" in subsection (b) of this section that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(B) The hospital must have submitted at least one adjudicated FFS Medicaid claim for each reporting period to be eligible for payment.

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

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating state government-owned IMD hospital's payment under this section, HHSC will use the hospital's inpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges. Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

(h) Payments for private IMDs.

(1) Eligible hospitals.

(A) Payments under this subsection will be limited to hospitals defined as "private IMD" in subsection (b) of this section that participate in Texas Medicaid fee-for-service.

(B) The hospital must have submitted at least one adjudicated FFS Medicaid claim for each reporting period to be eligible for payment.

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

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and CMS for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated in any paragraph under this subchapter, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share actually transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating private IMD hospital's payment under this section, HHSC will use the hospital's inpatient FFS Medicare payment gap. HARP payments will be limited such that total inpatient Medicaid payments including supplemental payments and the portion of HARP payments for the inpatient FFS Medicare payment gap do not exceed Medicaid charges.

Nominal charge providers as defined in subsection (b) of this section are exempt from this limitation.

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

(j) Reconciliation. HHSC will reconcile the amount of the non-federal funds actually expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period. If the amount of non-federal funds actually expended under this section is less than the amount transferred to HHSC, HHSC will refund the balance proportionally to how it was received.

(k) Payments under this section will be made on a semi-annual basis.

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

Filed with the Office of the Secretary of State on August 29, 2024.

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Karen Ray
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Texas Health and Human Services Commission
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SUBCHAPTER J. PURCHASED HEALTH SERVICES
DIVISION 11. TEXAS HEALTHCARE TRANSFORMATION AND QUALITY IMPROVEMENT PROGRAM REIMBURSEMENT

1 TAC §355.8212

STATUTORY AUTHORITY

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

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

§355.8212. Waiver Payments to Hospitals for Uncompensated Charity Care.

(a) Introduction. Texas Healthcare Transformation and Quality Improvement Program §1115(a) Medicaid demonstration waiver payments are available under this section to help defray the uncompensated cost of charity care provided by eligible hospitals on or after October 1, 2019. Waiver payments to hospitals for uncompensated care provided before October 1, 2019, are described in §355.8201 of this division (relating to Waiver Payments to Hospitals for Uncompensated Care). Waiver payments to hospitals must be in compliance with the Centers for Medicare & Medicaid Services approved waiver Program Funding and Mechanics Protocol, HHSC waiver instructions, and this section.

(b) Definitions.

(1) Allocation amount--The amount of funds approved by the Centers for Medicare & Medicaid Services for uncompensated-care payments for the demonstration year that is allocated to each uncompensated-care provider pool or individual hospital, as described in subsections (f)(2) and (g)(6) of this section.

(2) Centers for Medicare & Medicaid Services (CMS)--The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid, or its successor.

(3) Charity care--Healthcare services provided without expectation of reimbursement to uninsured patients who meet the provider's charity-care policy. The charity-care policy should adhere to the charity-care principles of the Healthcare Financial Management Association Principles and Practices Board Statement 15 (December 2012). Charity care includes full or partial discounts given to uninsured patients who meet the provider's financial assistance policy. Charity care does not include bad debt, courtesy allowances, or discounts given to patients who do not meet the provider's charity-care policy or financial assistance policy.

(4) Data year--A 12-month period that is described in §355.8066 of this subchapter (relating to State Payment Cap and Hospital-Specific Limit Methodology) and from which HHSC will compile cost and payment data to determine uncompensated-care payment amounts. This period corresponds to the Disproportionate Share Hospital data year.

(5) Demonstration year--The 12-month period beginning October 1 for which the payments calculated under this section are made. This period corresponds to the Disproportionate Share Hospital (DSH) program year. Demonstration year one corresponded to the 2012 DSH program year, October 1, 2011, through September 30, 2012.

(6) Disproportionate Share Hospital (DSH)--A hospital participating in the Texas Medicaid program as defined in §355.8065 of this subchapter (relating to Disproportionate Share Hospital Reimbursement Methodology).

(7) Governmental entity--A state agency or a political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county, or state entity.

(8) HHSC--The Texas Health and Human Services Commission, or its designee.

(9) Impecunious charge ratio--A ratio used to determine if a hospital is eligible to receive payment from the HICH (High Impecunious Charge Hospital) pool as described in subsection (f)(2)(C)(ii) of this section.

(10) Institution for mental diseases (IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness, defined in §1905(i) of the Social Security Act. IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.8060 of this subchapter (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities) and

§355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Diseases (IMD)).

(11) Intergovernmental transfer (IGT)--A transfer of public funds from a governmental entity to HHSC.

(12) Medicaid cost report--Hospital and Hospital Health Care Complex Cost Report (Form CMS 2552), also known as the Medicare cost report.

(13) Mid-Level Professional--Medical practitioners which include the following professions only:

(A) Certified Registered Nurse Anesthetists;

(B) Nurse Practitioners;

(C) Physician Assistants;

(D) Dentists;

(E) Certified Nurse Midwives;

(F) Clinical Social Workers;

(G) Clinical Psychologists; and

(H) Optometrists.

(14) Non-public hospital--A hospital that meets the definition of non-public provider as defined in §355.8200 of this division [subchapter] (relating to Retained Funds for the Uncompensated Care Program).

(15) Public funds--Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(16) Public Health Hospital (PHH)--The Texas Center for Infectious Disease or any successor facility operated by the Department of State Health Services.

(17) Rural hospital--A hospital enrolled as a Medicaid provider that:

(A) is located in a county with 68,750 or fewer persons according to most recent decennial census U.S. Census; or

(B) was designated by Medicare as a Critical Access Hospital (CAH) or a Sole Community Hospital (SCH) before October 1, 2021; or

(C) is designated by Medicare as a CAH, SCH, or Rural Referral Center (RRC); and is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or

(D) meets all of the following:

(i) has 100 or fewer beds;

(ii) is designated by Medicare as a CAH, SCH, or an RRC; and

(iii) is located in an MSA.

(18) Service Delivery Area (SDA)--The counties included in any HHSC-defined geographic area as applicable to each Managed Care Organization (MCO).

(19) State institution for mental diseases (State IMD)--A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness defined in §1905(i) of the Social Security Act and that is owned and operated by a state university or other state agency. State IMD hospitals are reimbursed as freestanding psychiatric facilities under §355.761 of this chapter (relating to Reimbursement Methodology for Institutions for Mental Disease (IMD)).

(20) State-owned hospital--A hospital that is defined as a state IMD, state-owned teaching hospital, or a Public Health Hospital (PHH) in this section.

(21) State-owned teaching hospital--A hospital that is a state-owned teaching hospital as defined in §355.8052 of this subchapter (relating to Inpatient Hospital Reimbursement).

(22) State Payment Cap--The maximum payment amount, as applied to payments that will be made for the program year, that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid-eligible or uninsured. The state payment cap is calculated using the methodology described in §355.8066 of this subchapter.

(23) Transferring public hospital--A hospital that is a transferring public hospital as defined in §355.8065 of this subchapter.

(24) Uncompensated-care application--A form prescribed by HHSC to identify uncompensated costs for Medicaid-enrolled providers.

(25) Uncompensated-care payments--Payments intended to defray the uncompensated costs of charity care as defined in this subsection.

(26) Uninsured patient--An individual who has no health insurance or other source of third-party coverage for the services provided. The term includes an individual enrolled in Medicaid who received services that do not meet the definition of medical assistance in section 1905(a) of the Social Security Act (Medicaid services), if such inclusion is specified in the hospital's charity-care policy or financial assistance policy and the patient meets the hospital's policy criteria.

(27) Waiver--The Texas Healthcare Transformation and Quality Improvement Program Medicaid demonstration waiver under §1115 of the Social Security Act.

(c) Eligibility. A hospital that meets the requirements described in this subsection may receive payments under this section.

(1) Generally. To be eligible for any payment under this section:

(A) A hospital must be enrolled as a Medicaid provider in the State of Texas at the beginning of the demonstration year.

(B) A hospital must meet any criteria described by the waiver as a condition of eligibility to receive an uncompensated-care payment.

(C) Non-public hospitals must not return or reimburse to a governmental entity any part of a payment under this section.

(D) Public Hospitals must be operated by a governmental entity, have that designation filed with HHSC and must not receive, and have no agreement to receive, any portion of the payments made to any non-public hospital.

(E) A non-public provider must have paid the Uncompensated Care (UC) application fee upon submission of the application in accordance with §355.8200 of this subchapter.

(F) Effective [Beginning in] demonstration year thirteen, all non-rural hospitals, except for state-owned hospitals, are [will be] required to enroll, participate in, and comply with requirements for all voluntary supplemental Medicaid or directed Medicaid programs

for which the hospital is eligible, including all components of those programs, within the State of Texas to participate in UC. This requirement does not apply to a program or component, as applicable, if:

(i) a hospital's estimated payment:

(I) is less than $25,000 from the entire program for a program without multiple components; or

(II) is less than $25,000 from a component for a program with multiple components; and

(ii) enrollment for the program concluded after the effective date of this requirement.

(2) Uncompensated-care payments. For a hospital to be eligible to receive uncompensated-care payments, in addition to the requirements in paragraph (1) of this subsection, the hospital must submit to HHSC an uncompensated-care application for the demonstration year, as is more fully described in subsection (g)(1) of this section, by the deadline specified by HHSC.

(3) Changes that may affect eligibility for uncompensated-care payments.

(A) If a hospital closes, loses its license, loses its Medicare or Medicaid eligibility, or files bankruptcy before receiving all or a portion of the uncompensated-care payments for a demonstration year, HHSC will determine the hospital's eligibility to receive payments going forward on a case-by-case basis. In making the determination, HHSC will consider multiple factors including whether the hospital was in compliance with all requirements during the demonstration year and whether it can satisfy the requirement to cooperate in the reconciliation process as described in subsection (i) of this section.

(B) A hospital must notify HHSC Provider Finance Department in writing within 30 days of the filing of bankruptcy or of changes in ownership, operation, licensure, or Medicare or Medicaid enrollment that may affect the hospital's continued eligibility for payments under this section.

(C) Merged Hospitals.

(i) HHSC will consider a merger of two or more hospitals for purposes of determining eligibility and calculating a hospital's demonstration year payments under this section if:

(I) a hospital that was a party to the merger submits to HHSC documents verifying the merger status with Medicare prior to the deadline for submission of the UC application for that demonstration year; and

(II) the hospital submitting the information under subclause (I) assumed all Medicaid-related liabilities of each hospital that is a party to the merger, as determined by HHSC after review of the applicable agreements.

(ii) If the requirements of clause (i) are not met, HHSC will not consider the merger for purposes of determining eligibility or calculating a hospital's demonstration year payments under this section. Until HHSC determines that the hospitals are eligible for payments as a merged hospital, each of the merging hospitals will continue to receive any UC payments to which they were entitled prior to the merger.

(d) Source of funding. The non-federal share of funding for payments under this section is limited to public funds from governmental entities. Governmental entities that choose to support payments under this section affirm that funds transferred to HHSC meet federal requirements related to the non-federal share of such payments, including §1903(w) of the Social Security Act. Prior to processing uncompensated-care payments for the final payment period within a waiver demonstration year for any uncompensated-care pool or sub-pool described in subsection (f)(2) of this section, HHSC will survey the governmental entities that provide public funds for the hospitals in that pool or sub-pool to determine the amount of funding available to support payments from that pool or sub-pool.

(e) Payment frequency. HHSC will distribute waiver payments on a schedule to be determined by HHSC and posted on HHSC's website.

(f) Funding limitations.

(1) Maximum aggregate amount of provider pool funds. Payments made under this section are limited by the maximum aggregate amount of funds allocated to the provider's uncompensated-care pool for the demonstration year. If payments for uncompensated care for an uncompensated-care pool attributable to a demonstration year are expected to exceed the aggregate amount of funds allocated to that pool by HHSC for that demonstration year, HHSC will reduce payments to providers in the pool as described in subsection (g)(6) of this section.

(2) Uncompensated-care pools.

(A) HHSC will designate different pools for demonstration years as follows:

(i) for demonstration years nine and ten, a state-owned hospital pool, a non-state-owned hospital pool, a physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool;

(ii) for demonstration year eleven, a state-owned hospital pool, a non-state-owned hospital pool, a state-owned physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool; and

(iii) for demonstration years twelve and beyond, a state-owned hospital pool, a non-state-owned hospital pool, a high impecunious charge hospital (HICH) pool, a state-owned physician group practice pool, a non-state-owned physician group practice pool, a governmental ambulance provider pool, and a publicly owned dental provider pool.

(B) The state-owned hospital pool.

(i) The state-owned hospital pool funds uncompensated-care payments to state-owned hospitals as defined in subsection (b) of this section.

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total annual maximum uncompensated-care payment amount for these hospitals as calculated in subsection (g)(2) of this section.

(C) The state-owned physician group practice pool.

(i) Beginning in demonstration year eleven, the state-owned physician group practice pool funds uncompensated-care payments to state-owned physician groups, as defined in §355.8214 of this division (relating to Waiver Payments to Physician Group Practices for Uncompensated Charity Care).

(ii) HHSC will determine the allocation for this pool at an amount less than or equal to the total maximum uncompensated-care payment amount for these physicians.

(D) The High Impecunious Charge Hospital (HICH) pool.

(i) Effective [Beginning in] demonstration year twelve, the HICH pool funds will be allocated amongst hospitals with a high proportion of uncompensated care charges, rural, and state-owned hospitals. While the funds are set aside before the non-state provider pools, the payments will be calculated for each hospital after both the state-owned hospital pool payments in subparagraph (B) of this paragraph and non-state-owned hospital pool payments in subparagraph (E) of this paragraph.

(ii) Beginning in demonstration year seventeen, the HICH pool funds will be allocated amongst hospitals with a high proportion of uncompensated care charges, rural, and state-owned hospitals. The funds will be set aside before the non-state provider pools and the payments will be calculated for each hospital after the state-owned hospital pool payments in subparagraph (B) of this paragraph and before the non-state-owned provider pool payments in subparagraph (E) of this paragraph.

(iii) [(ii)] A hospital will be deemed as having a high proportion of uncompensated care charges if its impecunious charge ratio is equal to or greater than 27.5 percent, calculated as follows.[:]

(I) The sum of the charges for DSH uninsured charges and total uninsured charity charges, minus any duplicate uninsured charges is the numerator.

(II) The total allowable hospital revenue is the denominator.

(iv) [(iii)] Beginning in demonstration year twelve, HHSC will determine the allocation for this pool at an amount less than the difference in the amount of the total allowable UC pool and the amount of the total allowable UC pool in DY11 but equal to a percentage determined by HHSC annually based on certain factors including charity-care costs, the ratio of reported charity-care costs to hospitals' charity-care costs, and the overall financial stability of hospitals of all ownership types and geographic locations as determined by HHSC.

(v) Beginning in demonstration year seventeen, HHSC will determine the allocation for this pool at an amount equal to or less than one billion but equal to a percentage determined by HHSC annually based on certain factors including charity-care costs, the ratio of reported charity-care costs to hospitals' charity-care costs, and the overall financial stability of hospitals of all ownership types and geographic locations as determined by HHSC.

(E) Non-state-owned provider pools. HHSC will allocate the remaining available uncompensated-care funds, if any, among the non-state-owned provider pools as described in this subparagraph. The remaining available uncompensated-care funds equal the amount of funds approved by CMS for uncompensated-care payments for the demonstration year less the sum of funds allocated to the pools under subparagraphs (B) - (D) of this paragraph. HHSC will allocate the funds among non-state-owned provider pools based on the following amounts.

(i) For the physician group practice pool in demonstration years nine and ten, or the non-state-owned physician group practice pool effective [beginning in] demonstration year eleven, the governmental ambulance provider pool, and the publicly owned dental provider pool:

(I) for demonstration year nine, an amount to equal the percentage of the applicable total uncompensated-care pool amount paid to each group in demonstration year six; and

(II) for demonstration years ten and after, an amount to equal a percentage determined by HHSC annually based on factors including the amount of reported charity-care costs and the ratio of reported charity-care costs to hospitals' charity-care costs. For physicians, current year charity-care costs will be used, while for dental and ambulance providers, prior year charity-care costs will be used.

(ii) For the non-state-owned hospital pool, all of the remaining funds after the allocations described in clause (i) of this subparagraph. HHSC will further allocate the funds in the non-state-owned hospital pool among all hospitals in the pool and create non-state-owned hospital sub-pools as follows:

(I) calculate a revised maximum payment amount for each non-state-owned hospital as described in subsection (g)(6) of this section and allocate that amount to the hospital; and

(II) group all non-state-owned hospitals and non-state-owned physician groups into sub-pools based on its geographic location within one of the state's Medicaid service delivery areas (SDAs), as described in subsection (g)(7) of this section.

(3) Availability of funds. Payments made under this section are limited by the availability of funds identified in subsection (d) of this section and timely received by HHSC. If sufficient funds are not available for all payments for which the providers in each pool or sub-pool are eligible, HHSC will reduce payments as described in subsection (h)(2) of this section.

(4) Redistribution. If for any reason funds allocated to a provider pool or to individual providers within a sub-pool are not paid to providers in that pool or sub-pool for the demonstration year, the funds will be redistributed to other provider pools based on each pool's pro-rata share of remaining uncompensated costs for the same demonstration year. The redistribution will occur when the reconciliation for that demonstration year is performed.

(g) Uncompensated-care payment amount.

(1) Application.

(A) Cost and payment data reported by a hospital in the uncompensated-care application is used to calculate the annual maximum uncompensated-care payment amount for the applicable demonstration year, as described in paragraph (2) of this subsection.

(B) Unless otherwise instructed in the application, a hospital must base the cost and payment data reported in the application on its applicable as-filed CMS 2552 Cost Report(s) For Electronic Filing Of Hospitals corresponding to the data year and must comply with the application instructions or other guidance issued by HHSC.

(i) When the application requests data or information outside of the as-filed cost report(s), a hospital must provide all requested documentation to support the reported data or information.

(ii) For a new hospital, the cost and payment data period may differ from the data year, resulting in the eligible uncompensated costs based only on services provided after the hospital's Medicaid enrollment date. HHSC will determine the data period in such situations.

(2) Calculation.

(A) A hospital's annual maximum uncompensated-care payment amount is the sum of the components described in clauses (i) - (iv) of this subparagraph.

(i) The hospital's inpatient and outpatient charity-care costs pre-populated in or reported on the uncompensated-care application, as described in paragraph (3) of this subsection, reduced by interim DSH payments for the same program period, if any, that reim-

burse the hospital for the same costs. To identify DSH payments that reimburse the hospital for the same costs, HHSC will:

(I) use self-reported information on the application to identify charges that can be claimed by the hospital in both DSH and Uncompensated Care (UC), convert the charges to cost, and reduce the cost by any applicable payments described in paragraph (3) of this subsection;

(II) calculate a DSH-only uninsured shortfall by reducing the hospital's total uninsured costs, calculated as described in §355.8066 of this subchapter, by the result from subclause (I) of this clause; and

(III) reduce the interim DSH payment amount by the sum of:

(-a-) the DSH-only uninsured shortfall calculated as described in subclause (II) of this clause; and

(-b-) the hospital's Medicaid shortfall, calculated as described in §355.8066 of this subchapter.

(ii) Other eligible costs for the data year, as described in paragraph (4) of this subsection.

(iii) Cost and payment adjustments, if any, as described in paragraph (5) of this subsection.

(iv) For each transferring public hospital, the amount transferred to HHSC to that hospital and private hospitals to support DSH payments for the same demonstration year.

(B) A hospital also participating in the DSH program cannot receive total uncompensated-care payments under this section (relating to inpatient and outpatient hospital services provided to uninsured charity-care individuals) and DSH payments that exceed the hospital's total eligible uncompensated costs. For purposes of this requirement, "total eligible uncompensated costs" means the hospital's state payment cap for interim payments or DSH hospital-specific limit (HSL) in the UC reconciliation plus the unreimbursed costs of inpatient and outpatient services provided to uninsured charity-care patients not included in the state payment cap or HSL for the corresponding program year.

(3) Hospital charity-care costs.

(A) For each hospital required by Medicare to submit schedule S-10 of the Medicaid cost report, HHSC will pre-populate the uncompensated-care application described in paragraph (1) of this subsection with the uninsured charity-care charges and payments reported by the hospital on schedule S-10 for the hospital's cost reporting period ending in the calendar year two years before the demonstration year. For example, for demonstration year 9, which coincides with the federal fiscal year 2020, HHSC will use data from the hospital's cost reporting period ending in the calendar year 2018. Hospitals should also report any additional payments associated with uninsured charity charges that were not captured in worksheet S-10 in the application described in paragraph (1) of this subsection.

(B) For each hospital not required by Medicare to submit schedule S-10 of the Medicaid cost report, the hospital must report its hospital charity-care charges and payments in compliance with the instructions on the uncompensated-care application described in paragraph (1) of this subsection.

(i) The instructions for reporting eligible charity-care costs in the application will be consistent with instructions contained in schedule S-10.

(ii) An IMD may not report charity-care charges for services provided during the data year to patients aged 21 through 64.

(4) Other eligible costs.

(A) In addition to inpatient and outpatient charity-care costs, a hospital may also claim reimbursement under this section for uncompensated charity care, as specified in the uncompensated-care application, that is related to the following services provided to uninsured patients who meet the hospital's charity-care policy:

(i) direct patient-care services of physicians and mid-level professionals; and

(ii) certain pharmacy services.

(B) A payment under this section for the costs described in subparagraph (A) of this paragraph are not considered inpatient or outpatient Medicaid payments for the purpose of the DSH audit described in §355.8065 of this subchapter.

(5) Adjustments. When submitting the uncompensated-care application, a hospital may request that cost and payment data from the data year be adjusted to reflect increases or decreases in costs resulting from changes in operations or circumstances.

(A) A hospital:

(i) may request that costs not reflected on the as-filed cost report, but which would be incurred for the demonstration year, be included when calculating payment amounts; and

(ii) may request that costs reflected on the as-filed cost report, but which would not be incurred for the demonstration year, be excluded when calculating payment amounts.

(B) Documentation supporting the request must accompany the application, and provide sufficient information for HHSC to verify the link between the changes to the hospital's operations or circumstances and the specified numbers used to calculate the amount of the adjustment.

(i) Such supporting documentation must include:

(I) a detailed description of the specific changes to the hospital's operations or circumstances;

(II) verifiable information from the hospital's general ledger, financial statements, patient accounting records or other relevant sources that support the numbers used to calculate the adjustment; and

(III) if applicable, a copy of any relevant contracts, financial assistance policies, or other policies or procedures that verify the change to the hospital's operations or circumstances.

(ii) HHSC will deny a request if it cannot verify that costs not reflected on the as-filed cost report will be incurred for the demonstration year.

(C) Notwithstanding the availability of adjustments impacting the cost and payment data described in this section, no adjustments to the state payment cap will be considered for purposes of Medicaid DSH payment calculations described in §355.8065 of this subchapter.

(6) Reduction to stay within uncompensated-care pool allocation amounts. Prior to processing uncompensated-care payments for any payment period within a waiver demonstration year for any uncompensated-care pool described in subsection (f)(2) of this section, HHSC will determine if such a payment would cause total uncompensated-care payments for the demonstration year for the pool to exceed the allocation amount for the pool and will reduce the maximum uncompensated-care payment amounts providers in the pool are eligible

to receive for that period as required to remain within the pool allocation amount.

(A) Calculations in this paragraph will be applied to each of the uncompensated-care pools separately.

(B) HHSC will calculate the following data points.

(i) For each provider, prior period payments equal prior period uncompensated-care payments for the demonstration year, including advance payments described in paragraph (9) of this subsection, and payments allocated in preceding UC pools. For example, the HICH pool will consider UC payments allocated in the state-owned hospital and non-state-owned hospital pools beginning in demonstration year twelve through demonstration year sixteen. Beginning in demonstration year seventeen, the non-state-owned hospital pool will consider UC payments allocated in the state-owned and HICH pools.

(ii) For each provider, a maximum uncompensated-care payment for the payment period to equal the sum of:

(I) the portion of the annual maximum uncompensated-care payment amount calculated for that provider (as described in this section and the sections referenced in subsection (f)(2) of this section) that is attributable to the payment period; and

(II) the difference, if any, between the portions of the annual maximum uncompensated-care payment amounts attributable to prior periods and the prior period payments calculated in clause (i) of this subparagraph.

(iii) The cumulative maximum payment amount to equal the sum of prior period payments from clause (i) of this subparagraph and the maximum uncompensated-care payment for the payment period from clause (ii) of this subparagraph for all members of the pool combined.

(iv) A pool-wide total maximum uncompensated-care payment for the demonstration year to equal the sum of all pool members' annual maximum uncompensated-care payment amounts for the demonstration year from paragraph (2) of this subsection.

(v) A pool-wide ratio calculated as the pool allocation amount from subsection (f)(2) of this section divided by the pool-wide total maximum uncompensated-care payment amount for the demonstration year from clause (iv) of this subparagraph.

(C) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is less than the allocation amount for the pool, each provider in the pool is eligible to receive its maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph without any reduction to remain within the pool allocation amount.

(D) If the cumulative maximum payment amount for the pool from subparagraph (B)(iii) of this paragraph is more than the allocation amount for the pool, HHSC will calculate a revised maximum uncompensated-care payment for the payment period for each provider in the pool as follows.

(i) The physician group practice pool, the governmental ambulance provider pool, and the publicly owned dental provider pool. HHSC will calculate a capped payment amount equal to the product of each provider's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the pool-wide ratio calculated in subparagraph (B)(v) of this paragraph.

(ii) The non-state-owned hospital pool.

(I) For rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all rural hospitals in the pool;

(-b-) in demonstration year:

(-1-) nine and ten, set aside for rural hospitals the amount calculated in item (-a-) of this subclause; or

(-2-) eleven and after, set aside for rural hospitals the lesser of the amount calculated in item (-a-) of this subclause or the amount set aside for rural hospitals in demonstration year ten;

(-c-) calculate a ratio to equal the rural hospital set-aside amount from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(II) For non-rural hospitals, HHSC will:

(-a-) sum the annual maximum uncompensated-care payment amounts from paragraph (2) of this subsection for all non-rural hospitals in the pool;

(-b-) calculate an amount to equal the difference between the pool allocation amount from subsection (f)(2) of this section and the set-aside amount from subclause (I)(-b-) of this clause;

(-c-) calculate a ratio to equal the result from item (-b-) of this subclause divided by the total annual maximum uncompensated-care payment amount for non-rural hospitals from item (-a-) of this subclause; and

(-d-) calculate a capped payment amount equal to the product of each non-rural hospital's annual maximum uncompensated-care payment amount for the demonstration year from paragraph (2) of this subsection and the ratio calculated in item (-c-) of this subclause.

(III) The revised maximum uncompensated-care payment for the payment period equals the lesser of:

(-a-) the maximum uncompensated-care payment for the payment period from subparagraph (B)(ii) of this paragraph; or

(-b-) the difference between the capped payment amount from subclause (I) or (II) of this clause and the prior period payments from subparagraph (B)(i) of this paragraph.

(IV) HHSC will allocate to each non-state-owned hospital the revised maximum uncompensated-care payment amount from subclause (III) of this clause.

(7) Non-state-owned hospital SDA sub-pools. After HHSC completes the calculations described in paragraph (6) of this subsection, HHSC will place each non-state-owned hospital into a sub-pool based on the hospital's geographic location in a designated Medicaid SDA for purposes of the calculations described in subsection (h) of this section.

(8) Prohibition on duplication of costs. Eligible uncompensated-care costs cannot be reported on multiple uncompensated-care applications, including uncompensated-care applications for other programs. Reporting on multiple uncompensated-care applications is a duplication of costs.

(9) Advance payments.

(A) In a demonstration year in which uncompensated-care payments will be delayed pending data submission or for other reasons, HHSC may make advance payments to hospitals that meet the eligibility requirements described in subsection (c)(2) of this section and submitted an acceptable uncompensated-care application for the preceding demonstration year from which HHSC calculated an annual maximum uncompensated-care payment amount for that year.

(B) The amount of the advance payments will:

(i) in demonstration year nine, be based on uninsured charity-care costs reported by the hospital on schedule S-10 of the CMS 2552-10 cost report used for purposes of sizing the UC pool, or on documentation submitted for that purpose by each hospital not required to submit schedule S-10 with its cost report; and

(ii) in demonstration years ten and after, be a percentage, to be determined by HHSC, of the annual maximum uncompensated-care payment amount calculated by HHSC for the preceding demonstration year.

(C) Advance payments are considered to be prior period payments as described in paragraph (6)(B)(i) of this subsection.

(D) A hospital that did not submit an acceptable uncompensated-care application for the preceding demonstration year is not eligible for an advance payment.

(E) If a partial year uncompensated-care application was used to determine the preceding demonstration year's payments, data from that application may be annualized for use in the computation of an advance payment amount.

(h) Payment methodology.

(1) Notice. Prior to making any payment described in subsection (g) of this section, HHSC will give notice of the following information:

(A) the maximum payment amount for each hospital in a pool or sub-pool for the payment period (based on whether the payment is made quarterly, semi-annually, or annually);

(B) the maximum IGT amount necessary for hospitals in a pool or sub-pool to receive the amounts described in subparagraph (A) of this paragraph; and

(C) the deadline for completing the IGT.

(2) Payment amount. The amount of the payment to hospitals in each pool or sub-pool will be determined based on the amount of funds transferred by governmental entities as follows.

(A) If the governmental entities transfer the maximum amount referenced in paragraph (1) of this subsection, the hospitals in the pool or sub-pool will receive the full payment amount calculated for that payment period.

(B) If the governmental entities do not transfer the maximum amount referenced in paragraph (1) of this subsection, each hospital in the pool or sub-pool will receive a portion of its payment amount for that period, based on the hospital's percentage of the total payment amounts for all providers in the pool or sub-pool.

(3) Final payment opportunity. Within payments described in this section, governmental entities that do not transfer the maximum IGT amount described in paragraph (1) of this subsection during a demonstration year will be allowed to fund the remaining payments to hospitals in the pool or sub-pool at the time of the final payment for that demonstration year. The IGT will be applied in the following order:

(A) to the final payments up to the maximum amount; and

(B) to remaining balances for prior payment periods in the demonstration year.

(i) Reconciliation. HHSC will reconcile actual costs incurred by the hospital for the demonstration year with uncompensated-care payments, if any, made to the hospital for the same period.

(1) If a hospital received payments in excess of its actual costs, the overpaid amount will be recouped from the hospital, as described in subsection (j) of this section.

(2) If a hospital received payments less than its actual costs, and if HHSC has available waiver funding for the demonstration year in which the costs were accrued, the hospital may receive reimbursement for some or all of those actual documented unreimbursed costs.

(3) Each hospital that received an uncompensated-care payment during a demonstration year must cooperate in the reconciliation process by reporting its actual costs and payments for that period on the form provided by HHSC for that purpose, even if the hospital closed or withdrew from participation in the uncompensated-care program. If a hospital fails to cooperate in the reconciliation process, HHSC may recoup the full amount of uncompensated-care payments to the hospital for the period at issue.

(j) Recoupment.

(1) In the event of an overpayment identified by HHSC or a disallowance by CMS of federal financial participation related to a hospital's receipt or use of payments under this section, HHSC may recoup an amount equivalent to the amount of the overpayment or disallowance. The non-federal share of any funds recouped from the hospital will be returned to the governmental entities in proportion to each entity's initial contribution to funding the program for that hospital's SDA in the applicable program year.

(2) Payments under this section may be subject to adjustment for payments made in error, including, without limitation, adjustments under §371.1711 of this title (relating to Recoupment of Overpayments and Debts), 42 CFR Part 455, and Chapter 403 of the Texas Government Code. HHSC may recoup an amount equivalent to any such adjustment.

(3) HHSC may recoup from any current or future Medicaid payments as follows.

(A) HHSC will recoup from the hospital against which any overpayment was made or disallowance was directed.

(B) If the hospital has not paid the full amount of the recoupment or entered into a written agreement with HHSC to do so within 30 days of the hospital's receipt of HHSC's written notice of recoupment, HHSC may withhold any or all future Medicaid payments from the hospital until HHSC has recovered an amount equal to the amount overpaid or disallowed.

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

Filed with the Office of the Secretary of State on August 29, 2024.

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Karen Ray
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Texas Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 487-3480

TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 25. SUBSTANTIVE RULES APPLICABLE TO ELECTRIC SERVICE PROVIDERS

SUBCHAPTER E. CERTIFICATION, LICENSING AND REGISTRATION

16 TAC §25.114

The Public Utility Commission of Texas (commission) proposes new §25.114, relating to Registration of Virtual Currency Mining Facilities. The proposed rule implements Public Utility Regulatory Act (PURA) §39.360 as enacted by Senate Bill (SB) 1929 from the 88th Texas Legislature (R.S.). Proposed §25.114 establishes a process for the registration of virtual currency mining facilities in the Electric Reliability Council of Texas (ERCOT) region that demand a large load of interruptible power.

The proposed rule would require a registrant to provide information to the commission annually about its virtual currency mining facility's location, owners, form of business, and demand for electricity. The commission may share the registrants' information with ERCOT.

Growth Impact Statement

The agency provides the following governmental growth impact statement for the proposed rule, as required by Texas Government Code §2001.0221. The agency has determined that for each year of the first five years that the proposed new rule is in effect, the following statements will apply:

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

(2) implementation of the proposed rule will not require the creation of new employee positions and will not require the elimination of existing employee positions;

(3) implementation of the proposed rule will not require an increase and will not require a decrease in future legislative appropriations to the agency;

(4) the proposed rule will not require an increase and will not require a decrease in fees paid to the agency;

(5) the proposed rule will create new regulations;

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

(7) the proposed rule will not change the number of individuals subject to the rules' applicability, because the rule did not previously exist; and

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

Fiscal Impact on Small and Micro-Businesses and Rural Communities

There is no adverse economic effect anticipated for small businesses, micro-businesses, or rural communities as a result of implementing the proposed rule. Accordingly, no economic impact statement or regulatory flexibility analysis is required under Texas Government Code §2006.002(c).

Takings Impact Analysis

The commission has determined that the proposed rule will not be a taking of private property as defined in chapter 2007 of the Texas Government Code.

Fiscal Impact on State and Local Government

Kim Van Winkle, Attorney, Market Analysis Division, has determined that for the first five-year period the proposed rule is in effect, there will be no fiscal implications for the state or for units of local government under Texas Government Code §2001.024(a)(4) as a result of enforcing or administering the section.

Public Benefits

Ms. Van Winkle has determined that for each year of the first five years the proposed section is in effect the public benefit anticipated as a result of enforcing the section will be improved electric grid reliability by providing ERCOT with information about the location and size of large flexible cryptocurrency mining loads, which sometimes engage in curtailment that can impact system frequency. There will be no significant economic cost to persons required to comply with the rules under Texas Government Code §2001.024(a)(5).

Local Employment Impact Statement

For each year of the first five years the proposed section is in effect, there should be no effect on a local economy; therefore, no local employment impact statement is required under Texas Government Code §2001.022.

Costs to Regulated Persons

Texas Government Code §2001.0045(b) does not apply to this rulemaking because the commission is expressly excluded under §2001.0045(c)(7).

Public Hearing

The commission staff will conduct a public hearing on this rulemaking if requested in accordance with Texas Government Code §2001.029. The request for a public hearing must be received by September 26, 2024. Interested persons may contact Kim Van Winkle (at kim.vanwinkle@puc.texas.gov) and Jacob Bulzak (at jacob.bulzak@puc.texas.gov) prior to requesting a public hearing to discuss the purpose and scope of a public hearing on the proposed rule. If a hearing is scheduled, commission staff will file in this project a notice of hearing.

Public Comments

Interested persons may file comments electronically through the interchange on the commission's website. Comments must be filed by September 26, 2024. Comments should be organized in a manner consistent with the organization of the proposed rule. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the proposed rule. All comments should refer to Project Number 56962.

Each set of comments should include a standalone executive summary as the last page of the filing. This executive summary must be clearly labeled with the submitting entity's name and should include a bulleted list covering each substantive recommendation made in the comments.

Statutory Authority

The new section is proposed under the following provisions of PURA: §14.001, which grants the commission the general power to regulate and supervise the business of each public utility within its jurisdiction and to do anything specifically designated or implied by this title that is necessary and convenient to the exercise of that power and jurisdiction; §14.002, which authorizes the commission to adopt and enforce rules reasonably required in the exercise of its powers and jurisdiction; and §39.360, which directs the commission to adopt criteria for determining whether a load is interruptible for the purposes of this section and establish a method to ensure compliance with the statutory registration requirements. Section 39.360(e) authorizes the commission to share the registration information with ERCOT.

Cross Reference to Statutes: Public Utility Regulatory Act §§14.001; 14.002; and 39.360.

§25.114. Registration of Virtual Currency Mining Facilities.

(a) Applicability. A person operating a virtual currency mining facility receiving retail electric service in the Electric Reliability Council of Texas (ERCOT) region must, not later than one working day after the date the facility begins receiving retail electric service, register the facility as a large flexible load if the facility requires a total load of more than 75 megawatts (MW) and the facility's interruptible load equals 10 percent or more of the actual or anticipated annual peak demand of the facility. A person operating a virtual currency mining facility that is required to register as a large flexible load under this section and began receiving retail electric service prior to the effective date of this rule must register no later than February 1, 2025.

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

(1) Virtual currency--has the meaning assigned by Section 12.001, Business & Commerce Code.

(2) Virtual currency mining facility--a facility that uses electronic equipment to add virtual currency transactions to a distributed ledger.

(3) Interruptible load-- the portion of the facility's load that the facility operator can choose to interrupt due to locational marginal prices, load zone prices, response to the ERCOT coincident peak demand for the months of June, July, August and September (4CP), or due to external grid conditions.

(c) A person seeking to register a virtual currency mining facility as a large flexible load must provide the information listed in this subsection in a format established by the commission.

(1) The registrant's legal business name, the name of the registrant's corporate parent or parents, the name of the registrant's principals, and all business names of the registrant.

(2) A mailing address, telephone number, and e-mail address of the principal place of business of the registrant.

(3) The current name, title, business mailing address, telephone number, and e-mail address for the registrant's regulatory contact person, and whether the regulatory contact is an internal staff member of the registrant.

(4) The form of business being registered (e.g., corporation, partnership, or sole proprietor).

(5) Applicable information on file with the Texas Secretary of State, including, the registrant's endorsed certificate of incorporation certified by the Texas Secretary of State, a copy of the registrant's certificate of fact - status or other business registration on file with the Texas Secretary of State.

(6) For each virtual currency mining facility operated by the registrant:

(A) the name, address, and county of operation of each facility;

(B) the identity of the property owner and lessor or facility host;

(C) the size of the facility in square feet and a description of the infrastructure, including whether it is fixed or movable, open or enclosed;

(D) the names of the transmission and distribution service providers serving the facility and the load zone the facility is located in;

(E) the Electric Service Identifier (ESIID) or equivalent unique premise identifier assigned to the facility;

(F) the anticipated peak electric demand, in MWs, from the facility for each year of the five-year period beginning on the date of the registration,

(G) the percentage of the site load that meets the definition of interruptible load in subsection (b)(3) of this section;

(H) the actual peak load in MWs and total power consumption in MWhs for the prior calendar year; and

(I) whether the facility has on-site backup generation and, if so, the nameplate capacity (in MWs) of the generation.

(7) An affidavit signed by a representative, official, officer, or other authorized person with binding authority over the registrant affirming that:

(A) the registrant is authorized to do business in Texas under all applicable laws and is in good standing with the Texas Secretary of State;

(B) that all statements made in the registration submission are true, correct, and complete;

(C) that any material changes in the information will be provided in a timely manner;

(D) that the registrant has provided notice of its compliance with this rule to transmission distribution service providers serving its registered facilities; and

(E) and that the registrant understands and will comply with all applicable law and rules.

(d) Update of registration. A registrant must amend its registration with the commission within 30 days of a change to the information required by subsection (c) of this section.

(e) Renewal of registration. A registered virtual currency mining facility must renew its registration on or before March 1 of every calendar year by submitting the information required by subsection (c) of this section or by submitting a statement that the facility's registration information on file with the commission is current and correct.

(1) No later than November 1 of each year, commission staff will send one notice by email to the regulatory contact listed for a virtual currency mining facility that has not submitted its registration renewal for the current calendar year. Commission staff's failure to send this notice does not excuse a virtual currency mining facility from complying with any of the requirements of this section.

(2) A virtual currency mining facility registration that is not renewed by December 31 of each calendar year expires.

(3) Commission staff will provide ERCOT a list of each virtual currency mining facility that has expired by January 31 each year.

(4) A person whose virtual currency mining facility registration is expired may apply for a new registration at any time.

(f) Administrative penalty. The commission may impose an administrative penalty on a person for a violation of the Public Utility Regulatory Act, commission rules, or rules adopted by an independent organization, including failure to failure to timely respond to commission or commission staff inquiries. A violation of this section is a Class A violation under §25.8, relating to Classification System for Violations of Statutes, Rules, and Orders Applicable to Electric Service Providers, of this Chapter.

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

Filed with the Office of the Secretary of State on August 29, 2024.

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Adriana Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 936-7322

SUBCHAPTER H. ELECTRICAL PLANNING
DIVISION 2. ENERGY EFFICIENCY AND CUSTOMER-OWNED RESOURCES

16 TAC §25.186

The Public Utility Commission of Texas (commission) proposes new 16 Texas Administrative Code (TAC) §25.186 relating to Goal for Average Total Residential Load Reduction. This proposed rule will implement Public Utility Regulatory Act (PURA) §39.919 as enacted by Senate Bill (SB) 1699, Section 5 during the Texas 88th Regular Legislative Session. The proposed rule will create an average total residential load reduction goal through the establishment of a demand response program that may be offered by retail electric providers to residential customers that utilize smart responsive appliances or devices to reduce electricity consumption during an ERCOT peak demand period.

Growth Impact Statement

The agency provides the following governmental growth impact statement for the proposed rule, as required by Texas Government Code §2001.0221. The agency has determined that for each year of the first five years that the proposed rule is in effect, the following statements will apply:

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

(2) implementation of the proposed rule will not require the creation of new employee positions and will not require the elimination of existing employee positions;

(3) implementation of the proposed rule will not require an increase and will not require a decrease in future legislative appropriations to the agency;

(4) the proposed rule will not require an increase and will not require a decrease in fees paid to the agency;

(5) the proposed rule will create a new regulation, as required by SB 1699 (88R);

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

(7) the proposed rule will change the number of individuals subject to the rule's applicability; and

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

Fiscal Impact on Small and Micro-Businesses and Rural Communities

There is no adverse economic effect anticipated for small businesses, micro-businesses, or rural communities as a result of implementing the proposed rule. Accordingly, no economic impact statement or regulatory flexibility analysis is required under Texas Government Code §2006.002(c).

Takings Impact Analysis

The commission has determined that the proposed rule will not be a taking of private property as defined in chapter 2007 of the Texas Government Code.

Fiscal Impact on State and Local Government

Ramya Ramaswamy, Division Director, Energy Efficiency Division has determined that for the first five-year period the proposed rule is in effect, there will be no fiscal implications for the state or for units of local government under Texas Government Code §2001.024(a)(4) as a result of enforcing or administering the section.

Public Benefits

Ms. Ramaswamy has determined that for each year of the first five years the proposed section is in effect the public benefit anticipated as a result of enforcing the section will be more efficient energy consumption by residential customers through the establishment of a load reduction goal and program to implement such a goal. There will not be any probable economic costs to persons required to comply with the rule under Texas Government Code §2001.024(a)(5).

Local Employment Impact Statement

For each year of the first five years the proposed section is in effect, there should be no effect on a local economy; therefore, no local employment impact statement is required under Texas Government Code §2001.022.

Costs to Regulated Persons

Texas Government Code §2001.0045(b) does not apply to this rulemaking because the commission is expressly excluded under subsection §2001.0045(c)(7).

Public Hearing

The commission will conduct a public hearing on this rulemaking if requested in accordance with Texas Government Code §2001.029. The request for a public hearing must be received by September 27, 2024. If a request for public hearing is received, commission staff will file in this project a notice of hearing.

Public Comments

Interested persons may file comments electronically through the interchange on the commission's website. Comments must be filed by September 27, 2024. Comments should be organized in a manner consistent with the organization of the proposed rule. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the proposed rule. The commission will consider the costs and benefits in deciding whether to modify the proposed rule on adoption. All comments should refer to Project Number 56966.

Each set of comments should include a standalone executive summary as the last page of the filing. This executive summary must be clearly labeled with the submitting entity's name and should include a bulleted list covering each substantive recommendation made in the comments.

Statutory Authority

The new section is proposed under Public Utility Regulatory Act (PURA) §14.001, which grants the commission the general power to regulate and supervise the business of each public utility within its jurisdiction and to do anything specifically designated or implied by this title that is necessary and convenient to the exercise of that power and jurisdiction; §14.002, which authorizes the commission to adopt and enforce rules reasonably required in the exercise of its powers and jurisdiction; §14.052, which requires the commission to adopt and enforce rules governing practice and procedure before the commission and, as applicable, practice and procedure before the State Office of Administrative Hearings; §39.905 which prescribes legislative goals for energy efficiency and requires the commission to provide oversight and adopt rules and procedures for such goals; and §39.919 which requires the commission to establish goals in the ERCOT power region to reduce the average total residential load and for the adoption of a program that effectuates such a goal through demand response participation to residential customers.

Cross Reference to Statute: Public Utility Regulatory Act §14.001, 14.002, 14.052, 39.905, 39.919.

§25.186. Goal for Average Total Residential Load Reduction.

(a) Application. This section applies to the independent organization certified under PURA §39.151 for the Electric Reliability Council of Texas (ERCOT) region, a transmission and distribution utility (TDU), and a retail electric provider (REP) providing demand response using a responsive device program to residential customers.

(b) Definition. When used in this section, the term "smart responsive appliance or device" has the following meaning unless the context indicates otherwise: An appliance or device that may be enabled to allow its electric usage or electric usage of connected appliances or devices to be adjusted remotely.

(c) Responsive Device Program. A REP may offer a responsive device program that offers an incentive to residential customers with smart responsive appliances or devices to reduce electricity consumption during an ERCOT peak demand period.

(1) A REP may contract with a demand response provider to provide a responsive device program.

(2) A responsive device program must:

(A) allow demand response participation by residential customers where reasonably available, including during the summer and winter seasons;

(B) be capable of responding to an emergency energy alert issued by the independent organization certified under Public Utility Regulatory Act (PURA) §39.151 for the ERCOT region;

(C) ensure that the program does not adversely impact the needs of a critical care residential customer or chronic condition residential customer as those terms are defined in §25.497 of this title, relating to Critical Load Industrial Customers, Critical Load Public Safety Customers, Critical Care Residential Customers, and Chronic Condition Residential Customers; and

(D) provide that a residential customer is limited to participation in a single demand response program within the ERCOT region.

(3) For the purposes of this section, an ERCOT peak demand period is an hour with the highest value of peak net load, where peak net load is calculated as gross load minus wind and solar.

(d) Average total residential load reduction goal.

(1) No later than 45 days following the end of each calendar quarter, a REP providing responsive device program within the ERCOT region must submit to ERCOT, on a form prescribed by ERCOT, the following information for each calendar month in the quarter:

(A) the electric service identifier (ESI ID) for each residential customer with smart appliances or devices enrolled in each demand response program offered by the REP; and

(B) the date of each demand response event, including each demand response event start time and stop time and the ESI IDs deployed for each event.

(2) No later than March 31 of each calendar year, for each daily ERCOT peak demand period and each ERCOT energy emergency alert period, ERCOT must provide the commission with the following information for the preceding twelve-month period ending on November 30 of the previous calendar year:

(A) the date and time of each period, the value of gross load, and the value of peak net load during those periods;

(B) the total amount of load reduced by all residential customers enrolled in a responsive device program during those periods; and

(C) the total amount of load of all the residential customers enrolled in a responsive device program during those periods.

(3) The average total residential load reduction goal is 0.25, unless the commission adopts an updated goal under subparagraph (C) of this paragraph.

(A) The ratio of load reduced by all responsive device programs during an ERCOT peak period and the total amount of demand of all residential customers participating in the responsive device programs should meet or exceed the average total residential load reduction goal.

(B) On or before June 30 of each even-numbered year, commission staff will review the data received from ERCOT under paragraph (2) of this subsection to assess the effectiveness of the responsive device programs offered by REPs and whether the average

total residential load reduction goal under paragraph (3) of this subsection is being achieved. Commission staff will file a recommendation in Project 56966 on whether the commission should adjust the goal.

(C) The commission will consider commission staff's recommendation under paragraph (3)(B) of this subsection and, if appropriate, issue a written order adopting an updated average total residential load reduction goal, effective December 1 of that calendar year.

(e) Confidentiality. ERCOT must treat the information submitted by a REP under subsection (d)(3) of this section as protected information as defined by the ERCOT protocols.

(f) Funding. A REP may receive funding for a responsive device program through an energy efficiency incentive program established under §25.181 of this title, relating to Energy Efficiency Goal, if the program complies with commission requirements related to the evaluation, measurement, and verification of demand response programs and if smart the responsive appliances or devices meet the requirements of subsection (c) of this section. A transmission and distribution utility required to provide an energy efficiency incentive program under PURA §39.905 may use up to 10 percent of the budgeted spending for responsive device programs offered by a REP under subsection (c) of this section.

(g) Additional information. Commission staff may request additional data from REPs and ERCOT regarding the responsive device program under subsection (c) of this section and to assist in evaluating and revising the goal under subsection (d) of this section.

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

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TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 289. RADIATION CONTROL
SUBCHAPTER G. REGISTRATION REGULATIONS

25 TAC §289.301

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC), on behalf of the Texas Department of State Health Services (DSHS), proposes an amendment to §289.301, concerning Registration and Radiation Safety Requirements for Lasers and Intense-Pulsed Light Devices.

BACKGROUND AND PURPOSE

The purpose of the proposal is to amend Texas Administrative Code, Title 25, Chapter 289 concerning registration and radiation safety requirements for lasers and intense-pulsed light devices. The proposed amendment adds and clarifies registration requirements, personnel requirements, facility requirements, and radiation machine requirements to protect workers and the public from laser radiation machine hazards.

The signage requirements are updated to match the guidelines set forth by the American National Standards Institute (ANSI). Specific warning labels, such as "Danger," "Warning," and "Caution," communicate the potential hazards associated with laser operations and promote a safer working environment for employees and visitors. Referencing the standard allows laser facilities to adhere to the most current national standards, which are often proposed and updated faster than regulatory amendments can be implemented.

SECTION-BY-SECTION SUMMARY

The proposed amendment replaces "agency" with "department," "title" with "chapter," and "shall" with "must." Edits are made to improve grammar and clarity, update references, and clarify laser class throughout the rule. Formatting edits are made to update numbering.

The proposed amendment to §289.301(a)(2) adds language to "class of laser" to include both International Electrotechnical Commission (IEC) and United States Food and Drug Administration (FDA) classifications.

The proposed amendment to §289.301(a)(3)(A) requires users of a Class 3B or Class 4 laser to register with DSHS.

The proposed amendment to §289.301(a)(3)(B) expands the application of the rule to anyone who receives, possesses, uses, owns, or acquires a Class 3B or Class 4 laser.

The proposed amendment to §289.301(b)(1) adds language requiring veterinary facilities to follow applicable laser rules.

The proposed amendment to §289.301(c)(2)(C)(i)-(ii) adds requirements and exemptions for research facilities.

The proposed amendment to §289.301(d) adds definitions of "American National Standards Institute (ANSI)," "engineering controls," "laser light show," "manufacturer," "personal protective equipment (PPE)," "practitioner," "supervision," "veterinarian," and "veterinary medicine." The subsection amends definitions of "access to laser radiation," "accessible laser radiation," "class 1 (I) laser, IEC Class 1 and 1M," "class 2 (II) laser, IEC Class 2 and 2M," "class 3a (IIIa) laser, IEC Class 3R," "class 3b (IIIb) laser, IEC Class 3B," "class 4 (IV) laser, IEC Class 4," "coherent," "collateral radiation," "continuous wave," "controlled area," "divergence," "electromagnetic radiation," "electronic product," "energy," "healing arts," "infrared radiation," "inoperable," "Institutional Review Board (IRB)," "intense-pulsed light (IPL) device," "invisible radiation," "joule," "laser," "laser product," "laser safety officer (LSO)," "maximum permissible exposure (MPE)," "medical event," "mobile service operation," "nominal hazard zone (NHZ)," "optical density," "protective housing," "provider of lasers," "pulse duration," "pulsed laser," "reflection," "transmission," "ultraviolet radiation," "visible radiation (light)," and "wavelength (λ)." The proposal deletes "apparent visual angle" and "practitioner of the healing arts (practitioner)."

The proposed amendment to §289.301(g)(1)(C) updates RC form 226-01 for laser registration and requires the form to contain the legal name of the entity or business.

The proposed amendment to §289.301(g)(2)(D) clarifies laser machines may only be operated by a person qualified by training and experience to use the laser machines.

The proposed amendment to §289.301(g)(3)(B) requires that applications to use Class 3B or Class 4 lasers in industrial, academic, and research and development institutions, be signed by the applicant or registrant, or a person duly authorized to act for and on behalf of the applicant or registrant, and the Laser Safety Officer (LSO).

The proposed amendment to §289.301(g)(4) requires companies that service laser machines to register with DSHS. The application must be signed by the applicant, registrant, or a person duly authorized to act on behalf of the applicant or registrant, and the LSO. Additionally, service companies are required to verify the facility has a valid certificate of registration issued by DSHS before providing services. The language "application for demonstration for the purpose of sales of Class 3b or 4 lasers" was removed.

The proposed amendment to §289.301(g)(5) requires an application for a laser light show be signed by the applicant, registrant, or a person duly authorized to act on behalf of the applicant or registrant, and the LSO. The language "application for providers and the application for alignment, calibration, and/or repair of Class 3b or 4 lasers" was removed.

The proposed amendment to §289.301(h)(1) clarifies a certificate of registration application will only be approved if DSHS determines the application meets all requirements of the chapter.

The proposed amendment to §289.301(j)(1) requires the registrant to comply with the section and the conditions of the certificate of registration.

The proposed amendment to §289.301(j)(2) requires the registrant to designate an LSO and ensures the LSO performs the duties required of the subsection (p).

The proposed amendment to §289.301(j)(3) prohibits a person from making, selling, leasing, transferring, or lending lasers unless such machines and equipment meet the applicable requirements of this section.

The proposed amendment to §289.301(j)(7) adds language registrants must follow in the event of a bankruptcy.

The proposed amendment to §289.301(j)(11) requires an individual to apply for a certificate of registration within 30 days of beginning to use the laser machines.

The proposed amendment to §289.301(j)(12) prohibits a service company from providing laser services to a person who cannot produce evidence of a completed application for registration, or a valid certificate of registration issued by DSHS, except for the initial installation or for demonstration and sales.

The proposed amendment to §289.301(j)(13) adds requirements for a person authorized to perform alignment, calibration, installation, and repair of lasers, in Texas, to maintain a daily log that includes the date of service, name, customer address, certificate of registration number, and records of all services for inspection.

The proposed amendment to §289.301(j)(14) adds requirements for providers of lasers. Providers are required to keep a log of lasers supplied in Texas and only provide lasers to facilities with a valid certificate of registration.

The proposed amendment to §289.301(j)(15) adds requirements for a person authorized to demonstrate and sell lasers in Texas. The registrant is required to maintain records, perform demonstrations only on phantoms, and prohibits deliberate exposure to an individual unless ordered by a licensed practitioner of the healing arts.

The proposed amendment to §289.301(j)(16) adds requirements for a person using loaner laser machines to apply for a certificate of registration or amend a valid certificate of registration within 30 days of receiving the machine.

The proposed amendment to §289.301(l)(1)(A) clarifies the request for termination must be signed by the LSO, owner, or an individual authorized to act on behalf of the registrant.

The proposed amendment to §289.301(n)(3) clarifies that DSHS will notify a registrant in writing, of the department's intent to suspend or revoke a certificate of registration and be provided an opportunity to demonstrate compliance before proceedings to suspend or revoke begin.

The proposed amendment §289.301(o) removes the language concerning bankruptcy and places the language in §289.301(j)(7).

The proposed amendment to §289.301(u)(3) updates laser signage and posting requirements to include updated language in the Danger, Warning, and Caution signs. The updated signage and posting requirements replace §289.301(dd).

The proposed amendment to §289.301(cc) requires records and documentation be maintained at each site, including mobile services. This subsection replaces §289.301(ee).

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rule will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Dr. Timothy Stevenson, Associate Commissioner, Consumer Protection Division, has determined, for each year of the first five years the rule is in effect, the public will benefit from adoption of the rule. The anticipated public benefit of enforcing or administering the rule is improved protection from unnecessary exposure to radiation for the public, patients, workers, and the environment.

Christy Havel Burton, Chief Financial Officer, has also determined, for the first five years the rule is in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because the rule updates procedural requirements, and does not increase equipment testing frequency or fees to the facility.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Radiation Section, Consumer Protection Division, DSHS, Mail Code 1987, P.O. Box 149347, Austin, Texas 78714-9347, or street address 1100 West 49th Street, Austin, Texas 78756; fax (512) 206-3793 or by email to CPDRuleComments@dshs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) faxed or emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When faxing or emailing comments, please indicate "Comments on Proposed Rule 23R012" in the subject line.

The amendment is authorized by Texas Health and Safety Code Chapter 401 (the Texas Radiation Control Act), which provides for DSHS radiation control rules and regulatory program to be compatible with federal standards and regulation; §401.051, which provides the required authority to adopt rules and guidelines relating to the control of sources of radiation; §401.064, which provides for the authority to adopt rules related to inspection of x-ray equipment; §401.101, providing for DSHS registration of facilities possessing sources of radiation; Chapter 401, Subchapter J, which authorizes enforcement of the Act; and Texas Government Code §531.0055 and Texas Health and Safety Code §1001.075, which authorize the Executive Commissioner of HHSC to adopt rules and policies for the operation and provision of health and human services by DSHS and for the administration of Texas Health and Safety Code Chapter 1001.

The amendment implements Texas Health and Safety Code Chapters 401 and 1001; and Texas Government Code Chapter 531.

§289.301. Registration and Radiation Safety Requirements for Lasers and Intense-Pulsed Light Devices.

(a) Purpose.

(1) This section establishes requirements for protection against all classes of laser radiation and intense-pulsed light (IPL) device hazards. This section includes the responsibilities of the registrant and the laser safety officer (LSO), laser and IPL device hazard control methods, training requirements, and notification of injuries.

(2) For the purpose of this section, any reference to a class of laser includes both International Electrotechnical Commission (IEC) and United States Food and Drug Administration (FDA) classifications, as appropriate.

[(2) This section establishes requirements for the registration of persons who receive, possess, acquire, transfer, or use Class 3b (IIIb), International Electrotechnical Commission (IEC) Class 3B and Class 4 (IV), IEC Class 4 lasers in the healing arts, veterinary medicine, industry, academic, research and development institutions, and of persons who are in the business of providing laser services. No person shall use Class 3b (IIIb), IEC Class 3B or 4 (IV), IEC Class 4 lasers or perform laser services except as authorized in a certificate of laser registration issued by the agency in accordance with the requirements of this section. Class 1 (I) lasers, IEC Class 1 and 1M, Class 2 (II) lasers, IEC Class 2 and 2M, and Class 3a (IIIa) lasers, IEC Class 3R and IPL devices are not required to be registered. However, use of Class 1 (I) lasers, IEC Class 1 and 1M, Class 2 (II) lasers, IEC Class 2 and 2M, and Class 3a (IIIa) lasers, IEC Class 3R and IPL devices are subject to other applicable requirements in this section.]

(3) This section establishes requirements for the registration of a person who receives, possesses, acquires, uses, or transfers Class IIIb (3B), or Class IV (4) lasers in the healing arts, veterinary medicine, and industrial, academic, research and development institutions, and of a person in the business of providing laser services.

(A) A person must not use a Class 3B or Class 4 laser or perform laser services except as authorized in a certificate of registration issued by the Texas Department of State Health Services (department) as specified in this section.

(B) A person who receives, possesses, uses, owns, or acquires a Class 3B or Class 4 laser before receiving a certificate of registration is subject to the requirements of this chapter.

(4) Class I (1) lasers, Class II (2) lasers, FDA Class IIIa (3a) lasers, IEC Class 3R lasers, and IPL devices are not required to be registered. However, the use of Class 1, Class 2, Class 3a, Class 3R lasers, and IPL devices is subject to applicable requirements in this section.

(b) Scope.

(1) Except as otherwise [specifically] provided, this section applies to a person who receives, possesses, acquires, transfers, or uses [all persons who receive, possess, acquire, transfer, or use] lasers that emit or may emit laser radiation. Lasers [Individuals shall not use lasers] or IPL devices must not be used on humans or animals unless under the supervision of a licensed practitioner of the healing arts (practitioner) or veterinary medicine and unless the use of lasers or IPL devices is within the scope [of practice] of their professional license. This section does not limit [Nothing in this section shall be interpreted as limiting] the intentional exposure of patients to laser or IPL device radiation for the purpose of diagnosis, therapy, or treatment

by a [licensed] practitioner of the healing arts or veterinary medicine within the scope [of practice] of their professional license. This section does not apply to the manufacture of lasers or IPL devices.

(2) This section applies to lasers operating [that operate] at wavelengths between 180 nanometers (nm) and 1 millimeter (mm).

(3) This section applies to IPL devices. These devices must [shall] be Class 2 or Class 3 surgical devices certified as complying with the designing [design], labeling, and manufacturing standards of the FDA [United States Food and Drug Administration (FDA)].

(4) This section applies to lasers meeting [that meet] the requirements of IEC standards 60825-1 and 60601-2-22 as allowed by the FDA [United States Food and Drug Administration] Centers for Devices and Radiological Health in the guidance document, Laser Notice No.50[, dated July 26, 2001].

(5) In addition to the requirements of this section, all registrants authorized to use Class 3B [3b] and Class 4 lasers are subject to the following requirements:

(A) §289.203 of this chapter [title] (relating to Notices, Instructions, and Reports to Workers; Inspections) except for [with the exception of] subsection (d), "Notifications and reports to individuals," and information relating to ionizing radiation or exposure history contained in subsection (i), "Notice to employees."

(B) §289.204 of this chapter [title] (relating to Fees for Certificates of Registration, Radioactive Material Licenses, Emergency Planning and Implementation, and Other Regulatory Services);

(C) §289.205 [subsections] (a), (b), and (h) - (n) [of §289.205] of this chapter [title] (relating to Hearing and Enforcement Procedures); and

(D) §289.231 [subsections] (d), (f) - (j), (aa), (bb), (ff), (kk), and (ll)(1), (2), and (5) of [§289.231 of] this chapter [title] (relating to General Provisions and Standards for Protection Against Machine-Produced Radiation) and the applicable definitions in §289.231(c) [subsection (c) of §289.231] of this chapter [title].

(c) Prohibitions.

(1) The department prohibits [agency may prohibit] the use of lasers and IPL devices posing a [that pose] significant threat or endangering [endanger] occupational or public health and safety as specified [,] in [accordance with] §289.205 [of this title] and §289.231 of this chapter [title].

(2) An individual must [Individuals shall] not be intentionally exposed to laser or [and] IPL radiation above the maximum permissible exposure (MPE) unless a practitioner has authorized such exposure [such exposure has been authorized by a licensed practitioner of the healing arts].

(A) Exposure of an individual for training, demonstration, or other non-healing arts purposes is prohibited unless authorized by a practitioner [licensed practitioner of the healing arts].

(B) Exposure of an individual for the purpose of healing arts screening is prohibited, except as specifically authorized by the department [agency].

(C) Research and development using radiation machines on humans is prohibited except for the following. [Exposure of an individual for the purpose of research is prohibited, except as authorized in research studies. Any research using radiation-producing devices on humans must be approved by an institutional review board (IRB) as required by Title 45, Code of Federal Regulations (CFR), Part 46 and Title 21, CFR, Part 56. The IRB must include at least one practitioner of the healing arts to direct use of laser and IPL device radiation in accordance with subsection (b)(1) of this section.]

(i) Any research using radiation machines on humans must be approved by an Institutional Review Board (IRB) as required by 45 Code of Federal Regulations (CFR) Part 46, and 21 CFR Part 56. The IRB must include at least one physician to direct any laser radiation or IPL device use as specified in subsection (b)(1) of this section.

(ii) Facilities with radiation machines, with investigational device exemptions, involved in clinical studies must follow regulations governing the conduct of clinical studies and applying to the manufacturers, sponsors, clinical investigators, IRBs, and the medical device. These regulations include:

(I) 21 CFR Part 812, Investigational Device Exemptions;

(II) 21 CFR Part 50, Protection of Human Subjects;

(III) 21 CFR Part 56, Institutional Review Boards;

(IV) 21 CFR Part 54, Financial Disclosure by Clinical Investigators; and

(V) 21 CFR Part 820, Subpart C, Design Controls of the Quality System Regulation.

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

(1) Access to laser radiation--Proximity to radiation [that is] not blocked by an intervening barrier or filter.

(2) Accessible emission limit (AEL)--The maximum accessible emission level permitted within a particular class.

(3) Accessible laser radiation--Proximity to radiation [that is] not blocked by an intervening barrier or filter.

(4) American National Standards Institute (ANSI) standards--Specific standards for lasers and IPL devices published by the American National Standards Institute.

(5) [(4)] Aperture--An opening through which radiation can pass.

[(5) Apparent visual angle--The angular subtense of the source as calculated from source size and distance from the eye. It is not the beam divergence of the source.]

(6) Beam--A collection of rays characterized by direction, diameter (or dimensions), and divergence (or convergence).

(7) Class 1 [(I)] laser [, IEC Class 1 and 1M]--Any laser not permitting human exposure [that does not permit access] during [the] operation to levels of visible laser radiation more than [in excess of] the accessible emission limits contained in ANSI [American National Standards Institute (ANSI) Z136.1-2000, Safe Use of Lasers].

(8) Class 2 [(II)] laser [, IEC Class 2 and 2M]--Any laser permitting [that permits] human exposure [access] during operation to levels of visible laser radiation more than [in excess of] the accessible emission limits of Class 1 lasers contained in ANSI [Z136.1-2000, Safe Use of Lasers,] but does not permit human exposure [access] during operation to levels of visible laser radiation more than [in excess of] the accessible emission limits of Class 2 lasers contained in ANSI [Z136.1-2000, Safe Use of Lasers].

(9) Class 3a [(IIIa)] laser, IEC Class 3R--Any laser permitting [that permits] human exposure [access] during operation to levels of [visible] laser radiation more than [in excess of] the accessible emission limits of Class 2 lasers contained in ANSI [Z136.1-2000, Safe Use of Lasers,] but does not permit human exposure [access] during operation to levels of laser radiation more than [in excess of] the accessible emission limits of Class 3a lasers contained in ANSI [Z136.1-2000, Safe Use of Lasers].

(10) Class 3B [3b (IIIb)] laser[, IEC Class 3B]--Any laser permitting [that permits] human exposure [access] during operation to levels of laser radiation more than [in excess of] the accessible emission limits of FDA Class 3a lasers in ANSI [Z136.1-2000, Safe Use of Lasers] but does not permit human exposure [access] during operation to levels of laser radiation in excess of the emission limits of Class 3B [3b] lasers contained in ANSI [Z136.1-2000, Safe Use of Lasers].

(11) Class 4 [(IV)] laser[, IEC Class 4]--Any laser permitting [that permits] human exposure [access] during operation to levels of laser radiation more than [in excess of] the accessible emission limits of Class 3B [3b] lasers contained in [the most recent edition of] ANSI [Z136.1-2000, Safe Use of Lasers].

(12) Coherent--A light beam is [said to be] coherent when the electric vector at any point in it is related to [that at] any other point by a definite, continuous function.

(13) Collateral radiation--Any electromagnetic radiation, except laser radiation, emitted by a laser that is physically necessary for its operation. The applicable, accessible emission limits for collateral radiation are [may be] found in 21 CFR §1040.10 [Title 21, CFR, Part 1040.10].

(14) Continuous wave--A [The output of a laser that is operated in a continuous rather than a pulsed mode. In this section, a] laser operating with a continuous output for greater than or equal to [a period of â‰¥]0.25 seconds is regarded as a continuous wave laser.

(15) Controlled area--An area where the occupancy and activity of those within are [is] subject to control and supervision by the registrant for the purpose of protection from radiation hazards.

(16) Divergence--The increase in the diameter of the laser beam with propagation distance from the exit aperture. This is also referred to as beam spread [For the purposes of this section, divergence is taken as the plane angle projection of the cone that includes 1 - 1/e (for example 63.2%) of the total radiant energy or power]. The value of the divergence is expressed in radians or milliradians.

(17) Electromagnetic radiation--Radiation consisting of electromagnetic waves, including x-ray [The flow of energy consisting of orthogonally vibrating electric and magnetic fields lying transverse to the direction of propagation. X-ray], ultraviolet, visible, infrared, and radio waves occupying [occupy] various portions of the electromagnetic spectrum and differing [differ] only in frequency, wavelength, or photon energy.

(18) Electronic product--Any product or article defined as follows:

(A) any manufactured or assembled product [that], when in operation:

(i) contains or acts as part of an electronic circuit; and

(ii) emits, or in the absence of effective shielding or other controls would emit[,] electronic product radiation; or

(B) any manufactured or assembled article [that is] intended for use as a component, part, or accessory of a product described in subparagraph (A) of this paragraph and [that] when in operation emits, or in the absence of effective shielding or other controls would emit[, such] radiation.

(19) Energy--The capacity for doing work. Energy content is commonly used to characterize the output from pulsed lasers[,] and is [generally] expressed in joules (J).

(20) Engineering controls--Control measures designed or incorporated into the laser or laser system (e.g., interlocks, shutters, watchdog timer) or its application.

(21) [(20)] Healing arts--Any system, treatment, operation, diagnosis, prescription, [or practice for the ascertainment,] cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition.

(22) [(21)] Infrared radiation--The region of the electromagnetic spectrum between the long-wavelength extreme of the visible spectrum (about 0.7 micrometer (Âµm)) [Âµm)] and the shortest microwaves (about 1 mm).

(23) [(22)] Inoperable--Incapable of operation because [by reason] of damage, disassembly, removal, or inactivation of key components that cannot be restored without significant repair or renovation.

(24) [(23)] Institutional Review Board (IRB)--Any board, committee, or other group formally designated by an institution to review, approve the initiation of, and conduct a periodic review of biomedical research involving human subjects.

(25) [(24)] Intense-pulsed light (IPL) device--A device that emits radiation to energy density levels that could [reasonably] cause bodily harm and [that is] used for photothermolysis. This device is a Class 2 or Class 3 surgical device certified as complying with FDA designing, labeling, and manufacturing standards [the design, labeling, and manufacturing standards of the United States Food and Drug Administration (FDA)].

(26) [(25)] Invisible radiation--Laser or collateral radiation having wavelengths greater than or [of] equal to [or greater than] 180 nm but less than or equal to 400 nm or greater than 710 nm but less than or equal to 1.0 x 106 nm (1 millimeter).

(27) [(26)] Irradiance--Radiant power incident per unit area upon a surface, expressed in watts-per-square-centimeter (W-cm-2).

(28) [(27)] Joule (J)--A unit of energy. One joule is equal to one watt • [â€¢] second.

(29) [(28)] Laser--An electronic device that emits stimulated radiation to energy density levels that could [reasonably] cause bodily harm. A laser may also produce an intense, coherent, directional beam of light by stimulating electronic or molecular transitions to lower energy levels. The term "laser" [also] includes the assembly of electrical, mechanical, and optical components associated with the laser. A laser can be a component of a product or system.

(30) Laser light show--Use of lasers for entertainment, advertising display, or artistic composition.

(31) [(29)] Laser product--Any manufactured product or assemblage of components constituting, incorporating, or intending [that constitutes, incorporates, or is intended] to incorporate a laser and is classified as a Class 1 [(I), IEC Class 1 and 1M], Class 2 [(II), IEC Class 2 and 2M], Class 3a [(IIIa), IEC Class 3R], Class 3B, [3b (IIIb), IEC Class 3B] or Class 4 [(IV), IEC Class 4] laser product according to the performance standards set by the FDA [United States Food and Drug Administration (FDA)]. A laser [that is] intended for use as a component of an electronic product must [shall itself] be considered a

laser product. A laser product can contain an enclosed laser with an assigned class number higher than the inherent capability of the laser product in which it is incorporated and where the product's lower classification is appropriate due to the engineering features limiting accessible emission.

(32) [(30)] Laser safety officer (LSO)--An individual with [who has a] knowledge of and the authority and responsibility to apply appropriate laser radiation protection rules, standards, and practices, and is [who must be] specifically authorized on a certificate of laser registration.

(33) Manufacturer--Any person who designs, manufactures, assembles, fabricates, or processes a finished laser device.

(34) [(31)] Maximum permissible exposure (MPE)--The level of laser radiation [to which] a person may be exposed to without hazardous effects [effect] or adverse biological changes in the eye or skin. Maximum [For the purposes of this section, maximum] permissible exposures to [for] laser radiation may be found in ANSI [Z136.1-2000, Safe Use of Lasers].

(35) [(32)] Medical event--Any adverse patient health effect directly resulting from the use of laser equipment on an individual [that is a result of failure or misuse of laser safety equipment].

(36) [(33)] Mobile service operation--The provision of lasers and personnel at temporary sites for limited time periods. The lasers may be fixed inside a motorized vehicle or [may be] a portable laser that can [may] be removed from the vehicle and taken into a facility for use.

(37) [(34)] Nominal hazard zone (NHZ)--The space where [within which] the level of direct, reflected, or scattered radiation during operation exceeds the applicable MPE. Exposure levels beyond the boundary of the NHZ are below the applicable MPE level.

(38) [(35)] Optical density (D_λ) [(D_λ)]--The logarithm to the base ten of the reciprocal of the transmittance. $D_\lambda = -\log_{10} \tau_\lambda$ [$-\log_{10} \tau_\lambda$], where τ_λ is transmittance.

(39) Personal protective equipment (PPE)--Device used to mitigate hazards associated with laser use, including laser eye protection (LEP), protective clothing, and gloves.

(40) Practitioner--A person licensed under Texas Occupations Code Title 3 Health Professions. A practitioner's use of a laser is limited to the person's scope of professional practice as determined by the appropriate licensing agency.

[(36) Practitioner of the healing arts (practitioner)--For the purposes of this section, a person licensed to practice the healing arts by either the Texas Medical Board as a physician; the Texas State Board of Dental Examiners; the Texas Board of Chiropractic Examiners; or the Texas State Board of Podiatric Medicine. A practitioner's use of a laser is limited to his/her scope of professional practice as determined by the appropriate licensing agency.]

(41) [(37)] Protective housing--An enclosure surrounding the laser preventing [that prevents] access to laser radiation above the applicable MPE level. The aperture through which the useful beam is emitted is not part of the protective housing. The protective housing may enclose associated optics and a workstation [work station] and must [shall] limit access to other associated radiant energy emissions and to electrical hazards associated with components and terminals.

(42) [(38)] Provider of lasers--A person providing [Provision of] lasers on a routine basis to a facility for limited time periods.

(43) [(39)] Pulse duration--The duration of a laser pulse. This is [usually] measured as the time interval between the half-power points on the leading and trailing edges of the laser pulse.

(44) [(40)] Pulsed laser--A laser delivering [that delivers] its energy in the form of a single pulse or a train of pulses. In this section, the duration of a pulse is less than 0.25 seconds [<5seconds].

(45) [(41)] Reflection--The deviation of laser radiation following incidence on a surface.

(46) [(42)] Source--A laser or a laser-illuminated reflecting surface.

(47) Supervision--Delegating to a person under the practitioner's authority, the task of applying laser radiation to persons or animals under this section. The practitioner assumes full responsibility for these tasks and must ensure the tasks are administered correctly.

(48) [(43)] Transmission--Passage of laser radiation through a medium.

(49) [(44)] Ultraviolet radiation--Electromagnetic radiation with wavelengths shorter than those of visible radiation; for [the purposes of] this section, 0.18 to 0.4 Âµm.

(50) Veterinarian--A person licensed as a veterinarian by the Texas Board of Veterinary Medical Examiners.

(51) Veterinary medicine--When used in this chapter, has the same meaning as found in Texas Occupations Code Chapter 801.

(52) [(45)] Visible radiation (light)--Electromagnetic [In this section, the term is used to describe electromagnetic] radiation that can be detected by the human eye. This term is commonly used to describe wavelengths [that lie] in the range of 0.4 to 0.7 Âµm.

(53) [(46)] Watt--The unit of power or radiant flux. 1 watt equals 1 joule per second.

(54) [(47)] Wavelength (λ)--The distance between two successive points on a periodic wave having [that have] the same phase.

(e) Exemptions.

(1) Lasers in storage or [transit or in storage incident to] transit are exempt from the requirements of this section. This exemption does not apply to the providers of lasers.

(2) Inoperable lasers are exempt from the requirements of this section.

(3) Class 1 [(I), IEC Class 1 and 1M], Class 2 [(II), IEC Class 2 and 2M], and Class 3a [(IIIa)] lasers, IEC Class 3R lasers, or products and IPL devices are exempt from the registration requirements of subsections (f) and (g) of this section.

(4) Facilities, including academic institutions and research or development facilities, registered for the use of lasers are exempt from the registration requirements of subsection [subsections] (f) of this section, regarding laser services, and the applicable paragraphs of subsection (g) of this section, to the extent [that] their personnel perform laser services only for the registrant by whom they are employed.

(f) Registration for the [of] use of Class 3B [3b] and Class 4 lasers and laser services.

(1) For purposes of this section, use of Class 3B [3b] or Class 4 lasers and laser services includes [shall include, but may not be limited to]:

(A) possession and use of lasers in the healing arts, veterinary medicine, industry, academics [academic], and research and development institutions;

(B) demonstration or sale [and sales] of lasers requiring [that require] the person [individual] to operate or cause a laser to be operated [in order] to demonstrate or sell;

(C) provision of lasers on a routine basis to a facility for limited time periods by a provider of lasers. For healing arts facilities, the use of lasers must [shall] be directed by a practitioner employed by the contracting facility;

(D) alignment, calibration, installation, or [and/or] repair; or

(E) laser light shows.

(2) A person who applies [has made application] for registration as specified in [accordance with] this section and uses [is using] a Class 3B [3b] or Class 4 laser before [prior to] receiving a certificate of laser registration is subject to the requirements of this chapter.

(g) Application requirements.

(1) General application requirements.

(A) Application for certificate of laser registration must [shall] be completed on forms prescribed by the department [agency] and must [shall] contain all the information required by the form and accompanying instructions.

(B) An LSO must [shall] be designated on each application form. The qualifications of that individual must [shall] be submitted to the department [agency] with the application. The LSO must [shall] meet the applicable requirements of subsection (o) [(p)] of this section and carry out the responsibilities of subsection (p) [(q)] of this section.

(C) Each application must [shall] be accompanied by a completed RC [BRC] Form 226-01 [226-1] (Business Information Form), which must contain the legal name of the entity or business. Unless exempt under Texas Business and Commerce Code Chapter 71, the applicant must:

(i) be authorized to conduct business in the State of Texas as listed on the Texas Secretary of State (SOS) website; and

(ii) file an assumed name certificate with the Texas SOS if using an assumed name in their application.

(D) Each application for a certificate of laser registration must [shall] be accompanied by the appropriate fee prescribed in §289.204 of this chapter [title].

(E) An application for a certificate of laser registration may include a request for authorization of one or more activities.

(F) At [The agency may, at] any time after filing [of] the original application, the department may require further information [statements in order to enable the agency] to determine whether the certificate of laser registration will [should] be issued [granted] or denied.

(G) Applications and documents submitted to the department [agency] may be made available for public inspection, except [that] the department [agency] may withhold any document or part of a document [thereof] from public inspection as specified in [accordance with] §289.231(aa) of this chapter [title].

(2) Application for the use of Class 3B [3b] or Class 4 lasers on humans or animals.

(A) In addition to the requirements of subsection (g)(1) of this section, each person having a Class 3B [3b] or Class 4 laser for use in the healing arts[,] or for use on animals must[, shall] submit an application to the department [agency] within 30 days after beginning operation of the laser.

(B) Application signatures.

(i) An application for healing arts use must be signed by a practitioner [shall be signed by a licensed practitioner of the healing arts].

(ii) An application for veterinary medicine use must [shall] be signed by a licensed veterinarian.

(iii) The signature of the administrator, president, or chief executive officer will be accepted instead of the [in lieu of a licensed] practitioner's signature if the facility is a licensed hospital or a medical facility.

(iv) A signature by the administrator, president, or chief executive officer does not relieve the practitioner [user] or veterinarian [user] from following [complying with] the requirements of this section. The LSO must also sign the application.

(C) If a person is furnished a Class 3B [3b] or Class 4 laser by a provider of lasers, that person is responsible for ensuring [that] a practitioner [licensed practitioner of the healing arts] authorizes intentional exposure of laser radiation to humans.

(D) The applicant must ensure a laser machine is operated by a person qualified by training and experience to use the laser machine for the purpose requested, and in a manner minimizing danger to occupational and public health and safety.

(3) Application for the use of Class 3B [3b] or Class 4 lasers in industrial, academic, and research and development institutions.

(A) In addition to the requirements of subsection (g)(1) of this section, each person [applicant] having a laser [laser(s)] for use in industrial, academic, and research and development institutions must apply [shall submit an application] to the department [agency] within 30 days after beginning operation of the laser.

(B) An application for the use of Class 3B or Class 4 lasers in industrial, academic, and research and development institutions must be signed by the applicant or registrant or a person duly authorized to act on behalf of the applicant or registrant. The LSO must also sign the application.

(4) Application for registration of laser services.

(A) In addition to the requirements of subsection (g)(1) of this section, an applicant who intends to provide laser services described in subsection (f)(1) of this section must apply and receive a certificate of registration from the department before providing the services.

(B) An application for laser services must be signed by the applicant, registrant, or a person duly authorized to act on behalf of the applicant or registrant. The LSO must also sign the application.

(C) Providing services specified in subsection (f)(1) of this section, that are not specifically authorized by the department, is prohibited.

(D) A service provider must not provide laser machine services for a person who cannot produce evidence of a completed registration application or a valid certificate of registration issued by the department, except for the initial installation of the first machine for a new certificate of registration.

[(4) Application for demonstration for the purpose of sales of Class 3b or 4 lasers. Each applicant shall apply for and receive a

certificate of laser registration before the demonstration for purpose of selling laser(s) in accordance with paragraph (1) of this subsection.]

[(5) Application for providers of Class 3b or 4 lasers.]

[(A) Each applicant shall apply for and receive a certificate of laser registration before providing Class 3b or 4 lasers.]

[(B) In addition to the requirements of subsection (g)(1) of this section, the applicant shall submit the address of the established main location where the laser and records will be maintained for inspection. This shall be a physical street address, not a post office box number.]

[(6) Application for alignment, calibration, and/or repair of Class 3b or 4 lasers. In addition to the requirements of subsection (g)(1) of this section, each applicant shall apply for and receive a certificate of laser radiation for alignment, calibration, and/or repair before providing alignment, calibration, and/or repair of Class 3b or 4 lasers or other lasers that allow access, through alignment, calibration, and/or repair, to Class 3b or 4 lasers.]

(5) [(7)] Application for laser light show.

(A) Each applicant must [shall apply for and] receive a certificate of laser registration for a laser light show before beginning any show.

(B) An application to use Class 3B or Class 4 lasers in a laser light show must be signed by the applicant, registrant, or a person duly authorized to act on behalf of the applicant or registrant. The LSO must also sign the application.

(C) [(B)] According to [In accordance with] subparagraph (A) of this paragraph and in addition to the requirements of subsection (g)(1) of this section, each applicant must [shall] submit [the following]:

(i) a valid variance issued by [from] the FDA, or evidence of an Annual Report on Radiation Safety Testing of Laser and Laser Light Show Products meeting FDA variance requirements, for the laser intended to be used, with all applicable documents required by the variance; and

(ii) a written notice of the laser light show to be performed in Texas. The information contained in RC Form 301-05 must [BRC Form 301-3 shall] be provided at least seven days before [prior to] each show. If, in a specific case, the seven-day period would impose an undue hardship on the applicant, the applicant may, upon written request to the department [agency], obtain permission to proceed sooner.

(6) [(8)] Application for mobile service operation for Class 3B [3b] or Class 4 lasers used in the healing arts and veterinary medicine [arts].

(A) Each applicant must [shall] apply for and receive a certificate of laser registration for mobile service operation involving Class 3B [3b] or Class 4 lasers before beginning mobile service operation.

(B) In addition to the requirements of subsection (g)(1) of this section, each applicant must [shall] submit the address of the established main location where the laser and[,] records[, etc.,] will be maintained for inspection. This must [shall] be a physical street address, not a post office box number.

(C) An application for mobile service operation for the healing arts must be signed by a practitioner [shall be signed by a licensed practitioner of the healing arts] and an application for mobile services for veterinary medicine must [shall] be signed by a licensed veterinarian. The LSO must also sign the application.

(h) Issuance of certificate of laser registration.

(1) A certificate of registration application will be approved if the department determines an application meets the Texas Radiation Control Act (Act) requirements and the requirements of this chapter. The certificate of registration authorizes the proposed activity and contains the conditions and limitations the department requires. The certificate of laser registration must be maintained as specified in subsection (cc) of this section.

[(1) Upon determination that an application meets the requirements of the Texas Radiation Control Act (Act) and the rules of the agency, the agency may issue a certificate of laser registration authorizing the proposed activity in such form and containing such conditions and limitations as the agency deems appropriate or necessary.]

(2) The department [agency] may incorporate in the certificate of laser registration at the time of issuance, or [thereafter] by amendment, additional requirements and conditions concerning [with respect to] the registrant's receipt, possession, acquisition, use, and transfer of lasers subject to this section, as it deems appropriate or necessary [in order] to:

(A) minimize danger to occupational and public health and safety;

(B) prevent loss or theft of lasers; or [require additional reports and the keeping of additional records as may be appropriate or necessary; and]

(C) require additional reports and maintenance records as may be appropriate or necessary [prevent loss or theft of lasers subject to this section].

(3) At the request of the department [The agency may request, and] the registrant must [shall] provide[,] additional information after the certificate of laser registration has been issued for [to enable] the department [agency] to determine whether the certificate of laser registration will [should] be modified in accordance with subsection (n) of this section.

(i) Specific terms and conditions of certificates of laser registration.

(1) Each certificate of laser registration issued as specified in [accordance with] this section is [shall be] subject to the applicable provisions of the Act [, now or hereafter in effect,] and [to] the applicable rules in this chapter and orders issued by the department [agency].

(2) Each person registered by the department [agency] for laser use as specified in [accordance with] this section must [shall] confine use and possession of the laser registered to the locations and purposes authorized in the certificate.

(3) A [No] certificate of laser registration issued [or granted] under this section must not [shall] be transferred, assigned, or in any manner disposed of, either voluntarily or involuntarily, to any person unless the department [agency] authorizes the transfer, in writing.

(4) In determining [making a determination] whether to issue [grant], deny, amend, renew, revoke, suspend, or restrict a certificate of laser registration, the department [agency] may consider the technical competence and compliance history of an applicant or holder of a certificate of laser registration.

(5) After an opportunity for a hearing, the department will deny an application, amendment, or renewal of a certificate of laser registration if the applicant's compliance history reveals, within the previous six years, three or more actions have been issued against the applicant assessing administrative or civil penalties, or revoking or suspend-

ing a certificate of laser registration [After an opportunity for a hearing, the agency shall deny an application for a certificate of laser registration, an amendment to a certificate of laser registration, or renewal of a certificate of laser registration if the applicant's compliance history reveals that at least three agency actions have been issued against the applicant, within the previous six years, that assess administrative or civil penalties against the applicant, or that revoke or suspend the certificate of laser registration].

(j) Registrant responsibilities [Responsibilities of registrant].

(1) The registrant is responsible for complying with this section and the conditions listed on the certificate of registration.

(2) The registrant must designate a qualified individual as the LSO as specified in subsection (o) of this section and ensure the individual continually performs the responsibilities of the LSO as identified in subsection (p) of this section.

(3) A person must not make, sell, lease, transfer, or lend lasers unless the machine and equipment, when properly placed in operation and used, meet the applicable requirements of this section.

(4) [(1)] The registrant must [shall] notify the department [agency] in writing within 30 days of a change in any of the following:

(A) [business] name and mailing address;

(B) street address where laser [laser(s)] will be used;

(C) LSO; or [laser safety officer (LSO).]

(D) additional use location.

[(2) No person shall make, sell, lease, transfer, or lend lasers unless such machines and equipment, when properly placed in operation and used, meet the applicable requirements of this section.]

(5) [(3)] Each registrant must [shall] inventory all Class 3B and Class 4 lasers in their possession at an interval not to exceed 12 months [one year]. The inventory record must [shall] be maintained for inspection by the department as specified [agency] in [accordance with] subsection (cc) [(ee)] of this section and must [shall] include:

(A) the manufacturer's name;

(B) the model and serial number of the laser [laser(s)];

(C) a description of the laser [laser(s)] (for example, yag, silicon, CO_2, neon);

(D) the location of the laser [laser(s)] (for example, room number); and

(E) a complete inventory of equipment supplied by a provider of lasers [if using a provider of lasers] as defined in subsection (d)(42) [(d)(38)] of this section[, a statement with the inventory that the registrant is using lasers provided by a provider of lasers].

(6) [(4)] Notification to the department [agency] is required within 30 days of [the following]:

(A) any increase in the number of lasers above those authorized by the certificate of laser registration; or

(B) any change in the category of the machine type or type of use as specified in §289.231(ll) or as authorized on the certificate of registration [if the registrant begins or terminates the use of a provider of lasers as defined in subsection (d)(38) of this section].

(7) The registrant, or the parent company, must notify the department, in writing, immediately following the filing of a voluntary or involuntary petition for bankruptcy. The notification must include:

(A) the name of the bankruptcy court; and

(B) the case name, and number, when known, and the date the petition was filed.

(8) [(5)] A registrant must not engage a [No registrant shall engage any] person for services described in subsection (f)(1) [(g)(6)] of this section until the service provider demonstrates current [such person provides to the registrant evidence of] registration with the department [agency].

[(6) The registrant is responsible for complying with this section and the conditions of the certificate of laser registration.]

(9) [(7)] Registrants with certificates of laser registration as specified in [accordance with] subsection (g)(5) [(g)(7)] of this section must [shall] have the following documents on site at each laser light show:

(A) certificate of laser registration;

(B) FDA variance, or evidence of Annual Report on Radiation Safety Testing of Laser and Laser Light Show Products meeting FDA variance requirements, with all applicable documents required by the variance; and

(C) instructions for the safe use of lasers as specified in [accordance with] subsection (q)(2) [(r)(2)] of this section.

(10) [(8)] Each registrant must [shall] maintain records of receipt, transfer, and disposal of Class 3B [3b] or Class 4 lasers for inspection by the department [agency]. The records must [shall] include the following information and be maintained as specified in subsection (cc) of this section [shall be kept until disposal is authorized by the agency]:

(A) manufacturer's name;

(B) model and serial number of [from] the laser;

(C) date of the receipt, transfer, and disposal;

(D) name and address of the person the laser was [laser(s)] received from, transferred to, or disposed by [of]; and

(E) name of the person [individual] recording the information.

(11) A laser must not be used unless an application for registration is filed with the department, as specified in subsection (g) of this section, within the first 30 days of use. This section does not apply to operation of a laser for installation and calibration.

(12) A service provider must not provide laser services for a person who cannot produce evidence of a completed application for registration or a valid certificate of registration issued by the department, except for:

(A) the initial installation of the first machine for a new certificate of registration; and

(B) the registrant authorized for demonstration and sale, demonstrates a laser machine as specified in paragraph (15) of this subsection.

(13) A person authorized to perform alignment, calibration, installation, and repair of lasers in Texas must maintain:

(A) a daily log including:

(i) date of service;

(ii) name and address of the customer; and

(iii) customer's certificate of registration number, unless the service provided is an initial installation as described in paragraph (12)(A) of this subsection; and

(B) records of all services for inspection by the department as specified in subsection (cc) of this section.

(14) A person authorized to provide lasers must comply with the following.

(A) Providers of equipment must:

(i) ensure all lasers used on humans meet the requirements of this chapter;

(ii) provide lasers only to facilities holding a valid certificate of registration; and

(iii) keep a log of lasers provided in Texas, and record the following information:

(I) date machine provided;

(II) name of customer; and

(III) customer's certificate of registration number.

(B) Records of machines provided must be made and maintained for inspection by the department as specified in subsection (cc) of this section.

(15) A person authorized to demonstrate and sell lasers in Texas must comply with the following.

(A) Maintain a log including:

(i) date of all demonstrations and sales of lasers performed in Texas;

(ii) name and address of the customer; and

(iii) customer's certificate of registration number unless the service provided is an initial demonstration as described in paragraph (12)(B) of this subsection.

(B) Prevent exposure of individuals to a laser except for healing arts purposes and unless a licensed practitioner of the healing arts has authorized such exposure. This provision specifically prohibits the deliberate exposure of an individual for training, demonstrating, or other non-healing arts purposes.

(C) Demonstrate lasers on phantoms only.

(D) Document all tests required by this section when a demonstration of a laser involves exposure specifically and individually ordered by a practitioner.

(E) Records of demonstrations and sales must be made and maintained for inspection by the department as specified in subsection (cc) of this section.

(16) A person using loaner laser machines must comply with the following.

(A) For a person having a valid certificate of registration, loaner radiation machines may be used for up to 30 days. Within 30 days, the registrant must:

(i) notify the department of a change in the category of the machine type or type of use as specified in §289.231(ll) of this title and as authorized in the certificate of registration; or

(ii) notify the department of any increase in the number of machines beyond those authorized by the certificate of registration in any machine type or type of use category.

(B) For a person who does not hold a valid certificate of registration, a loaner laser may be used for human use for up to 30 days, by or under the direction of a practitioner, before applying for a certificate of registration as specified in subsection (g) of this section. This does not include mobile services.

(k) Expiration of certificates of laser registration.

(1) Except as provided by subsection (m) of this section, a [~~each~~] certificate of laser registration expires at 11:59 p.m. Central Time [~~the end of the day,~~] in the month and year stated in the certificate of laser registration.

(2) If a registrant does not submit an application for renewal of the certificate of laser registration as specified in [~~accordance with~~] subsection (m) of this section, as applicable, the registrant must, [~~shall on or~~] before the expiration date specified in the certificate of laser registration, terminate use of all lasers and laser services as specified in subsection (l) of this section.[~~:~~]

[~~(A) terminate use of all lasers and/or terminate laser servicing or laser services authorized under the certificate of laser registration;~~]

[~~(B) submit to the agency a record of the disposition of the lasers, if applicable, and if transferred, to whom it was transferred within 30 days following the expiration date; and~~]

[~~(C) pay any outstanding fees in accordance with §289.204 of this title.~~]

(3) The expiration [~~Expiration~~] of the certificate of laser registration does not relieve the registrant of the requirements of this chapter.

(l) Termination of certificates of laser registration.

(1) When a registrant decides to terminate all activities involving laser or laser services authorized under the certificate of laser registration, the registrant must [~~shall~~] immediately [~~do the following~~]:

(A) [~~(1)~~] request termination of the certificate of laser registration in writing, signed by the LSO, owner, or a person authorized to act on behalf of the registrant; and

(B) [~~(2)~~] submit to the department [~~agency~~] a record of the disposition of the laser [~~radiation machines~~], and, if applicable, include [~~; and~~] if the laser was transferred and [~~,~~]to whom it was transferred.[~~; and~~]

(2) [~~(3)~~] The registrant must pay any outstanding fees as specified in [~~accordance with~~] §289.204 of this chapter [~~title~~].

(m) Renewal of certificate of laser registration.

(1) An application for renewal of a certificate of laser registration must [~~shall~~] be filed as specified in [~~accordance with~~] subsection (g)(1)(A) - (G) and (g)(2) [~~(g)(1)(A) - (B), and (E) - (G) of this section and applicable paragraphs of subsections (g)(2), (4), and (7)~~] of this section.

(2) If a registrant applies [~~files an application~~] for a renewal [~~in proper form~~] before the existing certificate of laser registration expires, the [~~such~~] existing certificate of laser registration does [~~shall~~] not expire until the application status has been determined by the department [~~agency~~].

(n) Modification, suspension, and revocation of certificates of laser registration.

(1) The terms and conditions of all certificates of laser registration are [~~shall be~~] subject to revision or modification.

(2) Any certificate of laser registration may be revoked, suspended, or modified, in whole or in part for [~~, for any of the following~~]:

(A) any materially [material] false statement in the application or any false statement of fact required by [under the provisions of] the Act;

(B) information received by the department indicating a certificate of laser registration should not be issued [conditions revealed by such application or statement of fact, or any report, record, or inspection, or other means that would warrant the agency to refuse to grant a certificate of laser registration on an original application];

(C) violation of, or failure to observe any of the terms and conditions of the Act, this chapter, or of the certificate of laser registration, or order of the department or a court [agency]; or

(D) existing conditions threatening occupational safety, [that constitute a substantial threat to the] public health and [or] safety, or the environment.

[(3) Each certificate of laser registration revoked by the agency ends at the end of the day on the date of the agency's final determination to revoke the certificate of laser registration, or on the revocation date stated in the determination, or as otherwise provided by the agency order.]

(3) [(4)] Except in cases in which [the] occupational and public health or safety requires otherwise, a registrant will be notified, in writing, of the department's intent to suspend or revoke a certificate of registration and be provided an opportunity to demonstrate compliance before proceedings to suspend or revoke begin [no certificate of laser registration shall be suspended or revoked unless, prior to the institution of proceedings therefore, facts or conduct that may warrant such action shall have been called to the attention of the registrant in writing and the registrant shall have been afforded an opportunity to demonstrate compliance with all lawful requirements].

[(o) Notifications. The following applies to voluntary or involuntary petitions for bankruptcy.]

[(1) Each registrant shall notify the agency, in writing, immediately following the filing of a voluntary or involuntary petition for bankruptcy by the registrant or its parent company. This notification shall include:]

[(A) the bankruptcy court in which the petition for bankruptcy was filed; and]

[(B) the date of the filing of the petition.]

[(2) A copy of the "petition for bankruptcy" shall be submitted to the agency along with the written notification.]

(o) [(p)] LSO qualifications. LSO qualifications must [shall] be submitted to the department and [agency and shall] include [the following]:

(1) education [educational courses] related to laser radiation safety or a laser safety officer course; or

(2) experience in the use and familiarity of the type of equipment or services registered [for]; and

(3) knowledge of potential laser radiation hazards, [and] laser emergency situations, and the appropriate response to an injury.

(p) [(q)] LSO duties. The LSO must [Specific duties of the LSO shall include, but not be limited to the following]:

(1) ensure [ensuring that] users of lasers are trained in laser safety, as applicable for the class and type of lasers used [the individual uses];

(2) assume control and have the authority to institute corrective actions to include the shutdown of operations, when necessary, in emergencies [assuming control and having the authority to institute corrective actions including shutdown of operations when necessary in emergency situations] or unsafe conditions; [and]

(3) specify [specifying] whether any changes in control measures are required after [following]:

(A) any service and maintenance of lasers affecting [that may affect] the output power or operating characteristics; or

(B) a [whenever] deliberate modification is [modifications are] made that could change the laser class and affect the output power or operating characteristics;[.]

(4) ensure [ensuring] maintenance and other practices required for the safe operation of the laser [laser(s)] are performed;

(5) ensure [ensuring] the proper use of protective eyewear and other safety measures; and

(6) ensure [ensuring] compliance with the requirements in this section, the conditions of the certificate of laser registration, and [with] any engineering or operational controls specified by the registrant.

(q) [(r)] Requirements for protection against Class 3B [3b] or Class 4 lasers and IPL device radiation. These requirements are for Class 3B [3b] or Class 4 lasers and IPL devices in their intended mode of operation and include special requirements for service, testing, maintenance, and modification. During some operations, certain engineering controls may be inappropriate. When [In situations where] an engineering control may be inappropriate, for example, during medical procedures or surgery, the LSO must [shall] specify alternate controls to obtain equivalent safety protection.

(1) MPE. A [Each] registrant or user of any laser may [shall] not permit any individual to be exposed to levels of laser or collateral radiation higher than are specified in ANSI [Z136.1-2000, Safe Use of Lasers] and 21 CFR §1040.10 [Title 21, CFR, §1040.10], respectively.

(2) Instructions to personnel. Personnel using a laser must [operating each laser presently being used or listed on the registrant's current inventory, shall] be provided with written instructions for safe use, including clear warnings and precautions to avoid possible exposure to laser and collateral radiation more than [in excess of] the MPE, as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers] and the collateral limits listed in 21 CFR §1040.10 [Title 21, CFR, §1040.10]. The instructions to personnel must [shall] be maintained as specified in [accordance with] subsection (cc) [(ee)] of this section for inspection by the department [agency].

(3) Engineering controls.

(A) Protective housing.

(i) Each laser must [shall] have a protective housing preventing [that prevents] human exposure [access] during the operation to laser and [to] collateral radiation that exceeds the limits of Class 1 lasers as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers] and 21 CFR §1040.10, if [Title 21, CFR, Part 1040.10, respectively, wherever and whenever such] human exposure [access] is not necessary [in order] for the laser to perform its intended function.

(ii) If [Wherever and whenever] human exposure [access] to laser radiation levels more than [that exceed] the limits of Class 1 is necessary, these levels must [shall] not exceed the limits of the lowest laser class required [necessary] to perform the intended function [function(s)].

(B) Safety interlocks.

(i) A safety interlock ensuring[, that shall ensure that] radiation is not accessible above MPE limits as specified [delineated] in ANSI must [Z136.1-2000, Safe Use of Lasers, shall] be provided for any portion of the protective housing that, by design, can be removed or displaced during normal operation or maintenance, and thereby allows exposure [access] to radiation above the MPE limits.

(ii) Adjustment during operation, service, testing, or maintenance of a laser containing interlocks must [shall] not cause the interlocks to become inoperative or the radiation to exceed MPE limits outside protective housing except where a laser controlled area as specified in subparagraph (E) of this paragraph is established.

(iii) For pulsed lasers, interlocks must [shall] be designed [so as] to prevent the firing of the laser; for example, by dumping the stored energy into a dummy load.

(iv) For continuous wave lasers, the interlocks must [shall] turn off the power supply or interrupt the beam; for example, by using [means of] shutters.

(v) An interlock must [shall] not allow automatic accessibility of radiation emission above MPE limits when the interlock is closed.

(vi) Either multiple safety interlocks or a means to preclude removal or displacement of the interlocked portion of the protective housing upon interlock failure must [shall] be provided[,] if failure of a single interlock would allow the following:

(I) human exposure [access] to levels of laser radiation more than [in excess of] the accessible emission limit of FDA Class 3a laser radiation; or

(II) laser radiation more than [in excess of] the accessible emission limits of Class 2 [to be] emitted directly through the opening created by removing or displacing [removal or displacement of] that portion of the protective housing.

(C) Viewing optics and windows.

(i) All viewing ports, viewing optics, or display screens included as an integral part of an enclosed laser or laser product must [shall] incorporate suitable means[, (]such as interlocks, filters, or attenuators[,] to maintain the laser radiation at the viewing position at or below the applicable MPE as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers] and the collateral limits listed in 21 CFR §1040.10 [Title 21, CFR, §1040.10], under any conditions of operation or use of the laser.

(ii) All collecting optics, such as lenses, telescopes, microscopes, or endoscopes, [etc.,] intended for viewing use with a laser must [shall] incorporate suitable means[,] such as interlocks, filters, or attenuators[,] to maintain the laser radiation transmitted through the collecting optics to levels at or below the appropriate MPE, as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers]. Normal or prescription eyewear is not considered collecting optics.

(D) Warning systems. Each Class 3B [3b] or Class 4 laser or laser product must [shall] provide visual or audible indication during the emission of accessible laser radiation. In the case of Class 3B [3b] lasers, except those only allowing access [that allow access only] to less than 5 milliwatt (mW) peak visible laser radiation, and Class 4 lasers, the [this] indication must [shall] be sufficient before [prior to] emission of such radiation to allow appropriate action to avoid exposure. Any visual indicator must [shall] be [clearly] visible through protective eyewear designed specifically for the wavelength [wavelength(s)] of the emitted laser radiation. If the laser and laser energy source are housed separately and can be operated at a separation distance of greater than two meters, both laser and laser energy source must [shall] incorporate visual or audible indicators. The visual indicators must [shall] be positioned so [that] viewing does not require human exposure [access] to laser radiation more than [in excess of] the MPE, as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers].

(E) Controlled area. With a Class 3B [3b] laser, except those only allowing access [that allow access only] to less than 5 mW visible peak power, or Class 4 laser, a controlled area must [shall] be established when exposure to the laser radiation more than [in excess of] the MPE, as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers] or the collateral limits listed in 21 CFR §1040.10 [Title 21, CFR, §1040.10], is possible. The controlled area must [shall] meet the following requirements, as applicable.

(i) The area is [shall be] posted with hazard signs as required by subsection (u) [(v)] of this section.

(ii) Access to the controlled area is [shall be] restricted.

(iii) For Class 4 indoor controlled areas, latches, interlocks, or other appropriate means are [shall be] used to prevent unauthorized entry into controlled areas.

(I) Such measures are [shall be] designed to allow rapid exit [egress] by [the] laser personnel [at all times] and allow admittance to the controlled area for emergency personnel [in an emergency condition]. For such emergency conditions, a control-disconnect switch or equivalent device (panic button) must [shall] be available for deactivating the laser.

(II) Where safety latches or interlocks are not feasible or are inappropriate, for example, during medical procedures, such as surgery, the following applies [shall apply].

(-a-) All authorized personnel are [shall be] trained in laser safety, and appropriate PPE is [personal protective equipment shall be] provided upon entry.

(-b-) A door, blocking barrier, screen, or curtains is [shall be] used to block, screen, or attenuate the laser radiation at the entryway. The level at the exterior of these devices cannot be more than [shall not exceed] the applicable MPE, as specified [delineated] in ANSI [Z136.1-2000, Safe Use of Lasers, nor shall personnel experience any exposure above the MPE immediately upon entry].

(-c-) Within the laser controlled area, [At the entryway] there is [shall be] a visible or audible signal indicating [that] the laser is energized and operating at Class 4 levels. A lighted laser warning sign, flashing light (visible through laser protective eyewear), and other appropriate signage are [some of the] methods to accomplish this requirement. [Alternatively, an entryway warning light assembly may be interfaced to the laser in such a manner that one light will indicate when the laser is not operational (high voltage off) and by an additional light when the laser is powered up (high voltage applied, but no laser emission) and by an additional (flashing optional) light that activates when the laser is operating.]

(iv) For Class 4 indoor controlled areas, during tests requiring continuous operation, the person [individual] in charge of the controlled area is [shall be] permitted to momentarily override the safety interlocks to allow access by [to] other authorized personnel if it is [clearly] evident [that] there is no optical radiation hazard at the point of entry, and if the necessary protective devices are being worn by the entering personnel.

(v) For Class 4 indoor controlled areas, optical paths (for example, windows) from an indoor facility must [shall] be controlled [in such a manner as] to reduce the transmitted values of the laser radiation to levels at or below the appropriate ocular MPE, as specified

[~~delineated~~] in ANSI [~~Z136.1-2000, Safe Use of Lasers~~] and the collateral limits listed in 21 CFR §1040.10 [~~Title 21, CFR, §1040.10~~]. When the laser beam must exit the indoor controlled area (as in the case of exterior atmospheric beam paths), the operator is [~~shall be~~] responsible for ensuring [~~that~~] air traffic is protected from any laser projecting into navigable air space (contact Federal Aviation Administration (FAA) or other appropriate agencies, as necessary) or controlled ground space when the beam irradiance or radiant exposure is above the appropriate MPE, as specified [~~delineated~~] in ANSI [~~Z136.1-2000, Safe Use of Lasers~~].

(vi) When the removal of panels or protective covers or [~~and/or~~] overriding of interlocks becomes necessary, such as for servicing, testing, or maintenance, and accessible laser radiation exceeds the MPE, as specified [~~delineated~~] in ANSI [~~Z136.1-2000, Safe Use of Lasers~~] and the collateral limits listed in 21 CFR §1040.10 [~~Title 21, CFR, §1040.10~~], a temporary controlled area must [~~shall~~] be established and posted.

(4) Key control. Each Class 3B [~~3b~~] or Class 4 laser and IPL device must [~~shall~~] incorporate a key-actuated or computer-actuated primary [~~master~~] control. The key must [~~shall~~] be removable, and the Class 3B [~~3b~~] or Class 4 laser or IPL device must [~~shall~~] not be operable when the key is removed. When the device is not being prepared for operation or is unattended, the key must [~~will~~] be removed from the device and stored in a location away from the machine.

(r) [~~(s)~~] Additional requirements for special lasers and applications.

(1) Infrared laser. The beam from a laser must [~~shall~~] be terminated in fire-resistant material, where necessary. Inspection intervals of absorbent material and actions to be taken in the event [~~or evidence~~] of degradation must [~~shall~~] be specified in the operating and safety procedures.

(2) Laser optical fiber transmission system.

(A) Laser transmission systems employing [~~that employ~~] optical cables are [~~shall be~~] considered enclosed systems with the optical cable forming part of the protective housing.

(B) Disconnection of a connector resulting in exposure [~~access~~] to radiation more than [~~in excess of~~] the applicable MPE limits, as specified [~~delineated~~] in ANSI [~~Z136.1-2000, Safe Use of Lasers~~] and the collateral limits listed in 21 CFR §1040.10 [~~Title 21, CFR, §1040.10~~], must [~~shall~~] take place in a controlled area. Except for medical lasers whose manufacture has been approved by the FDA, the use of a tool is [~~shall be~~] required for the disconnection of a connector for service and maintenance purposes when the connector is not within a secured enclosure. All connectors must [~~shall~~] bear the appropriate label or tag as specified in subsection (u)(3) [~~(v)(3)~~] of this section.

(s) [~~(t)~~] Additional requirements for safe operation.

(1) Eye protection. Protective eyewear must [~~shall~~] be worn by each individual exposed to laser radiation from IPL, [~~all individuals with access to~~] Class 3B, or [~~3b and/or~~] Class 4 levels of laser radiation. Protective eyewear devices must [~~shall~~] meet the following requirements:

(A) provide a comfortable and appropriate fit all around the area of the eye;

(B) be in proper condition to ensure the optical filter [~~filter(s)~~] and holder provide the required optical density or greater at the desired wavelengths, and retain all protective properties during its use;

(C) be suitable for the specific wavelength of the laser and be of optical density adequate for the energy involved;

(D) have the optical density or densities and associated wavelength [~~wavelength(s)~~] permanently labeled on the filters or eyewear; and

(E) be examined, at intervals not to exceed 12 months, to ensure the reliability of the protective filters and integrity of the protective filter frames. Unreliable eyewear must [~~shall~~] be discarded. Documentation of the examination is required to be [~~shall be made and~~] maintained as specified in [~~accordance with~~] subsection (cc) [~~(ee)~~] of this section for inspection by the department [~~agency~~].

(2) Skin protection. When there is a possibility of exposure to laser radiation more than [~~that exceeds~~] the MPE limits for skin as specified in ANSI [~~Z136.1-2000 Safe Use of Lasers,~~] the registrant must [~~shall~~] require the use of appropriate PPE [~~use of protective gloves, clothing, or shields~~].

(t) [~~(u)~~] NHZ. Where applicable, in the presence of unenclosed Class 3B [~~3b~~] and Class 4 laser beam paths, an NHZ must [~~shall~~] be established. If the beam of an unenclosed Class 3B [~~3b~~] and Class 4 laser is contained within a region by adequate control measures to protect personnel from exposure to levels of radiation more than the [~~above the appropriate~~] MPE, as specified [~~delineated~~] in ANSI [~~Z136.1-2000, Safe Use of Lasers~~], that region is [~~may be considered to be~~] the NHZ. The NHZ may be determined by information supplied by the laser manufacturer, by measurement, or by using the appropriate laser range equation or other equivalent assessment.

(u) [~~(v)~~] Hazard [~~Caution~~] signs, labels, and posting for lasers and IPL devices.

(1) General requirements. Except as otherwise authorized by the department [~~agency~~], signs, symbols, and labels prescribed by this section must [~~shall~~] use the design and colors as specified in paragraph (3) of this subsection [~~subsection (dd) of this section~~].

(2) Posting. The laser controlled area must [~~shall~~] be conspicuously posted with a sign or signs as specified in paragraph (3) of this subsection [~~and subsection (dd) of this section~~].

(3) Labeling lasers and posting laser facilities. All signs and labels associated with Class 2, 3a, 3B [~~3b~~], and 4 lasers must [~~shall~~] contain the following wording or sign posting requirements found in ANSI.

(A) Danger sign.

(i) The signal word "DANGER" indicating death or serious injury will occur if required control measures are not implemented to mitigate the hazards within the laser controlled area. This signal word is restricted to those Class 4 lasers with high (e.g., multi-kilowatt) output power or pulse energies with exposed beams.

(ii) The danger sign must include:

(I) The signal word "DANGER" in white letters on a rectangular safety red background placed at the top of the sign.

(II) "Class 4 Laser Controlled Area."

(III) "Avoid eye or skin exposure to direct or scattered radiation. Do not enter when light is illuminated."

(IV) "Laser eye protection required: OD>7@ 1070 nm. Yb: Fiber Laser, 1070nm. 10 kilowatt (kW) maximum average power."

(iii) The safety alert symbol must precede the signal word.

(I) The base of the symbol must be on the same horizontal line as the base of the letter of the signal word.

(II) The height of the safety alert symbol must be equal to or exceed the signal word letter height.

(III) The words "Avoid eye or skin exposure to direct or scattered radiation" must appear to the right of the safety alert symbol.

(iv) The following sign meets the requirements of this subparagraph.
Figure: 25 TAC §289.301(u)(3)(A)(ii)

[(A) The signal word "CAUTION" shall be used with all signs and labels associated with all Class 2 lasers and all Class 3a lasers that do not exceed the appropriate MPE, as designated in ANSI Z136.1-2000, Safe Use of Lasers. This signal word is used in accordance with the sign in subsection (dd)(1) of this section.]

(B) Warning sign.

(i) The signal word "WARNING" must be used with all signs and labels associated with lasers and laser systems whose output is more than the applicable MPE for irradiance, including all Class 3B and most Class 4 lasers and laser systems.

(ii) The warning sign must include:

(I) The signal word "WARNING" in black letters on a rectangular orange background placed at the top of the sign.

(II) "Class 4 Laser Controlled Area."

(III) "Avoid eye or skin exposure to direct or scattered radiation."

(IV) "Do not enter when light is illuminated."

(V) "Laser eye protection required: ODâ‰¥ 5@ 532 nm. Diode laser, 670 nm. Freq. Doubled Nd: YAG laser, 532 nm. 10 watts maximum average power."

(iii) The safety alert symbol must precede the signal word.

(I) The base of the symbol must be the same horizontal line as the base of the letter of the signal word.

(II) The height of the safety alert symbol must be equal to or exceed the signal word letter height.

(III) The words "Avoid eye or skin exposure to direct or scattered radiation" must appear to the right of the safety alert symbol.

(iv) The following sign meets the requirements of this subparagraph.
Figure: 25 TAC §289.301(u)(3)(B)(ii)

[(B) The signal word "DANGER" shall be used with all Class 3a lasers that exceed the appropriate MPE, as designated in ANSI Z136.1-2000, Safe Use of Lasers, and all Class 3b and 4 lasers. This signal word is used in accordance with the sign in subsection (dd)(2) of this section.]

(C) Caution sign.

(i) The signal word "CAUTION" must be used with all signs and labels associated with Class 2 and Class 2M lasers and laser systems not more than the applicable MPE for irradiance.

(ii) The caution sign must include:

(I) The signal word "CAUTION" in black letters on a rectangular yellow background placed at the top of the sign.

(II) "Class 2M Laser In Use."

(III) "Do not stare into beam or view directly with optical instruments. Diode laser, 670 nm. 20 mW maximum power."

(iii) The safety alert symbol must precede the signal word.

(I) The base of the symbol must be on the same horizontal line as the base of the letters of the signal word.

(II) The height of the safety alert symbol must be equal to or exceed the signal word letter height.

(III) The words "Do not stare into beam or view directly with optical instruments" must appear to the right of the safety alert symbol.

(iv) The following sign meets the requirements of this subparagraph.
Figure: 25 TAC §289.301(u)(3)(C)(ii)

[(C) Position 1 in the signs in subsection (dd)(1) and (dd)(2) of this section shall contain the following information, as applicable:]

[(i) for all Class 2 lasers, the words "LASER RADIATION - DO NOT STARE INTO BEAM";]

[(ii) for Class 3a lasers that do not exceed the appropriate MPE, as designated in ANSI Z136.1-2000, Safe Use of Lasers, the words "LASER RADIATION - DO NOT STARE INTO BEAM OR VIEW DIRECTLY WITH OPTICAL INSTRUMENTS";]

[(iii) for all other Class 3a lasers, the words "LASER RADIATION - AVOID DIRECT EYE EXPOSURE";]

[(iv) for all Class 3b lasers, the words "LASER RADIATION - AVOID DIRECT EYE EXPOSURE"; or]

[(v) for Class 4 lasers, the words "LASER RADIATION - AVOID EYE or SKIN EXPOSURE to DIRECT or SCATTERED RADIATION".]

[(D) Positions 2 and 3 in the signs in subsections (dd)(1) and (2) of this section shall contain the following information, as applicable.]

[(i) Position 2 shall contain the type of laser or the emitted wavelength, pulse duration (if appropriate), or maximum output.]

[(ii) Position 3 shall contain the class of laser.]

(D) [(E)] Lasers, except a laser [lasers] used in the practice of medicine or veterinary medicine, must[, shall] have a label [label(s)] in close proximity to each aperture emitting [through which is emitted] accessible laser or collateral radiation in excess of the limits specified in ANSI [Z136.1-2000, Safe Use of Lasers] and the collateral limits listed in 21 CFR §1040.10 [Title 21, CFR, §1040.10], labeled with the following [wording] as applicable:[.]

(i) "AVOID EXPOSURE - Laser radiation is emitted from this aperture," if the radiation emitted through the [such] aperture is laser radiation;[.]

(ii) "AVOID EXPOSURE - Hazardous electromagnetic radiation is emitted from this aperture," if the radiation emitted through the [such] aperture is collateral radiation; or[.]

(iii) "AVOID EXPOSURE - Hazardous x-rays are emitted from this aperture," if the radiation emitted through the [such] aperture is collateral x-ray radiation.

(E) [(F)] Each defeatable or non-interlocked [noninterlocked or defeatably interlocked] portion of the protective housing or enclosure [that is] designed to be displaced or removed during normal operation or servicing[, and] that permits [would permit] human exposure [access] to laser or collateral radiation[,] must have the following label [shall have labels as follows]:

(i) for Class 3B [3b] accessible laser radiation, the wording, "DANGER - LASER RADIATION WHEN OPEN. AVOID DIRECT EXPOSURE TO BEAM";

(ii) for Class 4 accessible laser radiation, the wording, "DANGER - LASER RADIATION WHEN OPEN. AVOID EYE OR SKIN EXPOSURE TO DIRECT OR SCATTERED RADIATION"; or

(iii) for collateral radiation more than [in excess of] the emission limits as specified [described] in 21 CFR §1040.10 [Title 21, CFR, §1040.10], "CAUTION - HAZARDOUS ELECTROMAGNETIC RADIATION WHEN OPEN" and "CAUTION - HAZARDOUS X-RAY RADIATION" as applicable.

(F) [(G)] For protective housing or enclosures providing [that provide] a defeatable interlock, the words "and interlock defeated" must [shall] be included in the labels as specified in subparagraph (E)(i) and (ii) [(F)(i) and (ii)] of this paragraph.

(G) [(H)] Other required information.

(i) The word "invisible" must [shall] immediately precede the word "radiation" on labels and signs required by this subparagraph for wavelengths of laser and collateral radiation [that are] outside of the range of 400 to 700 nm.

(ii) The words "visible and invisible" must [shall] immediately precede the word "radiation" on labels and signs required by this subparagraph for wavelengths of laser and collateral radiation [that are] both within and outside the range of 400 to 700 nm.

(H) [(I)] Labels and signs required by this subparagraph must [shall] be clearly visible, legible, and permanently attached to the laser or facility. [Signs required by this subparagraph shall be clearly visible, legible, and securely attached to the facility.]

(4) In lieu of the requirements in paragraphs (1) - (3) of this subsection [and subsection (dd) of this section], the department [agency] will accept labeling and signage as specified [designated] by [the following]:

(A) 21 CFR §1040.10 [Title 21, CFR, §1040.10];

(B) ANSI [Z136.1-2000, Safe Use of Lasers]; and

(C) IEC standards 60825-1 and 60601-2-22.

(v) [(w)] Surveys. Each registrant must conduct [shall make or cause to be made such] surveys [as may be] necessary to comply with this section and maintain records of the surveys as specified in [accordance with] subsection (cc) [(ee)] of this section for inspection by the department [agency]. Surveys must [shall] be performed at intervals not to exceed 12 months, and [to] include [but not be limited to the following]:

(1) a determination if [that] all laser and IPL protective devices are labeled correctly, functioning within the design specifications, and properly chosen for lasers and IPL devices in use;

(2) a determination if [that] all warning devices are functioning within their design specifications;

(3) a determination if [that] the controlled area is properly controlled and posted with accurate warning signs as specified in [accordance with] subsection (u) [(v)] of this section;

(4) a re-evaluation of potential hazards from surfaces [that may be] associated with beam paths; and

(5) additional surveys [that may be required] to evaluate the primary and collateral radiation hazard incident to the use of lasers and IPL devices.

(w) [(x)] Records or documents [Records/documents]. Each registrant must [shall] maintain current records or documents [records/documents] required by this subsection as specified in [accordance with] subsection (cc) [(ee)] of this section for inspection by the department [agency].

(x) [(y)] Measurements and instrumentation. Each determination requiring a measurement for compliance with this section must use instrumentation calibrated and designed for use with the laser or IPL device to be tested. Records of measurements and instrumentation must be maintained as specified in subsection (cc) of this section [shall use instrumentation that is calibrated and designed for use with the laser or IPL device that is to be tested].

(y) [(z)] Notification of injury other than a medical event.

(1) Each registrant of Class 3B [3b] or Class 4 lasers or user of an IPL device must [shall] immediately seek appropriate medical attention for the injured individual and notify the department [agency] by telephone of any injury involving a laser possessed by the registrant or an IPL device, other than intentional exposure of patients for medical purposes, that has or may have caused:

(A) an injury to an individual involving [that involves] the partial or total loss of sight in either eye; or

(B) an injury to an individual involving [that involves] intentional perforation of the skin or other serious injury excluding [exclusive of] eye injury.

(2) Each registrant of Class 3B [3b] or Class 4 lasers or user of an IPL device must [shall], within 24 hours of the discovery of an injury, notify [report to] the department of any [agency each] injury involving a [any] laser possessed by the registrant or IPL device possessed by a user, as applicable, other than intentional exposure of patients for medical purposes, that has or may have caused, or threatens to cause, [an] exposure to an individual with second or third-degree burns to the skin or potential injury and partial loss of sight. Record of a notification of injury must be documented and maintained as specified in subsection (cc) of this section.

(z) [(aa)] Reports of injuries.

(1) Each registrant of Class 3B [3b] or Class 4 lasers or user of an IPL device must [shall] make a report, in writing, or by electronic transmittal, within 30 days to the department [agency] of any injury required to be reported as specified in [in accordance with] subsection (y) [(z)] of this section.

(2) Each report must [shall] describe [the following]:

(A) the extent of injury to each individual [individuals] from radiation caused by [from] lasers or IPL devices;

(B) power output of laser or IPL device involved;

(C) the cause of the injury; and

(D) corrective steps taken or planned [to be taken] to prevent a recurrence.

(3) A [Any] report filed with the department [agency] as specified in [accordance with] this subsection must [shall] include the full name of each individual injured and a description of the injury. The report must include personally identifying [shall be prepared so that this] information [is stated] in a separate part of the report.

(4) When a registrant or user of an IPL device is required, as specified in [accordance with] paragraphs (1) - (3) of this subsection, to report to the department [agency] any injury of an individual caused by [from] radiation from a laser or IPL device [from lasers or IPL devices], the registrant or user of an IPL device must [shall also] notify the individual. The [Such] notice must [shall] be sent [transmitted] to the individual at the same [a] time the report is sent to the department [not later than the transmittal to the agency]. Record of a report of injury must be documented and maintained as specified in subsection (cc) of this section.

(aa) [(bb)] Medical event.

(1) The registrant of a Class 3B [3b] or Class 4 laser [lasers] or user of an IPL device must [shall] notify the department [agency], by telephone or electronic transmittal, within 24 hours of the discovery of a medical event involving a Class 3B or Class 4 laser resulting in [or of any] injury [to] or death of a patient. Within 30 days after a 24-hour [24 hour] notification is made, the registrant of a Class 3B [3b] or Class 4 laser [lasers] or the user of an IPL device must [shall] submit a written report to the department [agency] of the event. Record of a medical event must be documented and maintained as specified in subsection (cc) of this section.

(2) The written report must [shall] include [the following]:

(A) the registrant's or user's name;

(B) a brief description of the event;

(C) the effect on the patient;

(D) the action taken to prevent recurrence; and

(E) whether the registrant or user informed the patient or the patient's responsible relative or legal guardian.

(3) When a medical event occurs, the registrant or user must [shall] promptly investigate its cause, make a record for department [agency] review, and retain the records as specified [stated] in subsection (cc) [(ee)] of this section.

(bb) [(cc)] Reports of stolen, lost, or missing Class 3B [3b] or Class 4 lasers and IPL devices.

(1) Each registrant of Class 3B [3b] or Class 4 lasers or user of an IPL device must [shall] report to the department [agency] by telephone at (512) 458-7460, or email at RAMAssist@dshs.texas.gov, a stolen, lost, or missing laser or IPL device within 24 hours after its occurrence becomes known to the registrant or IPL device user.

(2) Each person required to make a report as specified in [accordance with] paragraph (1) of this subsection must [shall], within 30 days after making the telephone or email report, make a written report to the department including [agency that includes the following information]:

(A) a description of the laser or IPL device involved, including the manufacturer, model, serial number, and class;

(B) a description of the circumstances under which the loss or theft occurred;

(C) a statement of disposition, or probable disposition, of the laser or IPL device involved;

(D) actions [that have been] taken, or to [will] be taken, to recover the laser or IPL device; and

(E) procedures or measures [that have been] taken to prevent a recurrence of the loss or theft of lasers or IPL devices.

(3) Report of a stolen, lost, or missing Class 3B or Class 4 laser and IPL device must be maintained as specified in subsection (cc) of this section.

(cc) Record or document retention requirements for registration of a radiation machine. Each registrant must maintain the following records or documents at each site, including authorized records sites for mobile services at the time intervals specified for inspection by the department.

Figure: 25 TAC §289.301(cc)

[(dd) Caution and danger signs. The following contains signs required in accordance with subsection (v)(3) of this section.]

[(1) This sign shall be used with all Class 2 lasers and Class 3a lasers that do not exceed the appropriate MPE, as designated in ANSI Z.136-2000, Safe Use of Lasers.]

[Figure: 25 TAC §289.301(dd)(1)]

[(2) This sign shall be used with all Class 3a lasers that exceed the appropriate MPE, as designated in ANSI Z.136-2000, Safe Use of Lasers, and all Class 3b and Class 4 lasers.]

[Figure: 25 TAC §289.301(dd)(2)]

[(ee) Keeping records/documents. The following chart contains time requirements for keeping records/documents:]

[Figure: 25 TAC §289.301(ee)]

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

Filed with the Office of the Secretary of State on August 29, 2024.

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Cynthia Hernandez
General Counsel
Department of State Health Services
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For further information, please call: (512) 834-6655

TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 306. BEHAVIORAL HEALTH DELIVERY SYSTEM

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §306.151, relating to Purpose; §306.152, relating to Application and Responsibility for Compliance; §306.153, relating to Definitions; §306.154, relating to Notification and Appeals Process for Local Mental Health Authority or Local Behavioral Health Authority Services; §306.161 relating to Screening and Assessment; §306.162, relating to Determining County of Residence; §306.163, relating to Most Appropriate and Available Treatment

Options; §306.171, relating to General Admission Criteria for a State Mental Health Facility or Facility with a Contracted Psychiatric Bed; §306.172, relating to Admission Criteria for Maximum-Security Units; §306.173, relating to Admission Criteria for an Adolescent Forensic Unit; §306.174 relating to Admission Criteria for Waco Center for Youth; §306.175, relating to Voluntary Admission Criteria for a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility; §306.176, relating to Admission Criteria for a Facility with a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility for Emergency Detention; §306.177, relating to Admission Criteria Under Order of Protective Custody or Court-ordered Inpatient Mental Health Services; §306.178, relating to Voluntary Treatment Following Involuntary Admission; §306.191, relating to Transfers Between State Mental Health Facilities; §306.192, relating to Transfers Between a State Mental Health Facility and a State Supported Living Center; §306.193, relating to Transfers Between a State Mental Health Facility and an Out-of-State Institution; §306.194, relating to Transfers Between a State Mental Health Facility and Another Facility in Texas; §306.195, relating to Changing Local Mental Health Authorities or Local Behavioral Health Authorities; §306.201, relating to Discharge Planning; §306.202, relating to Special Considerations for Discharge Planning; §306.203, relating to Discharge of an Individual Voluntarily Receiving Treatment; §306.204, relating to Discharge of an Individual Involuntarily Receiving Treatment; §306.205, relating to Pass or Furlough from a State Mental Health Facility or a Facility with a Contracted Psychiatric Bed; §306.207, relating to Post Discharge or Absence for Trial Placement: Contact and Implementation of the Recovery or Treatment Plan; and §306.221, relating to Screening and Intake Assessment Training Requirements at a State Mental Health Facility and a Facility with a Contracted Psychiatric Bed.

HHSC proposes new §306.155, relating to Local Mental Health Authority, Local Behavioral Health Authority, and Continuity of Care Liaison Responsibilities; §306.361, relating to Purpose; §306.363, relating to Application; §306.365, relating to Definitions; §306.367, relating to General Provisions; and §306.369, relating to Documentation Requirements.

HHSC proposes the repeal of §306.206, relating to Absence for Trial Placement.

BACKGROUND AND PURPOSE

The Texas Health and Human Services Commission (HHSC) proposes amendments and the repeal of a rule in the Texas Administrative Code (TAC), Title 26 Chapter 306, Subchapter D relating to Mental Health Services--Admission, Continuity, and Discharge and proposes new rules in 26 TAC Chapter 306, Subchapter H relating to Behavioral Health Services--Telecommunications. The rule proposal is necessary to implement Senate Bill (S.B.) 26, 88th Legislature, Regular Session, 2023 and House Bill (H.B.) 4, 87th Legislature, Regular Session, 2021.

S.B. 26 requires HHSC to adopt or amend existing rules to address a local mental health authority's (LMHA's) responsibility for ensuring the successful transition of patients determined ready for discharge from an HHSC mental health facility. To implement S.B. 26, the proposal amends the rules to do the following. Require state hospitals to participate in joint discharge planning with an LMHA. Require coordination between the LMHAs and the state hospital to determine appropriate community services for a patient. Require an LMHA to arrange for the provision of services upon discharge. Require the LMHA's transition support services to complement joint discharge planning efforts. Require each state hospital to designate at least one employee to provide transition support services for patients determined medically appropriate for discharge. Require each state hospital to concentrate transition support services on patients admitted and discharged multiple times within 30 days, or patients who had a long-term stay (more than 365 consecutive days). And allow voluntary admission to an inpatient mental health facility, including a state hospital, only if space is available.

H.B. 4 directs HHSC to ensure that individuals receiving HHSC-funded behavioral health services have the option to receive services as telemedicine or telehealth services, including using an audio-only platform, to the extent it is clinically effective and cost-effective.

Additionally, HHSC proposes amendments to clarify statutory requirements; add, remove, and update definitions; delete references to managed care organizations (MCOs) and update Medicaid-related information; update and add cross-references; and make grammatical and editorial changes for understanding, accuracy, and uniformity.

SECTION-BY-SECTION SUMMARY

The proposed amendment to the title of 26 TAC Chapter 306, Subchapter D, Mental Health Services--Admission, Continuity, and Discharge, replaces "Admission, Continuity, and Discharge" with "Mental Health Services--Admission, Discharge, and Continuity of Care" to make the subchapter's title more representative of the body text.

Division 1, General Provisions

The proposed amendment to §306.151 updates the description of the purpose of the subchapter by adding it provides requirements for admission, discharge, and continuity of care and specifies that state hospitals, facilities with contracted psychiatric beds (CPBs), and local intellectual and developmental disability authorities (LIDDAs) are included in the service array. The proposed amendment also includes in the purpose for the rules to establish criteria for the delivery of substance use disorder (SUD) services to individuals. The proposed amendment also updates the purpose section to include criteria and guidelines in the subchapter for individuals receiving both mental health and SUD disorder services. The proposed amendment also formats the rule as subsection (a) and subsection (b) to improve the readability of the rule.

The proposed amendment to §306.152 clarifies that the rules apply to a state hospital, a CPB, an LMHA, a local behavioral health authority (LBHA), and a LIDDA. The proposed amendment also clarifies that an LMHA or LBHA must require its subcontractors to comply with Subchapter D.

The proposed amendment to §306.153 adds new definitions to define what these terms mean when used in Subchapter D: "Audio-only technology," "Audiovisual technology," "CoC liaison--Continuity of care liaison," "DFPS--Texas Department of Family and Protective Services or its designee," "Discharge planning specialist," "DSM --Diagnostic and Statistical Manual of Mental Disorders," "Family partner," "Furlough," "In person," "Involuntary admission," "LPHA--Licensed practitioner of the healing arts," "Outpatient management plan," "Pass," "PE--PASRR level II evaluation," "PL1--PASRR level I screening," "SED--Serious emotional disturbance," "State hospital," and "Voluntary admission."

The proposed amendment to §306.153 revises the following definitions for clarification and to align with other rules: "Absence," "Admission," "Adolescent," "Adult," "Advance directive," "Alternate provider," "Assessment," "Assessment professional," "Child," "Continuity of care," "Continuity of care worker," "COPSD," "COPSD model," "CPB--Contracted psychiatric bed," "CRCG," "Crisis," "Crisis treatment alternatives," "Day," "DD--Developmental disability," "Designated LMHA or LBHA," "Discharge," "Discharged unexpectedly," "Emergency medical condition," "ID--Intellectual disability," "Inpatient services," "Intake assessment," "LAR--Legally authorized representative," "LBHA--Local behavioral health authority," "LIDDA--Local intellectual and developmental disability authority," "LMHA or LBHA network provider," "LMHA or LBHA services," "Local service area," "Mental illness," "MH priority population--Mental health priority population," "Minor," "Nursing facility," "Offender with special needs," "Ombudsman," "PASRR," "Peer specialist," "Permanent residence," "QMHP-CS--Qualified mental health professional-community services," "Recovery," "Recovery or treatment plan," "Screening," "SSLC--State supported living center," "SUD--Substance use disorder," and "Treatment team."

The proposed amendment to §306.153 deletes the following definitions because they no longer need to be defined or are no longer used in Subchapter D: "ATP--Absence for trial placement;" "Face to face;" "Facility;" "Individual involuntarily receiving treatment;" "Individual voluntarily receiving treatment;" "MCO--Managed care organization;" "PASRR Level I screening;" "PASRR Level II evaluation;" "SMHF--State mental health facility," which is being replaced by "state hospital" throughout Subchapter D; and "Transfer." The proposed amendment renumbers the definitions to account for new and deleted definitions.

The proposed amendment to §306.154 clarifies that any individual eligible for Medicaid and whose services have been terminated, suspended, or reduced by HHSC is entitled to a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearings Rules). The proposed amendment renumbers the remaining subsections, deletes repetitive language in §306.154(b), and clarifies information on how to contact the Office of the Ombudsman.

Proposed new §306.155 establishes LMHA, LBHA, and CoC liaison responsibilities and requires the LMHA or LBHA to develop policies and procedures for specific CoC liaison duties and responsibilities.

Division 2, Screening and Assessment for Crisis Services and Admission into Local Mental Health Authority or Local Behavioral Health Authority Services--Local Mental Health Authority or Local Behavioral Health Authority Responsibilities retitled as "Screening and Assessment for Crisis Services and Admission into Local Mental Health Authority or Local Behavioral Health Authority Services".

The proposed amendment to §306.161, in subsection (a), clarifies that an LMHA or LBHA must ensure an individual's immediate screening, and if emergency care services are recommended based on the screening, that the staff member complies with access to community service requirements. The proposed amendment to subsection (c) clarifies screening and assessment requirements if an individual not in crisis presents for services. The proposed amendment to subsection (d) clarifies that an LMHA or LBHA must provide services immediately for eligible individuals in the MH priority population. The proposed amendment to subsection (d)(4) specifies that an LMHA or LBHA has three business days to provide an individual not in the mental health priority population with written notification regarding denial of services and updates that the information provided to include how to contact the Office of the Ombudsman.

The proposed amendment to §306.162, in subsection (a), clarifies county of residence requirements for adults and removes repetitive language. The proposed amendment adds a new paragraph (b)(3) to clarify LMHA and LBHA requirements for a minor in DFPS conservatorship. The proposed amendment in subsections (c) and (d) replaces "dispute" with "disagreement" and clarifies who initiates the disagreement related to an individual's county of residence for LMHA or LBHA services. The proposed amendment in subsection (e) clarifies the role of the LMHA or LBHA when an individual changes county of residence status.

The proposed amendment to §306.163, in subsection (a), adds SUD services to LMHA or LBHA services. The proposed amendment in subsection (b)(2) clarifies that inpatient services need to be the least restrictive "and most appropriate setting" available. The proposed amendment in subsection (b)(3) adds "or a DD" for accuracy and uniformity regarding referrals to LIDDAs. The proposed amendment adds a new paragraph (9) in subsection (b) regarding the LMHA's or LBHA's responsibility for continuity of care and planning. The proposed amendment in subsection (d) replaces "most integrated setting" with "least restrictive and most appropriate setting" for clarity.

Division 3, Admission to a State Mental Health Facility or a Facility with a Contracted Psychiatric Bed--Provider Responsibilities, retitled as "Admission to a State Hospital or a Facility with a Contracted Psychiatric Bed--Provider Responsibilities."

The proposed amendment to §306.171 retitles the rule from "General Admission Criteria for a State Mental Health Facility or Facility with a Contracted Psychiatric Bed" to "General Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed" to update terminology. The proposed amendment in subsection (b)(1) clarifies that a state hospital or CPB may not admit an individual with a medical condition that requires medical care not available at the facility. The proposed amendment in subsection (c)(1) specifies a time frame of within three business days of the individual's presentation for services that a state hospital or CPB has to notify the designated LMHA or LBHA that the individual has presented for services. The proposed amendment in subsection (c)(2)(A) clarifies a statutory reference for Emergency Medical Treatment and Active Labor Act (EMTALA), and in subsection (c)(2)(B) requires that hospital transfers must occur according to Medicare, Medicaid, and EMTALA regulations. The proposed amendment in subsection (d) clarifies a facility must contact the designated LMHA or LBHA to coordinate alternate outpatient community services at time of admission denial. The proposed amendment in renumbered subsection (e) requires the designated LMHA or LBHA to contact and notify the individual, or the individual's LAR if applicable, that the LMHA or LBHA will provide referrals and referral follow-up.

The proposed amendment to §306.172, replaces "HHSC state hospital policies" with a reference to "25 TAC Chapter 415, Subchapter G," relating to Determination of Manifest Dangerousness, and makes a minor editorial changes.

The proposed amendment to §306.173 (a)(1)(A) removes the term "specialized" that currently describes mental health treatment, and replaces "to address violent behavior" with "to ad-

dress a risk of dangerousness." These changes are made to offer greater flexibility for individual eligibility and to align rule language. The proposed amendment revises the admission criteria in subsection (a)(1)(C) to require a written letter of recommendation from the local Community Resource Coordination Group (CRCG) that confirms available community resources for an adolescent have been exhausted. The proposed amendment revises the admission criteria in subsection (a)(3) by replacing "in accordance with HHSC state hospital policies" with "in accordance with 25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness)." The proposed amendment in subsection (b) removes the requirement for a physician to determine if the adolescent has an ID diagnosis.

The proposed amendment to §306.174 removes repetitive language in subsection (a)(1) and amends subsection (a)(2) to specify that an individual's admission to Waco Center for Youth may occur if an individual has an SED based on the version of the DSM currently recognized by HHSC. The proposed amendment to subsection (a)(3) replaces "behavior adjustment problems" with "behavior adjustment concerns" to exercise person-first language. The proposed amendment to subsection (a)(5)(A) clarifies that a referral for Waco Center for Youth admission can be made by the LMHA, LBHA, or CRCG when all appropriate community-based resources have been exhausted and the Center is the least restrictive and most appropriate environment. The proposed amendment adds new subparagraph (C) to add DFPS as a referral source for Waco Center for Youth admission to align with statute. The proposed amendment to subsection (b)(1) updates the minimum age for admission to 13 and adds that admission may not occur if the adolescent's age at admission does not allow adequate time for treatment programming before reaching 18 years of age. The proposed amendment to subsection (b)(4) removes the requirement for a physician determination for an ID diagnosis. The proposed amendment to subsection (c) specifies a time frame of within three business days for Waco Center for Youth to provide an adolescent's LAR and LMHA or LBHA written notification that states the reason for a denial in services. The proposed amendment to subsection (d) requires written clinical appropriateness of readmission to Waco Center for Youth and formats the last sentence in subsection (d) as new subsection (e) to make it a separate requirement. The proposed amendment adds a new subsection (f) to require an LMHA or LBHA to assess an adolescent for eligible services and continuity of care if a denial occurs.

The proposed amendment to §306.175 retitles the rule from "Voluntary Admission Criteria for a Facility with a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility" to "Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed" to update terminology. The proposed amendment to subsection (a)(1)(B) adds a cross-reference regarding LAR criteria for voluntary admission. The proposed amendment adds a new subsection (a)(4) to clarify who qualifies to be an LAR. The proposed amendment to subsection (b) adds "LIDDA" throughout the subsection as an entity to notify if an individual does not meet admission criteria to a state hospital or CPB; removes repetitive language in paragraph (1); and proposes new subsection (b)(2) to require the LMHA or LBHA to provide referrals and referral follow-up for ongoing services. The proposed amendment to subsection (c)(2)(C) adds language that specifies an assessment for SUD to be included in the state hospital or CPB admission examination. The proposed amendment replaces the current subsection (e) with a new subsection (e) to require an LMHA or LBHA to provide, or refer the individual to, community mental health services and supportive services to meet the needs of the individual who does not meet admission criteria. The proposed amendment to subsection (h), adds a new paragraph (4) to implement Texas Health and Safety Code §572.0026, which requires a state hospital or CPB to voluntarily admit an individual only if there is available space at the state hospital or CPB.

The proposed amendment to §306.176 retitles the rule from "Admission Criteria for a Facility with a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility for Emergency Detention" to "Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed for Emergency Detention" to update terminology.

The proposed amendment makes clarifying changes in subsections (a), (b), (c)(2), (d)(1) - (3), and (e) to use "must" where imposing a rule as a requirement is necessary and in subsection (e) to use "may" because the state hospital or CPB under certain conditions may or may not admit an individual for emergency detention. The proposed amendment to subsection (d)(2) clarifies that a facility is required to contact the designated LMHA or LBHA to provide referrals and referral follow-up for ongoing services for an individual who is not admitted on an emergency detention; and adds a reference to Texas Health and Safety Code Chapter 573. The proposed amendment, in subsection (d)(2), adds new subparagraphs (A) and (B) to require the LMHA or LBHA in the individual's county of residence to contact the individual within 24 hours of being notified that the individual does not meet emergency detention criteria and to provide referrals and referral follow-up for ongoing services. The proposed amendment to subsection (e) adds new language to require that all intake assessment documents must be provided to the individual or the individual's LAR. The proposed amendment in subsection (e)(1) - (5) makes minor editorial changes for clarity.

Proposed amendments to §306.177(a) clarifies a state hospital or CPB may admit an individual after receiving an order of protective custody; removes language in §306.177(b) that describes how an individual's admission is not a medical act; and amends §306.177(c) to clarify that the intake assessment must be conducted with an individual, and their LAR if applicable.

Division 4, Transfers and Changing Local Mental Health Authorities or Local Behavioral Health Authorities

The proposed amendment to §306.191 retitles the rule from "Transfers Between State Mental Health Facilities" to "Transfers Between State Hospitals" to update terminology. The proposed amendment in subsection (d) clarifies that the state hospital initiating the transfer must also notify the designated LMHA, LBHA, or LIDDA of the transfer.

The proposed amendment to §306.192 retitles the rule from "Transfers Between a State Mental Health Facility and a State Supported Living Center" to Transfers Between a State Hospital and a State Supported Living Center" to update terminology.

The proposed amendment to subsection (a)(1)(A) updates a rule reference and makes other minor editing changes. The proposed amendment to subsection (b)(1)(C) clarifies the rules and statutes governing the transfer of an individual from an SSLC to a state hospital by adding "Texas Health and Safety Code §575.012." The proposed amendment to subsection (b)(2) clarifies that the receiving state hospital and the initiating SSLC must notify the designated LMHA, LBHA, or LIDDA of the transfer.

The proposed amendment to §306.193 retitles the rule from "Transfers Between a State Mental Health Facility and an Out-of-State Institution" to "Transfers Between a State Hospital and an Out-of-State Facility" to update terminology.

The proposed amendment to §306.194 retitles the rule from "Transfers Between a State Mental Health Facility and Another Facility in Texas" to "Transfers Between a State Hospital and Another Facility in Texas" to update terminology. The proposed amendment to subsection (a) clarifies that the section applies to a transfer between a state hospital and a psychiatric hospital not operated by HHSC. The proposed amendment to subsection (b) clarifies that an individual may transfer from a state hospital to a federal agency and requires the transferring state hospital to notify the designated LMHA or LBHA of the transfer. The proposed amendment to subsection (c) replaces "govern transfer of" to "may transfer" for clarification. The proposed amendment also updates terminology.

The proposed amendment to §306.195, in subsection (a)(1)(A), requires the originating LMHA or LBHA to ensure the CoC liaison submits requested information to the new LMHA or LBHA within seven days after a transfer request. The proposed amendment adds a new subparagraph (a)(1)(B) to require the CoC liaison to initiate transition planning with the receiving LMHA or LBHA and renumbers the subsequent subparagraphs. The proposed amendment to subsection (a)(1)(C) updates LMHA or LBHA requirements to educate the individual, or the individual's LAR if applicable, on the provisions of the individual's transfer. The proposed amendment adds new paragraph (2) in subsection (a) to clarify requirements for the receiving LMHA or LBHA when an individual changes LMHAs or LBHAs and renumbers the subsequent paragraphs. The proposed amendment renumbers current paragraph (2) in subsection (a) as paragraph (3), and in renumbered paragraph (3)(A)(iv), removes "the individual" as a minor editorial change.

The proposed amendment to §306.201, in subsection (a), requires the state hospital or CPB to send an electronic admission initial notification within three business days to the appropriate LMHA, LBHA, and LIDDA to initiate discharge planning. The proposed amendment to subsection (b) requires the state hospital or CPB to initiate coordination of discharge planning. The proposed amendment to subsection (b)(2) adds a requirement for the state hospital or CPB to invite the LMHA, LBHA, or LIDDA, to routine recovery or treatment plan meetings with at least 24-hour notification of the meeting. The proposed amendment to subsection (b)(3) clarifies that the state hospital or CPB must coordinate discharge planning with the LMHA, LBHA, or LIDDA before the individual's discharge. The proposed amendment adds a paragraph (4) in subsection (b) to require the LMHA or LBHA to facilitate the transition of individuals who are determined by the state hospital or CPB to be medically appropriate for discharge by connecting them to resources available in the individual's county of residence or choice. The proposed amendment to §306.201 subsection (c)(2) clarifies requirements for the state hospital or CPB, and the LMHA, LBHA, or LIDDA to jointly identify, recommend, and help coordinate access to and supports for the individual and the individual's LAR if applicable. The proposed amendment to subsection (c)(3) clarifies requirements for the LMHA, LBHA, CoC liaison, or LIDDA continuity of care worker, to establish referrals to housing services and support. The proposed amendment to subsection (c)(4) requires the LMHA or LBHA CoC liaison, or LIDDA continuity of care worker, to identify potential providers and resources for the services and supports recommended and arrange for provision of services upon discharge to align with Texas Health and Safety Code §534.0535. The proposed amendment to subsection (c)(5) clarifies that the state hospital or CPB must attempt to educate the individual, and the individual's LAR if applicable, to prepare them for care after discharge or if the individual is on a pass or furlough from the facility. The proposed amendment to subsection (c)(7) adds LIDDAs as an entity that must comply with the PASSR requirements and replaces "recommended to move" with "referred" for clarity. The proposed amendment to subsection (d)(1) clarifies requirements for the discharge plan. The proposed amendments to subsection (d)(1)(A) - (C) removes "The SMHF or facility with a CPB documents" for clarity; adds proposed new §306.201(d)(1)(D) that requires the discharge plan to include documentation of arrangements and referrals, and renumbers subsequent paragraphs. The proposed amendment to subsection (d)(1)(E) replaces the word "problems" with "behavioral health symptoms" and replaces "issues" with "symptoms" for clarity. The proposed amendment to subsection (d)(1)(J)(ii) clarifies the required time frame for providing and paying for medication. The proposed amendment to subsection (d)(5)(B) updates the process for when an LMHA or LBHA disagrees with the treatment team's decision concerning discharge. The proposed amendment to subsection (e)(1) clarifies that discharge notification requires authorization by the individual or the individual's LAR, if applicable. The proposed amendment to subsection (e)(2) adds "who voluntarily consented for the individual's own admission" to discharge procedures when an individual is at least 16, but less than 18 years of age, and a 72-hour time frame for notifying the individual's family or any identified person providing support of the individual's discharge for clarification. The proposed amendment to subsection (e)(3) adds "must" to impose a requirement for the state hospital or DPB to notify the minor's LAR of the discharge. The proposed amendment to subsection (f)(1)(A) clarifies and adds two new requirements for a state hospital or CPB if the LAR or the LAR's designee is unwilling to retrieve the minor upon discharge and the LAR is not a state agency. The proposed amendment to subsection (g)(1) clarifies a state hospital or CPB must inform the designated LMHA, LBHA, or LIDDA of the individual's anticipated or unexpected discharge and convey the contact information of the individual, or the individual's LAR if applicable. The proposed amendment to subsection (g)(4) revises the requirement to include the individual's destination address after discharge, or while on pass or furlough. The proposed amendment to subsection (g)(7) adds "an ID, or a DD" as information provided to the designated LMHA, LBHA, or LIDDA before discharge. The proposed amendment to subsection (h)(2) removes extraneous information pertaining to an individual's records. The proposed amendment to subsection (i)(2) replaces "staff with an equivalent credential to a social worker" with "designee" for clarity. The proposed amendment to subsection (j)(1) includes a LIDDA as a collaborator for secure transportation for an individual's discharge. The proposed amendment adds a new subsection (l) to require an LMHA or LBHA to provide continuity of care services designed to support joint discharge planning efforts to align with Texas Health and Safety Code §534.0535. The proposed amendment updates terminology as needed throughout the section and updates rule references.

The proposed amendment to §306.202, subsection (a) clarifies that a mental health peer specialist or recovery support peer specialist can provide non-clinical supports, and updates the terminology for these roles. The proposed amendment creates new subsection (b) to align with Texas Health and Safety Code

§534.053 and renumbers the subsequent subsections. The proposed amendment to renumbered subsection (g)(1)(A) clarifies that an individual committed to a state hospital or a CPB under Texas Code of Criminal Procedure Article 46B.102, may only be discharged by order of the committing court, and in (g)(1)(B) clarifies that an individual committed to a state hospital or a CPB under Texas Code of Criminal Procedure Article 46B.073 must be discharged and transferred in accordance with Texas Code of Criminal Procedure Articles 46B.081. The proposed amendment to renumbered subsection (g)(2) clarifies that an individual committed to a state hospital or CPB under Texas Code of Criminal Procedure Chapter 46C may only be discharged by order of the committing court. The proposed amendment to renumbered subsection (h)(1)(A), (B), and (C) adds "LBHA" to replace one of the two references to "LMHA" to correct these rules. The proposed amendment to renumbered subsection (h)(1)(C) adds "required in paragraph (1)(A) of this subsection" for clarity. The proposed amendment updates terminology as needed and makes minor editing change. The term "face-to-face" is also replaced throughout the section with "in-person" for clarity.

The proposed amendment to §306.203 retitles the rule from "Discharge of an Individual Voluntarily Receiving Treatment" to "Discharge of an Individual Voluntarily Receiving Inpatient Treatment" to clarify the type of treatment. The proposed amendment adds "must" in subsections (b)(2) and (d)(2)(B) and (C), to clarify requirements regarding discharge requests. The proposed amendment in subsection (e)(1)(A) removes "treatment as a patient" and adds "and released to the minor's LAR" to subsection (e)(1)(B) for clarification regarding discharge. The proposed amendment to subsection (f) clarifies that when withdrawing the request for discharge, an individual documents and signs a written statement. The proposed amendment updates terminology and the titles of a division and a rule referenced in the section and makes other minor editorial changes.

The proposed amendment to §306.204 replaces "facility with a CPB administrator" with "administrator of the CPB" throughout subsection (b) for clarity and makes corrections by adding "state hospital or" to all instances of "CPB" in subsection (c)(3). The proposed amendment also adds that coverage for psychoactive medications also applies when an individual is on a pass under (c)(3).

The proposed amendment to §306.205 retitles the rule from "Pass or Furlough from a State Mental Health Facility or a Facility with a Contracted Psychiatric Bed" to "Pass or Furlough from a State Hospital or a Facility with a Contracted Psychiatric Bed" to update terminology. The proposed amendment replaces the current subsection (a) with new subsection (a) to clarify the pass or furlough requirements for an individual under consideration for discharge. The proposed amendment adds new subsection (b) to clarify the circumstances when a state hospital or CPB administrator may contact a peace officer. The proposed amendment adds new subsection (c) to clarify that the LMHA or LBHA must ensure an individual receives proper care and medical attention if detained in a nonmedical facility by a peace officer and renumbers the subsequent subsections. The proposed amendment to renumbered subsection (d) replaces "authorized absence that exceeds 72 hours" with "furlough" for clarity. The proposed amendment to renumbered subsection (d)(3) and (4) clarify the hearing officer's role and responsibilities after an administrative hearing regarding a furlough concludes. The proposed amendment to renumbered subsection (d)(5) replaces "absence" with "furlough" for clarity. The proposed amendment to renumbered subsection (e) replaces "absences" with "a pass or furlough" for clarity.

The proposed repeal of §306.206 is necessary because the terminology "ATP--absence for trial placement" is no longer used in Subchapter D.

The proposed amendment to §306.207 retitles the rule from "Post Discharge or Absence for Trial Placement: Contact and Implementation of the Recovery or Treatment Plan " to "Post Discharge or Furlough: Contact and Implementation of the Recovery or Treatment Plan" to update terminology and changes the formatting from paragraphs to subsections. The proposed amendment adds "within seven days after discharge" in subsection (a)(2), and adds a new paragraph (3) to require the designated LMHA or LBHA to ensure the successful transition of individuals determined by the state hospital or CPB to be medically appropriate for discharge in accordance with Texas Health and Safety Code §534.0535 to align with statute.

Division 6, Training

The proposed amendment to §306.221 retitles the rule from "Screening and Intake Assessment Training Requirements at a State Mental Health Facility and a Facility with a Contracted Psychiatric Bed" to "Screening and Intake Assessment Training Requirements at a State Hospital and a Facility with a Contracted Psychiatric Bed" and makes other editing changes where needed to update terminology.

Proposed new Subchapter H, Behavioral Health Services--Telecommunications

Proposed new §306.361 describes that the purpose of new Subchapter H is to establish methods and parameters of service delivery for individuals receiving general-revenue funded behavioral health services that the Texas Health and Human Services Commission determines are clinically effective and cost-effective in accordance with Texas Government Code §531.02161.

Proposed new §306.363 establishes that the rules apply to LMHAs, LBHAs, substance use intervention providers, substance use treatment providers, and their subcontracted providers.

Proposed new §306.365 defines terms used in the proposed new subchapter.

Proposed new §306.367 establishes parameters for the delivery of services using audiovisual or audio-only technology under this subchapter if permitted by provider's state license, permit, or other legal authorization. Proposed new subsection (b) requires providers adhere to Medicaid policy, procedures, rules, and guidance. Proposed new subsection (c) allows providers delivering behavioral health services that do not have a procedure code billable in Medicaid to deliver the service either in person, by audiovisual technology, or by audio-only technology. Proposed new subsection (d) sets forth the requirements for a provider delivering behavioral health services by audiovisual technology or by audio-only technology as permitted under proposed new Subchapter H. Proposed new subsection (e) requires a provider to ensure any software or technology used complies with all applicable state and federal requirements and confidentiality and data encryption requirements.

Proposed new §306.369, in subsection (a), requires a provider to accurately document the services rendered, identify the method of service delivery, and adhere to the same documentation requirements for behavioral health services delivered by audiovi-

sual or audio-only technology as for service delivery in person. Proposed new subsection (b) requires a provider, prior to delivering a behavioral health service by audio-only technology, to obtain informed consent from the individual, or the individual's LAR if applicable, and sets forth requirements for documentation of informed consent. Proposed new subsection (c) requires providers to adhere to documentation requirements in accordance with publications and conditions described in proposed new §306.367(b) if the general revenue-funded behavioral health service has a procedure code that is billable in Medicaid.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new regulations;

(6) the proposed rules will expand and repeal existing regulations;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities as there are no requirement to alter current business practices. The proposed rules provide guidance to providers on programmatic requirements.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Trina Ita, Deputy Executive Commissioner of Behavioral Health Services, has determined that for each year of the first five years the rules are in effect, the public benefit will be that transition support teams will prepare the highest need/most complex patients for transition, provide post-move monitoring, and ensure collaborative problem-solving among providers to avoid readmission or other undesired outcomes. The public benefit will also be increased access to services via telehealth.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because all new requirements are included in contracts already in place, therefore there is no change to current business practices and no new fees or costs imposed on those required to comply.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R018" in the subject line.

SUBCHAPTER D. MENTAL HEALTH SERVICES--ADMISSION, CONTINUITY, AND DISCHARGE

DIVISION 1. GENERAL PROVISIONS

26 TAC §§306.151 - 306.155

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendments affect Texas Government Code §531.0055.

§306.151. Purpose.

(a) The purpose of this subchapter is to:

(1) provide requirements on admission, discharge, and continuity of care; and

(2) address the interrelated roles and responsibilities of state hospitals, CPBs, LMHAs, LBHAs, and LIDDAs [mental health facilities, local mental health authorities, and local behavioral health authorities] in the delivery of mental health and co-occurring SUD services to individuals.

(b) This subchapter establishes criteria for individuals receiving mental health services and SUD services and provides guidelines related to:

(1) clinically appropriate [patient] placement in an inpatient, residential, or community setting based on screening and assessment of the individual;

(2) timely access to evaluation and mental health, SUD, and other [treatment] services in the least restrictive and most appropriate setting; and

(3) [effectively, and without interruption,] transitioning care between service types and providers for individuals receiving mental health or SUD services at state hospitals, CPBs, LMHAs, LBHAs, and LIDDAS, effectively and without interruption [mental health facilities, local mental health authorities, and local behavioral health authorities].

§306.152. Application and Responsibility for Compliance.

(a) This subchapter applies to:

(1) a state hospital [mental health facility (SMHF)];

(2) a CPB [facility with a contracted psychiatric bed (CPB)];

(3) an LMHA [a local mental health authority (LMHA)]; [or]

(4) an LBHA [a local behavioral health authority (LBHA)]; and

[(4) an LMHA or LBHA with a local service area that is served by a managed care organization (MCO), to the extent the contract between the Health and Human Services Commission (HHSC) and the LMHA or LBHA requires compliance with one or more provisions of this subchapter; and]

(5) a LIDDA.

[(5) an MCO, as required by the managed care contracts between HHSC and the MCO for delivery of Medicaid and CHIP managed care products.]

(b) [Responsibility for Compliance.] An LMHA or LBHA must require its subcontractors to comply with this subchapter.[:]

[(1) must require by contract with providers in its network, that the providers comply with Division 2 of this subchapter (relating to Screening and Assessment for Crisis Services and Admission into Local Mental Health Authority or Local Behavioral Health Authority Services--Local Mental Health Authority or Local Behavioral Health Authority Responsibilities) and Division 3 of this subchapter (relating to Admission to a State Mental Health Facility or a Facility with a Contracted Psychiatric Bed--Provider Responsibilities); and]

[(2) must monitor its providers for compliance with the contract and the requirements in Division 2 and Division 3 of this subchapter.]

§306.153. Definitions.

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

(1) Absence--When an individual, previously admitted to a state hospital or CPB, [an SMHF] and [who is] not discharged from the admitting facility [SMHF], is physically away from the facility [SMHF] for any reason, including hospitalization, home visit, special activity, or unauthorized departure[, or absence for trial placement].

(2) Admission--Includes:

(A) an [An] individual's acceptance to a state hospital or [an SMHF's custody or a facility with a] CPB for voluntary or involuntary inpatient or residential treatment services; or[, based on:]

[*(i)* a physician's order issued in accordance with §306.175(h)(2)(C) of this subchapter (relating to Voluntary Admission Criteria for a Facility with a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility);]

[*(ii)* a physician's order issued in accordance with §306.176(c)(3) of this subchapter (relating to Admission Criteria for a Facility with a Contracted Psychiatric Bed Authorized by an LMHA or LBHA or for a State Mental Health Facility for Emergency Detention);]

[*(iii)* a court's order of protective custody issued in accordance with Texas Health and Safety Code §574.022;]

[*(iv)* a court's order for temporary inpatient mental health services issued in accordance with Texas Health and Safety Code §574.034, or Texas Family Code Chapter 55;]

[*(v)* a court's order for extended inpatient mental health services issued in accordance with Texas Health and Safety Code §574.035, or Texas Family Code Chapter 55; or]

[*(vi)* a court's order for commitment issued in accordance with the Texas Code of Criminal Procedure, Chapter 46B or Chapter 46C.]

(B) the [The] acceptance of an individual in the mental health priority population into LMHA or LBHA services.

(3) Adolescent--An individual who is [at least] 13 years of age, but younger than 18 years of age.

(4) Adult--An individual who is at least 18 years of age or older.

(5) Advance directive--As used in this subchapter, includes:

(A) an instruction made under Texas Health and Safety Code Chapter 166 [§§166.032, 166.034 or 166.035 to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition]; or

[(B) an out-of-hospital DNR order, as defined by Texas Health and Safety Code §166.081;]

[(C) a medical power of attorney under Texas Health and Safety Code, Chapter 166, Subchapter D; or]

(B) [(D)] a declaration for mental health treatment made [for preferences or instructions regarding mental health treatment] in accordance with Civil Practice and Remedies Code Chapter 137.

(6) Alternate provider--An entity that provides mental health services or SUD [substance use disorder treatment] services in the community but does not provide these services under contract [pursuant to a contract or memorandum of understanding] with an LMHA or LBHA.

(7) APRN--Advanced practice registered nurse. A registered nurse licensed by the Texas Board of Nursing to practice as an advanced practice registered nurse as provided by Texas Occupations Code §301.152.

(8) Assessment--The administrative process a state hospital or [an SMHF or a facility with a] CPB uses to gather information from an individual [a prospective patient], including a medical history and the concerns [problem] for which the individual [prospective patient] is seeking treatment, to determine whether the individual [a prospective patient] should be examined by a physician to determine if admission is clinically justified, as defined by Texas Health and Safety Code §572.0025(h)(2).

(9) Assessment professional--In accordance with Texas Health and Safety Code §572.0025(c) - (d)[§572.0025(c)-(d)], a staff member of a state hospital or [an SMHF or facility with a] CPB, whose responsibilities include conducting the intake assessment described in §306.175(g) of this subchapter (relating to Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed) and §306.176(e) of this subchapter (relating to Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed for Emergency Detention), and who is:

(A) a physician licensed to practice medicine under Texas Occupations Code[,] Chapter 155;

(B) a physician assistant licensed under Texas Occupations Code[,] Chapter 204;

(C) an APRN licensed under Texas Occupations Code[,] Chapter 301;

(D) a registered nurse licensed under Texas Occupations Code[,] Chapter 301;

(E) a psychologist licensed under Texas Occupations Code[,] Chapter 501;

(F) a psychological associate licensed under Texas Occupations Code[,] Chapter 501;

(G) a licensed professional counselor licensed under Texas Occupations Code[,] Chapter 503;

(H) a licensed social worker licensed under Texas Occupations Code[,] Chapter 505; or

(I) a licensed marriage and family therapist licensed under Texas Occupations Code[,] Chapter 502.

(10) Audio-only technology--A synchronous interactive, two-way audio communication that uses only sound and that conforms to privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include audiovisual or in-person communication.

[(10) ATP--Absence for trial placement. When an individual, currently admitted to an SMHF, is physically away from the SMHF for the SMHF to evaluate the individual's adjustment to a particular living arrangement before the individual's discharge and as a potential residence following discharge. An ATP is a type of furlough, as referenced in Texas Health and Safety Code, Chapter 574, Subchapter F.]

(11) Audiovisual technology--A synchronous interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audiovisual does not include audio-only or in-person communication.

(12) [(11)] Business day--Any day except a Saturday, Sunday, or legal holiday listed in Texas Government Code §662.021.

(13) [(12)] Capacity--An individual's ability to understand and appreciate the nature and consequences of a decision regarding the individual's medical treatment, and the ability of the individual to reach an informed decision in the matter.

(14) [(13)] Child--An individual who is at least three years of age, but younger than 13 years of age.

(15) CoC liaison--Continuity of care liaison. A dedicated full-time staff member who is a QMHP-CS or LPHA that facilitates continuity of care.

(16) [(14)] Continuity of care--Activities designed to ensure an individual is provided uninterrupted services during a transition between inpatient and outpatient services and that assist the individual, and the individual's LAR if applicable, in identifying, accessing, and coordinating LMHA or LBHA services and other appropriate services and supports in the community needed by the individual, including:

(A) assisting with admissions and discharges;

(B) facilitating access to appropriate services and supports in the community, including identifying and connecting the individual with community resources, and coordinating the provision of services;

(C) participating in developing and reviewing the individual's recovery or treatment plan;

(D) promoting implementation of the individual's recovery or treatment plan; and

(E) coordinating notification of continuity of care services between the individual and the individual's family and any other person providing support as authorized by the individual, and the individual's LAR, if applicable [any].

(17) [(15)] Continuity of care worker--A [An LMHA, LBHA, or] LIDDA staff member responsible for providing continuity of care services. [The staff member may collaborate with a peer specialist, recovery specialist, or family partner to provide continuity of services.]

(18) [(16)] COPSD--Co-occurring psychiatric and substance use disorder.

(19) [(17)] COPSD model--An application of evidence-based practices for an individual diagnosed with co-occurring conditions of psychiatric [mental illness] and substance use disorder.

(20) [(18)] CPB--Contracted psychiatric bed. A facility with an HHSC-contracted [A state-funded contracted] psychiatric bed that:

(A) includes a community mental health hospital and a private psychiatric bed that:

(i) [(A)] is authorized by an LMHA or LBHA; and

(ii) [(B)] is used for inpatient care in the community; [,] and [this]

(B) does not include a crisis respite unit, crisis residential unit, an extended observation unit, or a crisis stabilization unit.

(21) [~~(19)~~] CRCG--Community Resource Coordination Group. A local interagency group comprised of public and private providers who collaborate to develop individualized service plans for individuals whose needs may be met through interagency coordination and cooperation. CRCGs are established and operate in accordance with a Memorandum of Understanding on Services for Persons Needing Multiagency Services, as required by Texas Government Code §531.055.

(22) [~~(20)~~] Crisis--A situation in which:

(A) an individual presents an immediate danger to self or others;

(B) an individual's mental or physical health is at risk of serious deterioration; or

(C) an individual believes the individual [~~he~~] presents an immediate danger to self or others, or the individual's mental or physical health is at risk of serious deterioration.

(23) [~~(21)~~] Crisis treatment alternatives--Community-based facilities or units and services providing short-term, residential crisis treatment to ameliorate a behavioral health crisis in the least restrictive and most appropriate environment, including crisis stabilization units, extended observation units, crisis residential units, and crisis respite units. The intensity and scope of services varies by facility type and is available in a local service area based upon the local needs and characteristics of the community.

(24) [~~(22)~~] Day--A calendar day, unless otherwise specified [~~Calendar day~~].

(25) [~~(23)~~] DD--Developmental disability. A disability that meets the criteria described in [~~As listed in the~~] Texas Health and Safety Code §531.002(15). [~~§531.002, an individual with a severe, chronic disability attributable to a mental or physical impairment or a combination of mental and physical impairments that:~~]

[~~(A) manifests before the person reaches 22 years of age;~~]

[~~(B) is likely to continue indefinitely;~~]

[~~(C) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of a lifelong or extended duration and are individually planned and coordinated; and~~]

[~~(D) results in substantial functional limitations in three or more of the following categories of major life activity:~~]

[~~*(i)* self-care;~~]

[~~*(ii)* receptive and expressive language;~~]

[~~*(iii)* learning;~~]

[~~*(iv)* mobility;~~]

[~~*(v)* self-direction;~~]

[~~*(vi)* capacity for independent living; and~~]

[~~*(vii)* economic self-sufficiency.~~]

(26) [~~(24)~~] Designated LMHA or LBHA--The LMHA or LBHA:

(A) that serves the individual's county of residence, which is determined in accordance with §306.162 of this subchapter (relating to Determining County of Residence); or

(B) that does not serve the individual's county of residence but has taken responsibility for ensuring the individual's [~~LMHA or LBHA~~] services.

(27) DFPS--Texas Department of Family and Protective Services or its designee.

(28) [~~(25)~~] Discharge--Means:

(A) the [~~From an SMHF or a facility with a CPB: The~~] release of an individual from the custody and care of a provider of inpatient services; or [~~.~~]

(B) the [~~From LMHA or LBHA services: The~~] termination of LMHA or LBHA services delivered to an individual by the individual's [~~an~~] LMHA or LBHA.

(29) Discharge planning specialist--A designated state hospital staff member responsible for coordinating continuity of care services with a specific focus on an individual's community transition in accordance with Texas Health and Safety Code §534.0535. This term is synonymous with a "transition support specialist."

(30) [~~(26)~~] Discharged unexpectedly--A discharge from the custody and care of a provider of inpatient services [~~an SMHF or facility with a CPB~~]:

(A) due to an individual's unauthorized departure;

(B) at the individual's request;

(C) due to a court releasing the individual;

(D) due to the death of the individual; or

(E) due to the execution of an arrest warrant for the individual.

(31) DSM--Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(32) [~~(27)~~] Emergency medical condition--This term has the meaning assigned by the Emergency Medical Treatment and Active Labor Act (42 U.S.C. §1395dd), regarding Examination and treatment for emergency medical conditions and women in labor. [~~A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance use disorder) such that the absence of immediate medical attention could reasonably result in:~~]

[~~(A) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) or others in serious jeopardy;~~]

[~~(B) serious impairment to bodily functions;~~]

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

[~~(D) serious disfigurement; or~~]

[~~(E) in the case of a pregnant woman having contractions:~~]

[~~*(i)* inadequate time to affect a safe transfer to another hospital before delivery; or~~]

[~~*(ii)* a transfer posing a threat to the health and safety of the woman or the unborn child.~~]

[~~(28) Face-to-face--A form of contact occurring in person or through the use of audiovisual or other telecommunications technology.~~]

[(29) Facility--A state mental health facility, private psychiatric hospital, medical hospital, and community setting, but does not include a nursing facility or an assisted living facility].

(33) Family partner--An experienced, trained primary caregiver, such as the parent of an individual with a mental illness or serious emotional disturbance, who provides peer mentoring, education, and support to the caregivers of a child who is receiving mental health community services in accordance with Chapter 301, Subchapter G of this title (relating to Mental Health Community Services Standards).

(34) Furlough--The authorization for an individual to leave from a state hospital or CPB for longer than a 72-hour period in accordance with Texas Health and Safety Code Chapter 574, Subchapter F.

(35) [(30)] HHSC--Texas Health and Human Services Commission or its designee.

(36) [(31)] ID--Intellectual disability. A disability that meets the criteria in [Consistent with] Texas Health and Safety Code §591.003[, significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating before age 18].

(37) [(32)] Individual--A person seeking or receiving services under this subchapter.

[(33) Individual involuntarily receiving treatment--An individual receiving inpatient services based on an admission to a state mental health facility or a facility with a CPB made in accordance with:]

[(A) §306.176 of this subchapter;]

[(B) §306.177 of this subchapter (relating to Admission Criteria Under Order of Protective Custody or Court-ordered Inpatient Mental Health Services);]

[(C) an order for temporary inpatient mental health services issued in accordance with Texas Health and Safety Code §574.034 or Texas Family Code, Chapter 55;]

[(D) an order for extended inpatient mental health services issued in accordance with Texas Health and Safety Code §574.035 or Texas Family Code, Chapter 55;]

[(E) an order for commitment issued in accordance with Texas Code of Criminal Procedure, Chapter 46B; or]

[(F) an order for commitment issued in accordance with Texas Code of Criminal Procedure, Chapter 46C.]

[(34) Individual voluntarily receiving treatment--An individual receiving inpatient services based on an admission made in accordance with:]

[(A) §306.175 of this subchapter; or]

[(B) §306.178 of this subchapter (relating to Voluntary Treatment Following Involuntary Admission).]

(38) [(35)] Inpatient services--Residential psychiatric treatment provided to an individual in:

(A) a state hospital; [an SMHF,]

(B) a [facility with a] CPB; [,]

(C) a hospital licensed under [the] Texas Health and Safety Code[,] Chapter 241 or Chapter 577; [, or]

(D) a crisis stabilization unit [CSU] licensed under Chapter 510 of this title (relating to Private Psychiatric Hospitals and Crisis Stabilization Units); or

(E) any other type of mental health hospital.

(39) In person--Within the physical presence of another person. In person does not include audiovisual or audio-only communication.

(40) [(36)] Intake assessment--The administrative process conducted by an assessment professional for:

(A) gathering information about an individual, [a prospective patient] including the psychiatric and medical history, social history, symptomology, and support system; and

(B) giving the individual [a prospective patient] information about the facility and the facility's treatment and services.

(41) Involuntary admission--An individual receiving inpatient services based on an admission to a state hospital or CPB in accordance with:

(A) §306.176 of this subchapter (relating to Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed for Emergency Detention);

(B) §306.177 of this subchapter (relating to Admission Criteria Under Order of Protective Custody or Court-ordered Inpatient Mental Health Services);

(C) an order for temporary inpatient mental health services issued in accordance with Texas Health and Safety Code §574.034 or Texas Family Code Chapter 55;

(D) an order for extended inpatient mental health services issued in accordance with Texas Health and Safety Code §574.035 or Texas Family Code Chapter 55;

(E) an order for commitment issued as described in Texas Code of Criminal Procedure Chapter 46B; or

(F) an order for commitment issued as described in Texas Code of Criminal Procedure Chapter 46C.

(42) [(37)] LAR--Legally authorized representative. A person authorized by state law to act on behalf of an individual. [for the purposes of:]

[(A) admission, transfer or discharge that includes:]

[(i) a parent, non-Department of Family and Protective Services managing conservator or guardian of a minor;]

[(ii) a Department of Family and Protective Service managing conservator of a minor acting pursuant to Texas Health and Safety Code §572.001 (c-2) - (c-4); and]

[(iii) a person eligible to consent to treatment for a minor under §32.001(a), Texas Family Code, or a person who may request from a district court authorization under Texas Family Code, Chapter 35 for the temporary admission of a minor.]

[(B) consent on behalf of an individual with regard to a matter described in this subchapter other than admission, transfer or discharge includes:]

[(i) persons described by subparagraph (A) of this paragraph; and]

[(ii) an agent acting under a Medical Power of Attorney under Texas Health and Safety Code, Chapter 166 or a Declaration

for Mental Health Treatment under Texas Civil Practice and Remedies Code, Chapter 137.]

(43) [(38)] LBHA--Local behavioral health authority. An entity designated as an LBHA by HHSC in accordance with Texas Health and Safety Code §533.0356(a) [§533.0356].

(44) [(39)] LIDDA--Local intellectual and developmental disability authority. An entity designated by HHSC in accordance with Texas Health and Safety Code §533A.035(a) [§533A.035].

(45) [(40)] LMHA--Local mental health authority. An entity designated as an LMHA by HHSC in accordance with Texas Health and Safety Code §533.035(a).

(46) [(41)] LMHA or LBHA network provider--An entity that provides mental health and SUD services in the community pursuant to a contract or memorandum of understanding with an LMHA or LBHA, including that part of an LMHA or LBHA directly providing mental health services.

(47) [(42)] LMHA or LBHA services--Inpatient mental health and outpatient mental health and SUD services provided by an LMHA or LBHA network provider to an individual in the individual's home community.

(48) [(43)] Local service area--A geographic area composed of one or more Texas counties defining the population that may receive services from an LMHA, [or] LBHA, or LIDDA.

[(44) MCO--Managed care organization. An entity governed by Chapter 843 of the Texas Insurance Code to operate as a health maintenance organization or to issue a private provider benefit plan.]

(49) LPHA--Licensed practitioner of the healing arts. This term has the meaning as defined in §301.303 of this title (relating to Definitions).

(50) [(45)] Mental illness--This term has the meaning as assigned by Texas Health and Safety Code §571.003. [An illness, disease, or condition, other than a sole diagnosis of epilepsy, dementia, substance use disorder, ID, or DD that:]

[(A) substantially impairs an individual's thought, perception of reality, emotional process, or judgment; or]

[(B) grossly impairs behavior as demonstrated by recent disturbed behavior.]

(51) [(46)] MH priority population--Mental health priority population. As identified in state performance contracts with LMHAs or LBHAs, those groups of children and adolescents[, adolescents , and adults] with SED, or adults with severe and persistent mental illness, [mental illness or serious emotional disturbance] assessed as [most] in need of mental health services.

(52) [(47)] Minor--An individual younger than 18 years of age who has not been emancipated under Texas Family Code Chapter 31.

(53) [(48)] Nursing facility--A Medicaid-certified [long-term care] facility licensed in accordance with [by HHSC as a nursing home, nursing facility, or skilled nursing facility as defined in] Texas Health and Safety Code[,] Chapter 242.

(54) [(49)] Offender with special needs--An individual who has a terminal or serious medical condition, a mental illness, an ID, a DD, or a physical disability, and is served by the Texas Correctional Office on Offenders with Medical or Mental Impairments as provided in Texas Health and Safety Code[,] Chapter 614.

(55) [(50)] Ombudsman--The Ombudsman for Behavioral Health Access to Care established by HHSC in accordance with Texas Government Code §531.9933 [§531.02251, which serves as a neutral party to help individuals, including individuals who are uninsured or have public or private health benefit coverage. The behavioral health care providers navigate and resolve issues related to the individual's access to behavioral health care, including care for mental health conditions and substance use disorders].

(56) Outpatient management plan--The prescribed regimen of medical, psychiatric, or psychological care or treatment as defined in Texas Code of Criminal Procedure Article 46C.263(c).

(57) [(51)] PASRR--Preadmission screening and resident review as defined in §303.102 of this title (relating to Definitions)[in accordance with 40 TAC Chapter 19, Subchapter BB (relating to Nursing Facility Responsibilities Related to Preadmission Screening and Resident Review (PASRR))].

[(52) PASRR Level I screening--The process of screening an individual to identify whether the individual is suspected of having a mental illness, ID, or DD.]

[(53) PASRR Level II evaluation--A face-to-face evaluation of an individual suspected of having a mental illness, ID, or DD performed by a LIDDA, LMHA, or LBHA to determine if the individual has a mental illness, ID, or DD, and if so, to:]

[(A) assess the individual's need for care in a nursing facility;]

[(B) assess the individual's need for nursing facility specialized services, LIDDA specialized services, and LMHA or LBHA specialized services; and]

[(C) identify alternate placement options.]

(58) Pass--The authorization for an individual to leave from a state hospital or CPB for not more than a 72-hour period in accordance with Texas Health and Safety Code Chapter 574, Subchapter F.

(59) PE--PASRR level II evaluation. This term has the meaning as defined in §303.102 of this title.

(60) [(54)] Peer specialist--A person who uses lived experience in addition to skills learned in formal training, to deliver strengths-based, person-centered services to promote an individual's recovery and resiliency in accordance with 1 TAC Chapter 354, Subchapter N (relating to Peer Specialist Services).

(61) [(55)] Permanent residence--The physical location in the community where an individual lives, or if a minor, where the minor's parents or legal guardian lives. A post office box is not considered a permanent residence.

(62) PL1--PASRR Level I screening. This term has the meaning as defined in §303.102 of this title.

(63) [(56)] Preliminary examination--An assessment for medical stability and a psychiatric examination in accordance with Texas Health and Safety Code §573.022(a)(2).

(64) [(57)] QMHP-CS--Qualified mental health professional-community services. An LMHA or LBHA [A] staff member who meets the qualifications [requirements] and performs the functions described in Chapter 301, Subchapter G of this title (relating to Mental Health Community Services Standards).

(65) [(58)] Recovery--A process of change through which an individual improves the individual's [individuals improve their]

health and wellness, lives [live] a self-directed life, and strives [strive] to reach the individual's [their] full potential.

(66) [(59)] Recovery or treatment plan--A written plan:

(A) developed in collaboration with an individual, or the individual's LAR if applicable [required], and a QMHP-CS or LPHA [Licensed Practitioner of the Healing Arts (LPHA)] as defined in §301.303 of this title [(relating to Definitions)];

(B) amended at any time based on an individual's needs or requests;

(C) that guides the recovery treatment process and fosters resiliency;

(D) completed in conjunction with the uniform assessment;

(E) that identifies the individual's changing strengths, capacities, goals, preferences, needs, and desired outcomes; and

(F) that includes recommended services and supports or reasons for the exclusion of services and supports.

(67) [(60)] Screening--Activities [performed by a QMHP-CS] to:

(A) collect triage information through [face-to-face or telephone] interviews with an individual or collateral contact;

(B) determine if the individual's need is emergent, urgent, or routine, and conducted before the [face-to-face] assessment to determine the need for emergency services; and

(C) determine the need for an in-depth assessment.

(68) SED--Serious emotional disturbance. A disorder that meets the criteria described in Texas Government Code §531.251.

[(61) SMHF--State mental health facility. A state hospital or a state center with an inpatient psychiatric component.]

(69) [(62)] SSLC--State supported living center. Consistent with Texas Health and Safety Code §531.002, a residential facility operated by HHSC [the State] to provide an individual [individuals] with an ID a variety of services, including medical treatment, specialized therapy, and training in the acquisition of personal, social, and vocational skills.

(70) State hospital--Consistent with Texas Health and Safety Code §552.002, a mental health facility operated by HHSC, including Waco Center for Youth.

(71) [(63)] SUD--Substance use disorder. [--] The use of one or more drugs, including alcohol, which significantly and negatively impacts one or more major areas of life functioning and which meets the criteria for SUD [substance use] as described in the version of the DSM currently recognized by HHSC[current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association].

(72) [(64)] TAC--Texas Administrative Code.

(73) [(65)] TCOOMMI--Texas Correctional Office on Offenders with Medical or Mental Impairments or its designee.

[(66) Transfer--To move from one facility to another facility.]

(74) [(67)] Treating physician--A physician who coordinates and oversees an individual's treatment.

(75) [(68)] Treatment team--A group of treatment providers, working with an individual, the individual's LAR[,] if applicable [any], and the LMHA, LBHA, or LIDDA [who work together] in a coordinated manner to provide comprehensive mental health, SUD, and ID services to the individual.

(76) [(69)] Uniform assessment--An assessment tool adopted by HHSC under §301.353 of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) used for recommending an individual's level of care.

(77) Voluntary admission--An individual receiving inpatient services based on an admission made in accordance with:

(A) §306.175 of this subchapter;

(B) §306.178 of this subchapter (relating to Voluntary Treatment Following Involuntary Admission);

(C) Texas Health and Safety Code §572.002; or

(D) Texas Health and Safety Code §572.0025.

§306.154. Notification and Appeals Process for Local Mental Health Authority or Local Behavioral Health Authority Services.

(a) [Right of an individual eligible for Medicaid to request a fair hearing.] Any individual who is eligible for Medicaid and whose request for eligibility to receive LMHA or LBHA Medicaid services is denied or is not acted upon with reasonable promptness [, or whose services have been terminated, suspended, or reduced by HHSC,] is entitled to a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearings Rules).

(b) Any individual who is eligible for Medicaid and whose services have been terminated, suspended, or reduced by HHSC is entitled to a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A.

(c) [(b)] [Right of an individual not eligible for Medicaid to request an appeal.] Any individual who has not applied for or is not eligible for Medicaid, whose request for eligibility to receive LMHA or LBHA services is denied or is not acted upon with reasonable promptness, or whose services have been terminated, suspended, or reduced by a provider, is entitled to notification and right of appeal in accordance with 25 TAC §401.464 (relating to Notification and Appeals Process).

(d) [(c)] At any time, an individual may contact the Ombudsman for additional information and resources by calling toll-free 1-800-252-8154 [(1-800-252-8154)] or on the HHSC website [online at hhs.texas.gov/ombudsman].

§306.155. Local Mental Health Authority, Local Behavioral Health Authority, and Continuity of Care Liaison Responsibilities.

LMHAs and LBHAs must develop policies and procedures that require:

(1) the LMHA or LBHA to employ at least one dedicated full-time staff member who is a QMHP-CS or LPHA to act as the CoC liaison to support continuity of care activities;

(2) a CoC liaison to delegate continuity of care responsibilities to other continuity of care staff, if necessary;

(3) a CoC liaison not to have assigned duties outside of activities supporting continuity of care and related functions;

(4) an alternate staff member to act as the CoC liaison in the absence of the person identified as the primary CoC liaison;

(5) communication and facilitation of services between the continuity of care team and parties involved in the individual's care; including:

(A) a mental health peer specialist or a recovery support peer specialist as described in 1 TAC §354.3159 (relating to Core and Supplemental Training); or

(B) a family partner;

(6) coordination with other state agencies responsible for the care of a child such as DFPS, the Texas Department of Criminal Justice, or the Texas Juvenile Justice Department;

(7) initiation of contact with the parties involved in the individual's care at a state hospital or CPB within three business days after admission;

(8) coordination of post-discharge activities with local community parties involved in the individual's care, including other LMHAs, LBHAs, and LIDDAs;

(9) a CoC liaison to conduct continuity of care activities, including responding to communications from a facility within three business days after the facility sent the communication;

(10) the LMHA or LBHA to provide notification of the CoC liaison's contact information, including if there is a CoC liaison personnel change, and the CoC liaison's designated alternate staff member's contact information within three business days to each facility that has an individual admitted in the LMHA's or LBHA's care;

(11) a QMHP-CS or LPHA acting as the CoC liaison to maintain the QMHP-CS' certification as a QMHP-CS or the LPHA's licensure as an LPHA;

(12) identification of a process for obtaining services and resources for an individual, as needed;

(13) LMHA or LBHA representation by an assigned CoC liaison in treatment team meetings at a state hospital or CPB as requested by the facility;

(14) the availability of a CoC liaison to communicate with providers from 8:00 a.m. to 5:00 p.m. on business days, coordinate coverage to respond to continuity of care service needs 24 hours a day, and follow up as necessary to ensure continuity of care needs are met;

(15) monitoring of the number of individuals who are currently admitted to state hospitals or CPBs and the number of individuals who are discharged from these facilities;

(16) a CoC liaison to conduct a uniform assessment, either in person or by audiovisual technology, to ensure a level of care determination is made within ten business days before discharge, and all LMHA, LBHA or LIDDA appointments scheduled in advance for needed programs and services, to ensure there is no disruption in services or support at the time of discharge and community integration;

(17) LMHA or LBHA staff to participate in all applicable court proceedings;

(18) LMHA or LBHA staff to participate in the development of an outpatient management plan for an individual who is on a Texas Code of Criminal Procedure Chapter 46C commitment and whom a state hospital identifies as suitable for outpatient placement; and

(19) a CoC liaison to initiate transition planning with the receiving LMHA or LBHA when the individual is changing LMHAs or LBHAs.

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

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DIVISION 2. SCREENING AND ASSESSMENT FOR CRISIS SERVICES AND ADMISSION INTO LOCAL MENTAL HEALTH AUTHORITY OR LOCAL BEHAVIORAL HEALTH AUTHORITY SERVICES--LOCAL MENTAL HEALTH AUTHORITY OR LOCAL BEHAVIORAL HEALTH AUTHORITY RESPONSIBILITIES

26 TAC §§306.161 - 306.163

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendments affect Texas Government Code §531.0055.

§306.161. Screening and Assessment.

(a) If an individual in an LMHA's or LBHA's local service area is in crisis, the [an] LMHA or LBHA must ensure: [ensures]

(1) immediate screening by a staff member trained in crisis screening, in accordance with §301.327(d)(1)(A)(ii) of this title (relating to Access to Mental Health Community Services); and[,]

(2) if emergency care services are recommended based on the screening, ensure the staff member complies with §301.327(d)(1)(B) [a face-to-face intake assessment of an individual in the LMHA's or LBHA's local service area in accordance with §301.327] of this title [(relating to Access to Mental Health Community Services)].

(b) When the crisis is resolved, the LMHA or LBHA must assess the individual using the uniform assessment and determine:

(1) referral for ongoing services at the LMHA or LBHA;

(2) referral to an alternate provider;

(3) referral to community-based crisis treatment alternative as described in §306.163 of this division (relating to Most Appropriate and Available Treatment Options);

(4) the individual's transportation by identifying and ensuring the individual's transportation needs were met; or

(5) no referral is needed.

(c) If an individual who is not in crisis presents for services, an LMHA or LBHA staff member [screens each individual presenting for services at the LMHA or LBHA as follows]:

(1) must determine whether the individual's county of residence is within the LMHA's or LBHA's local service area [an LMHA or LBHA staff who is a QMHP-CS or LPHA conducts a screening]; and

(2) who is a QMHP-CS or LPHA must conduct a screening [an LMHA or LBHA staff determines whether the individual's county of residence is within the LMHA's or LBHA's local service area].

(d) If the individual's county of residence is within the LMHA's or LBHA's local service area and the screenings described in subsections (b) [(a)] and (c) of this section indicates an intake assessment is needed, the LMHA or LBHA must conduct [conducts] an assessment in accordance with §301.353(a) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization).

(1) The LMHA or LBHA must [LMHAs and LBHAs] serve an individual [individuals] in the MH priority population designated by HHSC. For an individual in the MH priority population, the LMHA or LBHA must identify [identifies] which services the individual may be eligible to receive and, if applicable, must: [appropriate, determines whether the individual receives]

(A) provide services immediately; or [places]

(B) place the individual on a waiting list for services and refer [refers] the individual to other community resources.

(2) An individual who is [Individuals who are] enrolled in Medicaid must receive services immediately in accordance with §301.327 of this title (relating to Access to Mental Health Community Services) and pursuant to Medicaid regulations and policies [and may not be placed on a waiting list].

(3) An LMHA or LBHA must serve an individual in accordance with §301.327 of this title.

(4) For an individual not in the MH priority population, the LMHA or LBHA must provide the individual with written notification within three business days regarding:

(A) the denial of services and the opportunity to appeal in accordance with §306.154 of this subchapter (relating to Notification and Appeals Process for Local Mental Health Authority or Local Behavioral Health Authority Services); and

(B) how to contact the Ombudsman in a language the individual understands for [the availability of] information or [and] assistance [from the Ombudsman by contacting the Ombudsman] at 1-800-252-8154 or on the HHSC website [online at hhs.texas.gov/ombudsman].

§306.162. Determining County of Residence.

(a) County of Residence for Adults.

(1) An adult's county of residence is the county [which the adult or the adult's LAR indicates is the county] of the adult's permanent residence or, if applicable, the county of the LAR's permanent residence, unless there is a preponderance of evidence to the contrary. If the adult is not a Texas resident or indicates no permanent address, the adult's county of residence is the county in which the evidence indicates the adult resides.

(2) If an adult is unable to communicate the location of the adult's permanent residence, [and] there is no evidence indicating the location of an [the] adult's permanent residence, or if an adult is not a Texas resident, the adult's county of residence is the county in which the adult is physically present when the adult requests or requires services.

(3) The county in which the paying LMHA or LBHA is located is the adult's county of residence if the individual receives services:

(A) delivered in the local service area of another LMHA or LBHA for an adult's community mental health services; or

(B) for an adult's living arrangement located outside the paying LMHA's or LBHA's local service area.

[(3) If an LMHA or LBHA is paying for an adult's community mental health services delivered in the local service area of another LMHA or LBHA, or if an LMHA or LBHA is paying for an adult's living arrangement that is located outside the LMHA's or LBHA's local service area, the county in which the paying LMHA or LBHA is located is the adult's county of residence.]

(b) County of Residence for Minors.

(1) Except as provided in paragraph (2) of this subsection, a minor's county of residence is the county in which the minor's LAR's permanent residence is located.

(2) A minor's county of residence is the county in which the minor currently resides if:

(A) it cannot be determined in which county the minor's LAR's permanent residence is located;

(B) a state agency is the minor's LAR;

(C) the minor does not have an LAR; or

(D) the minor is at least 16 years of age and self-enrolling into services.

(3) A minor in DFPS conservatorship may continue receiving services from the LMHA or LBHA where the minor was last enrolled in services until another appropriate placement is established. Once placement is established, a transfer meeting will be held from the transferring LMHA or LBHA to the receiving LMHA or LBHA and the minor's LAR.

(c) Disagreements [Dispute] regarding county of residence initiated by an LMHA or LBHA.

(1) The LMHA or LBHA must initiate or continue providing clinically necessary services, including discharge planning, until a disagreement regarding county of residence is resolved [during the dispute resolution process].

(2) If an LMHA or LBHA initiates a disagreement regarding county of residence [dispute] that the executive directors of the affected LMHAs or LBHAs cannot resolve, the HHSC performance contract manager [manager(s)] of the affected LMHAs or LBHAs resolves the disagreement [dispute].

(d) Disagreements [Disputes] regarding county of residence initiated by an individual or another person or entity on behalf of the [an] individual. The Ombudsman may consult with the HHSC performance contract manager [manager(s)] of the affected LMHAs or LB-

HAs and help resolve a disagreement [dispute] initiated by an individual or by another person or entity [or] on behalf of the [an] individual.

(e) Changing county of residence status. If an individual currently receiving LMHA or LBHA services moves the individual's permanent residence to a county within the local service area of another LMHA or LBHA, [Changing an individual's county of residence requires agreement between] the LMHAs or LBHAs affected by the change must comply with [, except as provided in] §306.195 of this subchapter (relating to Changing Local Mental Health Authorities or Local Behavioral Health Authorities).

§306.163. Most Appropriate and Available Treatment Options.

(a) Recommendation for treatment. The designated LMHA or LBHA is responsible for recommending the most appropriate and available treatment alternative for an individual in need of mental health or SUD services.

(b) Inpatient services.

(1) Before an LMHA or LBHA refers an individual for inpatient services, the LMHA or LBHA must screen and assess the individual to determine if the individual requires inpatient services.

(2) If the screening and assessment indicates the individual requires inpatient services and inpatient services are the least restrictive and most appropriate setting available, the LMHA or LBHA must refer [refers] the individual:

(A) to a state hospital or [an SMHF or facility with a] CPB, if the LMHA or LBHA determines that the individual meets the criteria for admission; or

(B) to an LMHA or LBHA network provider of inpatient services.

(3) If the individual is identified in the applicable HHSC automation system as having an ID or a DD, the LMHA or LBHA must inform [informs] the designated LIDDA that the individual has been referred for inpatient services.

(4) If the LMHA, LBHA, or LMHA or LBHA-network provider refers the individual for inpatient services, the LMHA or LBHA must communicate necessary information to the contracted inpatient provider before or at the time of admission, including the individual's:

(A) identifying information, including address;

(B) legal status, for example [(e.g.,] regarding guardianship, charges pending, or custody, as applicable;

(C) pertinent medical and medication information, including known disabilities;

(D) behavioral information, including information regarding COPSD;

(E) other pertinent treatment information;

(F) finances, third-party coverage, and other benefits, if known; and

(G) advance directive.

(5) If an LMHA or LBHA, other than the individual's designated LMHA or LBHA, refers the individual for inpatient services, the state hospital or [the SMHF or facility with a] CPB must notify [notifies] the individual's designated LMHA or LBHA of the referral for inpatient services by the end of the next business day.

(6) The designated LMHA or LBHA must assign a CoC liaison [assigns a continuity of care worker] to an individual admitted to a state hospital, [an SMHF, a facility with] a CPB, or an LMHA or LBHA inpatient services network provider.

(7) If the individual has an ID or a DD, the designated LIDDA must assign [assigns] a continuity of care worker to the individual.

(8) The LMHA or LBHA CoC liaison [continuity of care worker], and LIDDA continuity of care worker as applicable, are responsible for the facilitation of the individual's continuity of services.

(9) The LMHA or LBHA is responsible for continuity of care and must plan to the greatest extent possible for the successful transition of individuals who are determined by a state hospital or CPB to be clinically appropriate for discharge from these facilities to a community setting in accordance with Texas Health and Safety Code §534.0535.

(c) Community-based crisis treatment options.

(1) An LMHA or LBHA must ensure the provision of crisis services to an individual experiencing a crisis while the individual is in its local service area.

(2) An individual [Individuals] in need of a higher level of care, but not requiring inpatient services, has [have] the option, as available, for admission to other services such as a diversion center, crisis respite unit, crisis residential unit, extended observation unit, or crisis stabilization unit.

(d) LMHA or LBHA Services.

(1) If an LMHA or LBHA admits an individual to LMHA or LBHA services, the LMHA or LBHA must ensure [ensures] the provision of services in the least restrictive and most appropriate [in the most integrated] setting available.

(2) The LMHA or LBHA must assign [assigns], to an individual receiving services, a staff member who is responsible for coordinating the individual's services.

(e) Court Ordered Treatment. The LMHA or LBHA must provide services to an individual ordered by a court to participate in outpatient mental health services or competency restoration services, if available, when the court identifies the LMHA or LBHA as being responsible for those services.

(f) Referral to alternate provider.

(1) If an individual requests a referral to an alternate provider, and there [it] is not a court order [ordered] to receive services from the LMHA or LBHA, the LMHA or LBHA must make [makes] a referral to an alternate provider in accordance with the individual's request.

(2) If an individual has third-party coverage, but the coverage will not pay for needed services because the designated LMHA or LBHA does not have a provider in its network that is approved by the third-party coverage, the designated LMHA or LBHA must comply [acts in accordance] with 25 TAC §412.106(c)(2) (relating to Determination of Ability to Pay).

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

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DIVISION 3. ADMISSION TO A STATE MENTAL HEALTH FACILITY OR A FACILITY WITH A CONTRACTED PSYCHIATRIC BED--PROVIDER RESPONSIBILITIES

26 TAC §§306.171 - 306.178

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendments affect Texas Government Code §531.0055.

§306.171. General Admission Criteria for a State Hospital [Mental Health Facility] or a Facility with a Contracted Psychiatric Bed.

(a) With the exceptions of Waco Center for Youth, a maximum-security unit, and an adolescent forensic unit, a state hospital [an SMHF] or [facility with a] CPB may admit an individual[,] who has been assessed by an LMHA or LBHA and recommended for inpatient admission[,] only if the individual has a mental illness and[,] because [as a result] of the mental illness:

(1) presents a substantial risk of serious harm to self or others; or

(2) evidences a substantial risk of mental or physical deterioration.

(b) An individual's admission to a state hospital [an SMHF] or [facility with a] CPB may not occur if the individual:

(1) has a condition that requires medical [specialized] care that is not available at the state hospital or [the SMHF or facility with a] CPB; or

(2) has a physical medical condition that is unstable and could reasonably require inpatient medical treatment for the condition.

(c) If an individual arrives at a state hospital [an SMHF] or [facility with a] CPB for mental health services, and the designated LMHA or LBHA did not screen or refer the individual [was not screened or referred by an LMHA or LBHA] as described in §306.163 of this subchapter (relating to Most Appropriate and Available Treatment Options):

(1) the state hospital [SMHF] or [facility with a] CPB must notify [notifies] the designated LMHA or LBHA that the individual has presented for services at the state hospital [the SMHF] or [facility with a] CPB within three business days of the individual's presentation for services; and

(2) the state hospital [SMHF] or [facility with a] CPB physician must determine [determines] if the individual has an emergency medical condition and decide [the physician decides] whether the facility has the capability to treat the emergency medical condition.

(A) If the state hospital [SMHF] or [facility with a] CPB has the capability to treat the emergency medical condition, the facility must admit [admits] the individual in accordance with [as required by] the Emergency Medical Treatment and Active Labor Act (EMTALA) as described in 42 U.S.C. §1395dd [(42 USC §1395dd]).

(B) If the state hospital [SMHF] or [facility with a] CPB does not have the capability to treat the emergency medical condition[in accordance with EMTALA], the facility must provide [provides] evaluation and treatment within its capability to stabilize the individual and arrange [arranges] for the individual to be transferred to a hospital that has the capability to treat the emergency medical condition in accordance with EMTALA and, as applicable, Medicare and Medicaid regulations.

(d) If an LMHA or LBHA authorized an individual's admission to a state hospital [an SMHF] or [a facility with a] CPB, and the facility determines that the individual does not meet inpatient criteria for admission, the facility must contact [contacts] the designated LMHA or LBHA to coordinate alternate outpatient community services at the time of the admission denial.

(e) The designated LMHA or LBHA must contact the individual, or the individual's LAR if applicable, within 24 hours after being notified that the individual does not meet inpatient admission criteria and notify the individual, or the individual's LAR if applicable, that the LMHA or LBHA will provide referrals and referral follow-up for ongoing services as clinically indicated to address the individual's mental health or other needs.

§306.172. Admission Criteria for Maximum-Security Units.

An individual's admission to a maximum-security unit may occur [occurs] only if the individual is:

(1) committed pursuant to Texas Code of Criminal Procedure Chapter 46B or Chapter 46C [of the Texas Code of Criminal Procedure] and determined to require admission to a maximum-security unit; or

(2) determined manifestly dangerous in accordance with 25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness) [HHSC state hospital policies].

§306.173. Admission Criteria for an Adolescent Forensic Unit.

(a) An adolescent forensic unit may admit [admits] an adolescent only if the adolescent meets the criteria described in paragraphs (1), (2), or (3) [a paragraph] of this subsection.

(1) Condition of probation or parole. The adolescent's admission to an adolescent forensic unit fulfills a condition of probation or parole for a juvenile offense if the adolescent:

(A) based on a clinical evaluation, is determined to [be in] need [of specialized] mental health treatment in a secure treatment

setting to address a risk of dangerousness [violent behavior] or delinquent conduct;

(B) has COPSD [co-occurring psychiatric and substance use disorders]; or

(C) has exhausted available community resources for treatment and has a letter written [been recommended for admission] by the local CRCG that confirms available community resources have been exhausted.

(2) Commitment under Texas Family Code [,]Chapter 55. The adolescent has been committed to a mental health facility under the Texas Family Code[,] Chapter 55, Subchapter C or D.

(3) Determined manifestly dangerous. The adolescent has been determined manifestly dangerous in accordance with 25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness) [HHSC state hospital policies].

(b) An adolescent may not be admitted to an adolescent forensic unit if [a physician determines] the adolescent has an ID.

§306.174. Admission Criteria for Waco Center for Youth.

(a) An individual's admission to Waco Center for Youth may occur [occurs] only if the individual:

(1) is an adolescent, [or an adolescent] whose age at admission allows adequate time for treatment programming before reaching 18 years of age;

(2) has an SED based on the version of the DSM currently recognized by HHSC [is diagnosed as emotionally disturbed];

(3) has a history of behavior adjustment concerns [problems];

(4) needs a structured treatment program in a residential facility; and

(5) is currently receiving LMHA or LBHA services or inpatient services at a state hospital [an SMHF] or [a facility with a] CPB and has been referred for admission to Waco Center for Youth by:

(A) the LMHA, [or] LBHA, or CRCG who confirms [after presentation and endorsement by the local CRCG] that:

(i) all appropriate community-based resources have been exhausted; and

(ii) Waco Center for Youth is the least restrictive and most appropriate environment needed[, the LMHA presents the CRCG letter of recommendation with the referral]; or

[(B) the LMHA or LBHA, following a documented LMHA or LBHA assessment that local resources have been explored and exhausted (if the full CRCG cannot convene in a timely manner); or]

(B) [(C)] a state hospital; or [an SMHF.]

(C) DFPS, as an adolescent under the agency's managing conservatorship in accordance with Texas Health and Safety Code §554.0001.

(b) Waco Center for Youth must [may] not admit:

(1) an individual who is younger than 13 years of age or an adolescent whose age at admission does not allow adequate time for treatment programming based on individual case review before reaching 18 [a child under 10] years of age;

(2) an adolescent who [that] has been found to have engaged in delinquent conduct or conduct indicating a need for supervision under the Texas Family Code, Title 3;

(3) an adolescent who [that] is acutely psychotic, suicidal, homicidal, or seriously violent; or

(4) an adolescent who [that] is determined [by a physician] to have an ID.

(c) If [the] Waco Center for Youth denies admission for services, Waco Center for Youth must provide [provides] the adolescent's LAR and LMHA or LBHA written notification within three business days stating:

(1) the reason for the denial of services; and

(2) that the LAR may appeal the denial by contacting the LMHA or LBHA.

(d) If an adolescent receiving services at Waco Center for Youth requires admission to a psychiatric hospital or another setting or program, the discharge planning process from the psychiatric hospital or another setting or program must include the written clinical appropriateness of readmission to Waco Center for Youth as jointly determined by [includes the joint determination of] the psychiatric hospital or another setting or program and Waco Center for Youth [of the clinical appropriateness of readmission to Waco Center for Youth].

(e) With the agreement of the adolescent's treatment team, the Waco Center for Youth leadership, psychiatric hospital leadership, and the adolescent's LAR, Waco Center for Youth must prioritize the adolescent [is prioritized] for readmission [to Waco Center for Youth].

(f) If a denial occurs under subsection (c) of this section and the adolescent is not currently receiving services from the appropriate LMHA or LBHA, the LMHA or LBHA must assess the adolescent for eligible services and continuity of care based on the adolescent's clinical needs.

§306.175. Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [Authorized by an LMHA or LBHA or for a State Mental Health Facility].

(a) Request for voluntary admission.

(1) In accordance with Texas Health and Safety Code §572.001, a request for voluntary admission of an individual with a mental illness may only be made by:

(A) the individual, if the individual is at least 16 years of age or older;

(B) an [the] LAR who meets the criteria described in paragraph (4)(A)(i) or (iii) of this subsection, if[:] the individual is younger than 18 years of age; or

[(i) the individual is younger than 18 years of age; and]

[(ii) the LAR is described by §306.153(36)(A)(i) or (iii) of this subchapter (relating to Definitions); or]

(C) an LAR who meets the criteria described in paragraph (4)(A)(ii) of this subsection, if the [the LAR, if the LAR is described by §306.153(36)(A)(ii), and] admission is sought pursuant to the provisions of Texas Health and Safety Code §572.001(c-1) - (c-4).

(2) In accordance with Texas Health and Safety Code §572.001(b) and (e), a request for admission must:

(A) be in writing and signed by the LAR or individual making the request; and

(B) include a statement that the LAR or individual making the request:

(i) agrees that the individual will remain [remains] in the state hospital [SMHF] or [facility with a] CPB until the individual's discharge; and

(ii) consents to diagnosis, observation, care, and treatment of the individual until:

(I) the discharge of the individual; or

(II) the individual is entitled to leave the state hospital [SMHF] or [facility with a] CPB, in accordance with Texas Health and Safety Code §572.004, after a request for discharge is made.

(3) The consent given under paragraph (2)(B)(ii) of this subsection does not waive an individual's rights described in:

(A) 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services);

(B) 25 TAC Chapter 405, Subchapter E (relating to Electroconvulsive Therapy (ECT));

(C) 25 TAC Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication--Mental Health Services); and

(D) 25 TAC Chapter 415, Subchapter F (relating to Interventions in Mental Health Services).

(4) An LAR is a person authorized by state law to act on behalf of an individual for the purposes of:

(A) admission, transfer, or discharge that includes:

(i) a parent, non-DFPS managing conservator, or guardian;

(ii) a representative of DFPS for a minor under DFPS conservatorship pursuant to Texas Health and Safety Code §572.001 (c-2) - (c-4); or

(iii) a person authorized by a district court under Texas Family Code Chapter 35A to consent for the temporary admission of a minor; or

(B) consent on behalf of an individual regarding a matter described in this subchapter other than admission, transfer, or discharge that includes:

(i) persons described in subparagraph (A) of this paragraph;

(ii) a person eligible to consent to treatment for a minor under Texas Family Code §32.001(a); and

(iii) an agent acting under a Medical Power of Attorney under Texas Health and Safety Code Chapter 166 or a Declaration for Mental Health Treatment under Texas Civil Practice and Remedies Code Chapter 137.

(b) Failure to meet admission criteria. If a [the] physician of a state hospital [an SMHF] or [facility with a] CPB determines that an individual does not meet admission criteria and that community resources may appropriately serve the individual, the facility must contact [contacts] the LMHA, [or] LBHA, or LIDDA to discuss the availability and appropriateness of community-based services for the individual [to receive]. The LMHA, [or] LBHA, or LIDDA must:

(1) contact the individual, [the individual's family or any other person providing support as authorized by the individual,] and the individual's LAR[,] if applicable [any], no later than 24 hours after the LMHA, [or] LBHA, or LIDDA is notified of the failure to meet the admission criteria; and[.]

(2) provide referrals and referral follow-up for ongoing services as clinically indicated to address the individual's mental health needs and SUD needs.

(c) Examination.

(1) A physician must conduct an examination on each individual requesting voluntary admission in accordance with this subsection.

(2) In accordance with Texas Health and Safety Code §572.0025(f)(1)(A), a physician must conduct [conducts] a physical and psychiatric examination, either in person or through [the use of] audiovisual or other telecommunications technology within 72 hours before voluntary admission or 24 hours after voluntary admission, that includes [for the following]:

(A) an assessment for medical stability; [and]

(B) a psychiatric examination; [,] and [,]

(C) if indicated, an assessment for a SUD [a substance use assessment].

(3) In accordance with Texas Health and Safety Code §572.0025(f)(1); the physician may not delegate the examination to a non-physician.

(d) Meets admission criteria. If, after examination, a [the] physician determines that an [the] individual meets the admission criteria of a state hospital [the SMHF] or [facility with a] CPB, the state hospital [SMHF] or [facility with a] CPB must admit [admits] the individual.

(e) To meet the needs of an individual who does not meet admission criteria to a state hospital or CPB, an LMHA or LBHA, as applicable, must:

(1) provide community mental health services and supportive services to the individual; or

(2) refer the individual, or the individual's LAR if applicable, to community mental health services and supportive services.

[(e) Does not meet admission criteria. If, after the examination, the physician determines that the individual does not meet the admission criteria of the SMHF or facility with a CPB, the SMHF or the facility with a CPB contacts the designated LMHA or LBHA to coordinate alternate outpatient community services as clinically indicated].

(f) Capacity to consent.

(1) If a physician determines that an individual whose consent is necessary for a voluntary admission does not have the capacity to consent to diagnosis, observation, care, and treatment, the state hospital [SMHF] or [the facility with a] CPB may not voluntarily admit the individual.

(2) When appropriate, the state hospital [the SMHF] or [the facility with a] CPB may initiate [initiates] an emergency detention proceeding in accordance with Texas Health and Safety Code[,] Chapter 573[,] or file [files] an application for court-ordered inpatient mental health services in accordance with Texas Health and Safety Code Chapter 574.

(g) Intake assessment. Before voluntary admission of an individual, in [In] accordance with Texas Health and Safety Code §572.0025(b), an assessment professional for a state hospital [an SMHF] or [facility with a] CPB, must conduct [before voluntary

~~admission of an individual, conducts~~] an intake assessment with the individual, and the individual's LAR if applicable, to [~~for~~]:

(1) obtain [~~obtaining~~] relevant information about the individual, including:

(A) psychiatric and medical history;

(B) social history;

(C) symptomology;

(D) support systems;

(E) finances;

(F) third-party coverage or insurance benefits; and

(G) advance directives;

(2) explain [~~explaining~~], orally and in writing, the individual's rights described in 25 TAC Chapter 404, Subchapter E;

(3) explain [~~explaining~~], orally and in writing, the state hospital's [~~SMHF's~~] or [~~facility with~~ a] CPB's services and treatment as the services and treatment [~~they~~] relate to the individual;

(4) explain [~~explaining~~], orally and in writing, the existence, purpose, telephone number, and address of the protection and advocacy system established in Texas, pursuant to Texas Health and Safety Code §576.008; and

(5) explain [~~explaining~~], orally and in writing, the individual trust fund account, charges for services, and the financial responsibility form.

(h) Requirements for voluntary admission. [~~An SMHF or facility with a CPB may voluntarily admit an individual only if:~~]

(1) An individual, or the individual's LAR if applicable, must make a request for admission [~~is made~~] in accordance with subsection (a) of this section;

(2) a physician must [~~has~~]:

(A) in accordance with Texas Health and Safety Code §572.0025(f)(1):

(i) conduct [~~conducted~~] an examination in accordance with subsection (c) of this section within 72 hours before the admission or 24 hours after the admission; or

(ii) consult [~~has consulted~~] with a physician who has conducted an examination in accordance with subsection (c) of this section within 72 hours before the admission or 24 hours after the admission;

(B) determine [~~determined~~] that the individual meets the admission criteria of the state hospital [~~SMHF~~] or [~~facility with a~~] CPB and that admission is clinically justified; and

(C) issue [~~issued~~] an order admitting the individual; [~~and~~]

(3) in accordance with Texas Health and Safety Code §572.0025(f)(2), the administrator or designee of the state hospital [~~SMHF~~] or [~~facility with a~~] CPB must sign [~~has signed~~] a written statement agreeing to admit the individual; and[~~.~~]

(4) in accordance with Texas Health and Safety Code §572.0026, the state hospital or CPB must have available space for the individual.

(i) Documentation of admission order. In accordance with Texas Health and Safety Code §572.0025(f)(1), the order described in subsection (h)(2)(C) of this section is issued:

(1) in writing and signed by the issuing physician; or

(2) orally or electronically if, within 24 hours after its issuance, the state hospital [~~SMHF~~] or [~~facility with~~ a] CPB has a written order signed by the issuing physician.

(j) Periodic evaluation. To determine the need for continued inpatient treatment, a physician or physician's designee must evaluate and document justification for continued stay for an individual voluntarily receiving acute inpatient treatment as often as clinically indicated, but no less than once a week.

§306.176. Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [~~Authorized by an LMHA or LBHA or for a State Mental Health Facility~~] for Emergency Detention.

(a) Acceptance for preliminary examination. In accordance with Texas Health and Safety Code §573.021 and §573.022, a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB must accept [~~accepts~~] for a preliminary examination:

(1) an individual, of any age, who has been apprehended and transported to the state hospital [~~SMHF~~] or [~~facility with a~~] CPB by a peace officer or emergency medical services personnel in accordance with Texas Health and Safety Code §573.001 or §573.012; or

(2) an adult who has been transported to the state hospital [~~the SMHF~~] or [~~facility with a~~] CPB by the adult's guardian in accordance with Texas Health and Safety Code §573.003.

(b) Preliminary examination.

(1) A physician must conduct [~~conducts~~] a preliminary examination of an individual as soon as possible but not more than 12 hours after the individual is transported to the state hospital [~~SMHF~~] or [~~facility with a~~] CPB for emergency detention.

(2) The preliminary examination must consist [~~consists~~] of:

(A) an assessment for medical stability; and

(B) a psychiatric examination, including a substance use assessment if indicated, to determine if the individual meets the criteria described in subsection (c)(1) of this section.

(c) Requirements for emergency detention. The state hospital [~~The SMHF~~] or [~~facility with a~~] CPB may admit [~~admits~~] an individual for emergency detention if:

(1) in accordance with Texas Health and Safety Code §573.022(a)(2), a physician determines from the preliminary examination that:

(A) the individual has a mental illness;

(B) the individual evidences a substantial risk of serious harm to himself or others;

(C) the described risk of harm is imminent unless the individual is immediately detained; and

(D) emergency detention is the least restrictive means by which the necessary detention may be accomplished;

(2) in accordance with Texas Health and Safety Code §573.022(a)(3), a physician must make [~~makes~~] a written statement documenting the determination described in paragraph (1) of this subsection and describing:

(A) the nature of the individual's mental illness;

(B) the risk of harm the individual evidences, demonstrated either by the individual's behavior or by evidence of severe emotional distress and deterioration in the individual's mental condition to the extent that the individual cannot remain at liberty; and

(C) the detailed information on which the physician based the determination;

(3) the physician issues and signs a written order admitting the individual for emergency detention; and

(4) the individual meets the admission criteria of the state hospital [SMHF] or [facility with a] CPB.

(d) Release.

(1) The state hospital [SMHF] or [facility with a] CPB must release [releases] the individual accepted for a preliminary examination if:

(A) a preliminary examination of the individual has not been conducted within 12 hours after the individual is apprehended and transported to the facility by the peace officer or transported for emergency detention; or

(B) in accordance with Texas Health and Safety Code §573.023(a), the individual is not admitted for emergency detention on completion of the preliminary examination.

(2) If the state hospital [SMHF] or [facility with a] CPB does not admit the individual on an emergency detention in accordance with Texas Health and Safety Code Chapter 573, the facility must contact [contacts] the designated LMHA or LBHA to provide referrals and referral follow-up for ongoing services as clinically indicated to address the individual's mental health needs. [coordinate alternate outpatient community services. The designated LMHA or LBHA must contact the individual within 24 hours of being notified that the individual does not meet inpatient admission criteria to coordinate alternate outpatient community services.]

(A) The LMHA or LBHA in the individual's county of residence must contact the individual within 24 hours of being notified that the individual does not meet emergency detention criteria.

(B) The LMHA or LBHA must provide referrals and referral follow-up for ongoing services as clinically indicated to address the individual's mental health needs, as applicable, when the individual does not meet admission criteria to a state hospital or CPB.

(3) In accordance with Texas Health and Safety Code §576.007(a), if an individual who is an adult is not admitted on emergency detention, the state hospital [SMHF] or [facility with a] CPB must make [makes] a reasonable effort to notify the individual's family, or any other person providing support as authorized by the individual, and the individual's LAR [,] if applicable[any], before the individual [he or she] is released.

(e) Intake assessment. An assessment professional for a state hospital [an SMHF] or [facility with a] CPB must conduct [conducts] an intake assessment as soon as possible, but not later than 24 hours after an individual is admitted for emergency detention. All documents related to the intake assessment must be provided to the individual, or the individual's LAR if applicable, and include[The intake assessment includes]:

(1) a request for [obtaining] relevant information about the individual, such as[including]:

(A) psychiatric and medical history;

(B) social history;

(C) symptomology;

(D) support systems;

(E) finances;

(F) third-party coverage or insurance benefits; and

(G) advance directives;

(2) a written and oral explanation of [explaining, orally and in writing,] the individual's rights described in 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services);

(3) a written and oral explanation of [explaining, orally and in writing,] the state hospital's [SMHF's] or [facility with a] CPB's services and treatment as the services and treatment [they] relate to the individual;

(4) a written and oral explanation of [explaining, orally and in writing,] the existence, purpose, telephone number, and address of the protection and advocacy system established in Texas, pursuant to Texas Health and Safety Code §576.008; and

(5) a written and oral explanation of the individual's [explaining, orally and in writing, the individual] trust fund account, charges for services, and the financial responsibility form.

§306.177. Admission Criteria Under Order of Protective Custody or Court-ordered Inpatient Mental Health Services.

(a) A state hospital [An SMHF] or [facility with a] CPB may admit [admits] an individual after receiving:

(1) an order of [under a] protective custody [order] only if a court has issued a protective custody order in accordance with Texas Health and Safety Code §574.022 and the facility has received it; or

(2) for court-ordered inpatient mental health services only if a court has issued:

(A) an order for temporary inpatient mental health services issued in accordance with Texas Health and Safety Code §574.034, or Texas Family Code Chapter 55;

(B) an order for extended inpatient mental health services issued in accordance with Texas Health and Safety Code §574.035, or Texas Family Code Chapter 55;

(C) an order for commitment issued in accordance with the Texas Code of Criminal Procedure [,] Chapter 46B; or

(D) an order for commitment issued in accordance with the Texas Code of Criminal Procedure [,] Chapter 46C.

(b) If a state hospital [an SMHF] or [facility with a] CPB admits an individual in accordance with subsection (a) of this section, a physician, PA, or APRN must issue and sign [issues and signs] a written order admitting the individual. [Admission of an individual in accordance with subsection (a) of this section is not a medical act and does not require the use of independent medical judgment or treatment by the physician, PA, or APRN issuing and signing the written order.]

(c) A state hospital [An SMHF] or [a facility with a] CPB must conduct [conducts] an intake assessment with the individual, and the individual's LAR if applicable, as soon as possible, but not later than 24 hours after the individual is admitted under a protective custody order or court-ordered inpatient mental health services that [. The intake assessment] includes:

(1) a request for [obtaining] relevant information about the individual, including:

(A) psychiatric and medical history;

(B) social history;

(C) symptomology;

(D) support systems;

(E) finances;

(F) third-party coverage or insurance benefits; and

(G) advance directives; [and]

(2) a written and oral explanation of [explaining, orally and in writing,] the individual's rights described in 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services);

(3) a written and oral explanation of [explaining, orally and in writing,] the state hospital's [SMHF's] or [facility with a] CPB's services and treatment as the services and treatment [they] relate to the individual; and

(4) a written and oral explanation of [explaining, orally and in writing,] the existence, purpose, telephone number, and address of the protection and advocacy system established in Texas, pursuant to Texas Health and Safety Code §576.008.

§306.178. Voluntary Treatment Following Involuntary Admission.

A state hospital [An SMHF] or [a facility with a] CPB must continue [continues] to provide inpatient services to an individual involuntarily receiving treatment after the individual is eligible for discharge as described in §306.204 of this subchapter (relating to Discharge of an Individual Involuntarily Receiving Treatment), if, after consultation with the designated LMHA or LBHA:

(1) the state hospital [SMHF] or [facility with a] CPB obtains written consent for voluntary inpatient services that meets the requirements of a request for voluntary admission, as described in §306.175(a) of this subchapter (relating to Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [Authorized by an LMHA or LBHA or for a State Mental Health Facility]); and

(2) the individual's treating physician:

(A) examines the individual; and

(B) based on the examination in subparagraph (A) of this paragraph, issues an order for voluntary inpatient services that meets the requirements of §306.175(i) of this subchapter.

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

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Karen Ray
Chief Counsel
Health and Human Services Commission
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DIVISION 4. TRANSFERS AND CHANGING LOCAL MENTAL HEALTH AUTHORITIES OR LOCAL BEHAVIORAL HEALTH AUTHORITIES

26 TAC §§306.191 - 306.195

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendments affect Texas Government Code §531.0055.

§306.191. Transfers Between State Hospitals[State Mental Health Facilities.]

(a) The individual, the individual's LAR if applicable, any other person authorized by the individual, state hospital [SMHF] staff, or the designated LMHA or LBHA, [or another interested person] may initiate a request to transfer an individual from one state hospital [SMHF] to another state hospital [SMHF].

(b) A transfer between state hospitals [SMHFs] may occur when deemed advisable by the administrator of the transferring state hospital [SMHF] with the agreement of the administrator of the receiving state hospital [SMHF] based on:

(1) the condition and desires of the individual;

(2) geographic residence of the individual;

(3) program and bed availability; and

(4) geographical proximity to the individual's family and any other person authorized by the individual, and the individual's LAR[,] if applicable [any].

(c) An individual voluntarily receiving treatment may not be transferred without the consent of the individual, or the individual's LAR if applicable, who made the request for voluntary admission in accordance with §306.175(a)(1) of this subchapter (relating to Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed[Authorized by an LMHA or LBHA or for a State Mental Health Facility)].

(d) In accordance with Texas Health and Safety Code §575.011 and §575.017, if a state hospital [If an SMHF] transfers an individual receiving court-ordered inpatient mental health services from one state hospital [SMHF] to another state hospital [SMHF], the transferring state hospital must notify [SMHF notifies] the committing court and the designated LMHA, LBHA, or LIDDA of the transfer.

(e) If a prosecuting attorney has notified the state hospital [SMHF] administrator that an individual has criminal charges pending, the administrator must notify [notifies] the judge of the court before which charges are pending if the individual transfers to another state hospital [SMHF].

(f) For [25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness) or HHSC state hospital policies govern transfer of] an individual transferring between a state hospital [an SMHF] and a maximum-security unit or adolescent forensic unit, 25 TAC Chapter 415, Subchapter G (relating to Determination of Manifest Dangerousness) governs the transfer.

§306.192. Transfers Between a State Hospital [Mental Health Facility] and a State Supported Living Center.

(a) For an individual transferring from a state hospital [mental health facility (SMHF)] to an SSLC [a state supported living center (SSLC)]:

(1) the state hospital and designated LIDDA must comply with [following rules and statutes govern the transfer]:

(A) Chapter 904, Subchapter C, of this title [40 TAC Chapter 2, Subchapter F, Division 3](relating to Transfers); and

(B) Texas Health and Safety Code §575.013 and §575.017; and

(2) the state hospital [SMHF] must not transfer the individual before the judge of the committing court enters an order approving the transfer.

(b) For an individual transferring from an SSLC to a state hospital [an SMHF]:

(1) the following rules and statutes govern the transfer:

(A) Section 902.1 of this title (relating to Transfer of an Individual from a State Supported Living Center to a State Hospital); [and]

(B) Texas Health and Safety Code §594.034; and

(C) Texas Health and Safety Code §575.012 [govern the transfer]; and

(2) the receiving state hospital and the initiating SSLC must notify [SMHF notifies] the designated LMHA, LBHA, [local mental health authority or local behavioral health authority] or LIDDA [the designated local intellectual and developmental disability authority] of the transfer.

§306.193. Transfers Between a State Hospital [Mental Health Facility] and an Out-of-State Facility [Institution].

A transfer between a state hospital [an SMHF] and an out-of-state facility is governed by Chapter 903 of this title [1 TAC Chapter 383] (relating to Interstate Compact on Mental Health and Intellectual and Developmental Disabilities [Mental Retardation]).

§306.194. Transfers Between a State Hospital [Mental Health Facility] and Another Facility in Texas.

(a) In accordance with Texas Health and Safety Code §575.011, §575.014, and §575.017 [govern transfer of] an individual may transfer between a state hospital [an SMHF] and a psychiatric hospital not operated by HHSC. The state hospital must notify the designated LMHA or LBHA of the transfer. A state hospital [An SMHF] must not transfer an individual voluntarily receiving treatment without the consent of the individual, or the individual's LAR if applicable, who made the request for voluntary admission in accordance with §306.175(a)(1) of this subchapter (relating to Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [Authorized by an LMHA or LBHA or for a State Mental Health Facility]).

(b) In accordance with Texas Health and Safety Code §575.015, [and §575.017 govern transfer of] an individual may transfer from a state hospital [an SMHF] to a federal agency [correctional facility]. The transferring state hospital must notify [SMHF notifies] the designated LMHA or LBHA of the transfer.

(c) In accordance with Texas Health and Safety Code §575.016 and §575.017, [govern transfer of] an individual may transfer from a facility of the institutional division of the Texas Department of Criminal Justice to a state hospital [an SMHF].

§306.195. Changing Local Mental Health Authorities or Local Behavioral Health Authorities.

(a) If [Requirements related to] an individual currently receiving LMHA or LBHA services [who] intends to move the individual's [his or her] permanent residence to a county within the local service area of another LMHA or LBHA and seek services from the new LMHA or LBHA the following requirements apply.

(1) The originating LMHA or LBHA must:

(A) ensure the CoC liaison submits requested information to the new LMHA or LBHA, including treatment information pertinent to the individual's continuity of care within seven days after the request, and coordinate an intake appointment at the receiving LMHA or LBHA [initiate transition planning with the receiving LMHA or LBHA];

(B) ensure the CoC liaison initiates transition planning with the receiving LMHA or LBHA in accordance with §306.155(19) of this subchapter (relating to Local Mental Health Authority, Local Behavioral Health Authority, and Continuity of Care Liaison Responsibilities);

(C) [(B)] educate the individual, or the individual's LAR if applicable, on the provisions of this subchapter regarding the individual's transfer, consisting of:

(i) information regarding walk-in intake services, if applicable, where no appointment is scheduled for the individual's initial intake to determine eligibility;

(ii) the rights of an individual [individual's rights as] eligible for services; [and]

(iii) notification for the receiving LMHA or LBHA [is notified] of the individual's intent to move the individual's permanent residence;

(iv) the point of contact at the receiving LMHA or LBHA;

(v) the 988 Suicide and Crisis Lifeline; and

(vi) the receiving LMHA's or LBHA's crisis hotline;

(D) [(C)] assist in facilitating and scheduling the intake appointment at the new LMHA or LBHA once the relocation has been confirmed;

[(D) submit to the receiving LMHA or LBHA treatment information pertinent to the individual's continuity of care with submission after the individual's transfer request;]

(E) ensure the individual has sufficient medication for up to 90 days or to last until the medication management appointment date at the receiving LMHA or LBHA; and

(F) maintain the individual's case in open status in the applicable HHSC automation system for 90 days or until notified that the individual has been admitted to services at the receiving LMHA or LBHA, whichever occurs first.[;]

[(G) conduct an intake assessment in accordance with §301.353(a) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) and determine whether the LMHA or LBHA has the capacity to serve the individual immediately or place the individual on a waiting list for services; and]

[(H) authorize an initial 180 days of services for an adult and 90 days for a child or an adolescent for transitioning and ongoing care, including the provision of medications, if the individual is eligible and not on the waiting list.]

(2) The receiving LMHA or LBHA must:

(A) initiate transition planning with the originating LMHA or LBHA;

(B) promptly request records pertinent to the individual's treatment, with the individual's consent, or the consent of the individual's LAR if applicable;

(C) conduct an intake assessment in accordance with §301.353(a) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) and determine whether the individual should receive services immediately or be placed on a waiting list for services;

(D) if the individual is eligible and is not on the waitlist, authorize an initial 180 days of services for an adult and 90 days for a child or an adolescent for transitioning and ongoing care, including the provision of medications;

(E) authorize the individual in the same level of care at the initial assessment in accordance with §301.327 of this title (relating to Access to Mental Health Community Services) and pursuant to Medicaid regulations and policies;

(F) provide the appropriate services based on the clinical needs of the individual;

(G) if there are resource limitations for the receiving LMHA or LBHA, follow the process outlined in §301.327 of this title; and

(H) initiate contact with individual within 14 days.

(3) [(2)] If the individual, or the individual's LAR if applicable, seeks services from the new LMHA or LBHA without prior knowledge of the originating LMHA or LBHA:

(A) the receiving LMHA or LBHA must:

(i) initiate transition planning with the originating LMHA or LBHA;

(ii) promptly request records pertinent to the individual's treatment, with the individual's consent, if applicable;

(iii) conduct an intake assessment in accordance with §301.353(a) of this title and determine whether the individual should receive services immediately or be placed on a waiting list for services; and

(iv) if the individual is eligible and [the individual] is not on the waitlist, authorize an initial 180 days of services for an adult and 90 days for a child or an adolescent for transitioning and ongoing care, including the provision of medications; and

(B) the originating LMHA or LBHA must:

(i) submit requested information to the new LMHA or LBHA within seven days after the request; and

(ii) maintain the individual's case in open status in the applicable HHSC automation system for 90 days or until notified that the individual has been admitted to services at the new LMHA or LBHA, whichever occurs first.

(4) [(3)] If the new LMHA or LBHA denies services to the individual during the transition period, or reduces or terminates services at the conclusion of the authorized period, the new LMHA or LBHA must notify the individual, or the individual's LAR if applicable, in writing within ten business days of the proposed action and the right to appeal the proposed action in accordance with §306.154 of this subchapter (relating to Notification and Appeals Process for Local Mental Health Authority or Local Behavioral Health Authority Services).

(b) Requirements related to an individual receiving inpatient services at a state hospital [an SMHF] or [facility with a] CPB. If an individual at a state hospital [an SMHF] or [facility with a] CPB, or the individual's LAR if applicable, informs the state hospital [SMHF] or [facility with a] CPB that the individual intends to move the individual's permanent residence to a county within the local service area of another LMHA or LBHA and seek services from the new LMHA or LBHA:

(1) the state hospital [SMHF] or [facility with a] CPB must notify [notifies] the following of the individual's intent to move the individual's permanent residence upon discharge:

(A) the originating LMHA or LBHA, if the individual was receiving LMHA or LBHA services from the originating LMHA or LBHA before admission to the state hospital [SMHF] or [facility with a] CPB; and

(B) the new LMHA or LBHA;

(2) the following must participate in the individual's discharge planning in accordance with §306.201 of this subchapter (relating to Discharge Planning):

(A) the state hospital [SMHF] or [facility with a] CPB;

(B) the new LMHA or LBHA; and

(C) the originating LMHA or LBHA, if the individual was receiving LMHA or LBHA services from the originating LMHA or LBHA before admission to the state hospital [SMHF] or [facility with a] CPB; and

(3) if the individual was receiving LMHA or LBHA services from the originating LMHA or LBHA before admission to the state hospital [SMHF] or [facility with a] CPB, the originating LMHA or LBHA must maintain [maintains] the individual's case in open status in the applicable HHSC automation system for 90 days or until notified that the individual is admitted to services at the new LMHA or LBHA, whichever occurs first.

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

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DIVISION 5. DISCHARGE AND ABSENCES FROM A STATE MENTAL HEALTH FACILITY OR FACILITY WITH A CONTRACTED PSYCHIATRIC BED

26 TAC §§306.201 - 306.205, 306.207

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of ser-

vices by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendments affect Texas Government Code §531.0055.

§306.201. Discharge Planning.

(a) At the time of an individual's admission to a state hospital [an SMHF] or [facility with a] CPB, the designated LMHA or LBHA, if applicable [any], and the state hospital [SMHF] or [facility with a] CPB must begin [begins] discharge planning for the individual. The state hospital or CPB must send an electronic admission initial notification within three business days to the appropriate LMHA, LBHA, and LIDDA to initiate discharge planning.

(b) The designated LMHA or LBHA CoC liaison [continuity of care worker] or other designated staff; the designated LIDDA continuity of care worker, if applicable; the individual; the individual's LAR[,] if applicable [any]; and any other person authorized by the individual, such as guardian ad litem or attorney ad litem, must participate in [coordinates] discharge planning with the state hospital [SMHF] or [facility with a] CPB. The state hospital or CPB must initiate coordination of discharge planning.

(1) Except for the state hospital [SMHF] or [facility with a] CPB treatment team and the individual, involvement in discharge planning may be through teleconference or video-conference calls.

(2) The state hospital [SMHF] or [the facility with a] CPB must invite the LMHA, LBHA, or LIDDA, as applicable, to routine recovery or treatment plan meetings as well as any additional meetings that arise specific to discharge planning. The state hospital or CPB must notify meeting participants [provide] a minimum of 24 hours [24-hour notification] before each scheduled meeting regarding recovery or treatment planning and any additional meetings specific to discharge [staffings and reviews to persons involved in discharge] planning.

(3) The state hospital [LMHA, LBHA, or LIDDA, if applicable, and the SMHF] or [facility with a] CPB must [involved in discharge planning must coordinate all discharge planning activities and] ensure the development and completion of the discharge plan as listed in subsection (c) of this section and coordinate with the LMHA, LBHA, or LIDDA, if applicable, before the individual's discharge.

(4) The LMHA or LBHA must facilitate the transition of individuals who are determined by the state hospital or CPB to be medically appropriate for discharge in accordance with Texas Health and Safety Code §534.0535 from a facility to a community setting by connecting the individuals to resources available in the individuals' county of residence or choice.

(c) Discharge planning must consist of the following activities:

(1) Considering all pertinent information about the individual's clinical needs, the state hospital [SMHF] or [facility with a] CPB must identify and recommend specific clinical services and supports needed by the individual after discharge or while on pass or furlough [ATP].

(2) The state hospital or CPB, and the LMHA, LBHA, or LIDDA, if applicable, must jointly identify, [and] recommend, and help coordinate access to services for the individual, and the individual's LAR if applicable, regarding specific non-clinical services and supports needed by the individual after discharge, including the individual's need for housing, supported employment, education resources, and[,] food assistance, [and] clothing resources, and other supplemental supports or governmental benefits as applicable.

(3) If an individual needs a living arrangement, the LMHA or LBHA CoC liaison, or LIDDA continuity of care worker must:

(A) identify a living arrangement [setting] consistent with the individual's clinical needs and preference that is available and has accessible services and supports as agreed upon by the individual, or the individual's LAR if applicable; or

(B) ensure the individual, or the individual's LAR if applicable, is referred to housing services and support the individual through the process of obtaining and applying for housing services during the discharge planning process if a living arrangement is unavailable.

(4) The LMHA or [,] LBHA CoC liaison, or LIDDA continuity of care worker in collaboration with the individual, and the individual's LAR if applicable, must identify potential providers and resources for the services and supports recommended and arrange for provision of services upon discharge in accordance with Texas Health and Safety Code §534.0535.

(5) The state hospital [SMHF] or [facility with a] CPB must attempt to educate [counsel] the individual, and the individual's LAR[,] if applicable [any], to prepare the individual [them] for care after discharge or while on pass or furlough [ATP].

(6) The state hospital [SMHF] or [facility with a] CPB must provide the individual, and the individual's LAR [,] if applicable [any], with written notification of the existence, purpose, telephone number, and address of the protection and advocacy system established in Texas, pursuant to Texas Health and Safety Code §576.008.

(7) The LMHA, [or] LBHA, or LIDDA must comply with the PASRR [Preadmission Screening and Resident Review] processes as described in Chapter 303 of this title (relating to Preadmission Screening and Resident Review (PASRR)) for an individual referred [recommended to move] to a nursing facility.

(d) Before an individual's discharge or approval for a pass or furlough:

(1) The individual's treatment team must ensure the development of [must develop] a [discharge] plan to include the individual's stated [wishes] goals. The [discharge] plan must consist of:

(A) a description of the individual's living arrangement after discharge, or while on pass or furlough [ATP], that reflects the individual's preferences, choices, and available community resources;

(B) arrangements and referrals for the available and accessible services and supports agreed upon by the individual, or the individual's LAR if applicable, recommended in the individual's discharge plan;

(C) a written description of recommended clinical and non-clinical services and supports the individual receives [may receive]

after discharge, or while on pass or furlough; [ATP. The SMHF or facility with a CPB documents]

(D) documentation of arrangements and referrals for the services and supports recommended upon discharge or while on pass or furlough [ATP in the discharge plan];

(E) [(D)] a description of behavioral health symptoms [problems] identified at discharge or before a pass or furlough [or ATP], including any symptoms [issues] that may disrupt the individual's stability in the community;

(F) [(E)] the individual's goals, strengths, interventions, and objectives as stated in the individual's discharge plan in the state hospital [SMHF] or [facility with a] CPB;

(G) [(F)] comments or additional information;

(H) [(G)] a final diagnosis based on the version of the DSM currently recognized by HHSC [current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association];

(I) [(H)] the names, contact information, and addresses of providers to whom the individual will be referred for any services or supports after discharge or while on pass or furlough[ATP]; and

(J) [(I)] [in accordance with Texas Health and Safety Code §574.081(c),] a description of:

(i) the types and amount of medication the individual needs after discharge or while on pass or furlough [ATP] until the individual is evaluated by a physician; or [and]

(ii) for 90 days after discharge, the person or entity responsible for providing and paying for the medication.

(2) The state hospital [SMHF]or [facility with a] CPB must request that the individual, or the individual's LAR if applicable[, as appropriate], sign the discharge plan, and document in the discharge plan whether the individual, or the individual's LAR if applicable, agree or disagree with the plan.

(3) If the individual, or the individual's LAR if applicable, refuses to sign the discharge plan described in paragraph (2) of this subsection, the state hospital [SMHF] or [facility with a] CPB must document [documents] in the individual's record whether [if] the individual, or the individual's LAR if applicable, agrees to the plan or not, reasons stated, and any other circumstances of the refusal.

(4) If applicable, the individual's treating physician must document in the individual's record reasons why the individual does not require continuing care or a discharge plan [in accordance with Texas Health and Safety Code §574.081(g)].

(5) If the LMHA or LBHA disagrees with the state hospital [SMHF] or [facility with a] CPB treatment team's decision concerning discharge:

(A) the treating physician of the state hospital [SMHF] or [facility with a] CPB must consult [consults] with the LMHA or LBHA physician or designee to resolve the disagreement within 24 hours; and

(B) [and] if the disagreement continues unresolved, the medical director or designee of the state hospital or CPB must refer the issue to the Texas State Hospitals Chief Medical Officer to render a final determination. [:]

[(i) the medical director or designee of the SMHF or facility with a CPB consults with the LMHA or LBHA medical director; and]

[(ii) if the disagreement continues unresolved after consulting with the LMHA or LBHA medical director:]

[(I) the medical director or designee of the SMHF or facility with a CPB refers the issue to the State Hospital System Chief Medical Officer; and]

[(II) the State Hospital System Chief Medical Officer collaborates with the Medical Director of the Behavioral Health Section to render a final decision within 24 hours of notification.]

(e) Discharge notice to family or the individual's LAR if applicable.

(1) In accordance with Texas Health and Safety Code §576.007, before discharging an [individual who is an] adult, the state hospital [SMHF] or [facility with a] CPB must make [makes] a reasonable effort to notify the individual's family or any identified [other] person providing support to the individual. Discharge notification requires authorization by the individual, or the individual's LAR if applicable [as authorized by the individual or LAR, if any, of the discharge if the adult grants permission for the notification].

(2) Before discharging an individual who is at least 16 years of age, but [or] younger than 18 years of age, who voluntarily consented for the individual's own admission, the state hospital [SMHF] or [facility with a] CPB must make [makes] a reasonable effort to notify the individual's [family as authorized by the individual or] LAR, if applicable [any], of the discharge within 72 hours before the date of discharge [if the individual grants permission for the notification].

(3) Before discharging a minor for whom a parent, managing conservator, or guardian provided consent for admission [an individual younger than 16 years of age], the state hospital [SMHF] or [facility with a] CPB must notify [notifies] the minor's [individual's] LAR of the discharge.

(f) Release of minors. Upon discharge, the state hospital [SMHF] or [facility with a] CPB may release a minor [younger than 16 years of age] only to the minor's LAR or the LAR's designee.

(1) If the LAR or the LAR's designee is unwilling to retrieve the minor from the state hospital [SMHF] or [facility with a] CPB and the LAR is not a state agency:

(A) the state hospital [SMHF] or [facility with a] CPB must:

(i) notify DFPS [notifies the Department of Family and Protective Services (DFPS)], so DFPS can take custody of the minor from the state hospital [SMHF] or [facility with a] CPB;

(ii) refer [refers] the matter to the LMHA or LBHA [local CRCG] to schedule a meeting with representatives from the required agencies described in subsection (f)(2)(A) of this section, the LAR, and minor to explore resources and make recommendations; [and]

(iii) document [documents] the LMHA or LBHA [CRCG] referral in the discharge plan; [and]

(iv) refer the matter to the local CRCG to schedule a meeting with representation from the required agencies described in subsection (f)(2)(A) of this section, the LAR, and the minor to explore resources and make recommendations; and

(v) document the CRCG referral in the discharge plan; and

(B) the medical directors or the medical directors' [their] designees of the state hospital [SMHF] or [facility with a]

CPB; designated LMHA, LBHA, or LIDDA; and DFPS must meet to develop and finalize [~~solidify~~] the discharge recommendations.

(2) If the LAR is a state agency unwilling to assume physical custody of the minor from the state hospital [~~SMHF~~] or [~~facility with a~~] CPB, the state hospital [~~SMHF~~] or [~~the facility with a~~] CPB must:

(A) refer [~~refers~~] the matter to the local CRCG office, or state CRCG office if applicable, to schedule a meeting with representatives from the member agencies, in accordance with 40 TAC, Part 19, Chapter 702, Subchapter E (relating to Memorandum of Understanding with Other State Agencies), the LAR, and minor to explore resources and make recommendations; and

(B) document [~~documents~~] the CRCG referral in the discharge plan.

(g) Notice to the designated LMHA, LBHA, or LIDDA. At least 24 hours before an individual's planned discharge, pass, or furlough[~~or ATP~~], and no later than 24 hours after an unexpected discharge, a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB must notify [~~notifies~~] the designated LMHA, LBHA, or LIDDA of the anticipated or unexpected discharge and convey [~~conveys~~] the following information about the individual:

(1) identifying information, including address and contact information of the individual, or the individual's LAR if applicable;

(2) legal status, for example [~~(e.g.~~], regarding guardianship, charges pending, or custody if the individual is a minor[~~)~~];

(3) the day and time the individual will be discharged or participating in a pass or furlough [~~on an ATP~~];

(4) the individual's destination address after discharge, or while on pass or furlough [~~ATP~~];

(5) [~~pertinent~~] medical information;

(6) current medications;

(7) clinical documentation [~~behavioral data~~], including information regarding a COPSD, an ID, or a DD; and

(8) other pertinent treatment information, including the discharge plan.

(h) Discharge packet.

(1) At a minimum, a discharge packet must include:

(A) the discharge plan;

(B) referral instructions, including:

(i) state hospital [~~SMHF~~] or [~~facility with a~~] CPB contact person;

(ii) name of the designated LMHA or[~~,~~] LBHA CoC liaison[~~,~~] or LIDDA continuity of care worker;

(iii) names of community resources and providers to whom the individual is referred, including contacts, appointment dates and times, addresses, and phone numbers;

(iv) a description of to whom or where the individual is released upon discharge, including the individual's intended residence, address, and phone number [~~(address and phone number)~~];

(v) instructions for the individual, or the individual's LAR if applicable[~~, and primary care giver as applicable~~];

(vi) medication regimen and prescriptions, as applicable; and

(vii) dated signature of the individual, or the individual's LAR if applicable, and a member of the state hospital [~~SMHF~~] or [~~facility with a~~] CPB treatment team;

(C) copies of all available, pertinent, current summaries, and assessments; and

(D) the treating physician's orders.

(2) At discharge, or while on pass or furlough [~~ATP~~], the state hospital [~~SMHF~~] or [~~facility with a~~] CPB provides a copy of the discharge packet or pass or furlough plan to the individual, and the individual's LAR if applicable. An individual [~~Individuals~~] may request additional records. [~~If the requested records are reasonably likely to endanger the individual's life or physical safety, these records can be withheld. Documentation of the determination to withhold records is required in the individual's medical record.~~]

(3) Within 24 hours after discharge [~~or ATP~~], or while on pass or furlough, the state hospital [~~SMHF~~] or [~~facility with a~~] CPB must send [~~sends~~] a copy of the discharge packet or pass or furlough plan to:

(A) the designated LMHA, LBHA, or LIDDA; and

(B) the providers to whom the individual is referred, including:

(i) an LMHA or LBHA network provider, if the LMHA or LBHA is responsible for ensuring the individual's services after discharge or while on pass or furlough [~~an ATP~~];

(ii) an alternate provider, if the individual requested referral to an alternate provider; and

(iii) a county jail, if the individual will be transported [~~taken~~] to the county jail upon discharge.

(i) Unexpected Discharge.

(1) The state hospital [~~SMHF~~] or [~~facility with a~~] CPB and the designated LMHA, LBHA, or LIDDA must make reasonable efforts to provide discharge planning for an individual discharged unexpectedly.

(2) If there is an unexpected discharge, the state hospital or CPB [~~facility~~] social worker or a designee [~~staff with an equivalent credential to a social worker~~] must document the reason for not completing discharge planning activities in the individual's record.

(j) Transportation. A state hospital [~~An SMHF~~] or [~~facility with a~~] CPB must:

(1) initiate and secure transportation in collaboration with an LMHA, an [~~or~~] LBHA, or a LIDDA pursuant to [~~a planned location after~~] an individual's discharge or pass or furlough plan; and

(2) inform a designated LMHA, LBHA, or LIDDA of an individual's transportation needs after discharge or while on pass or furlough[~~an ATP~~].

(k) Discharge summary.

(1) Within ten days after an individual's discharge, the individual's physician of the state hospital [~~SMHF~~] or [~~facility with a~~] CPB must complete [~~completes~~] a written discharge summary for the individual.

(2) Within 21 days after an individual's discharge from an [~~a~~] LMHA or LBHA, the LMHA or LBHA must complete a written discharge summary for the individual.

(3) The written [~~Written~~] discharge summary must include [~~includes~~]:

(A) a description of the individual's treatment and the individual's [their] response to that treatment;

(B) a description of the level of care for services received;

(C) a description of the individual's level of functioning at discharge;

(D) a description of the individual's living arrangement after discharge;

(E) a description of the community services and supports the individual will receive after discharge;

(F) a final diagnosis based on the version [current edition] of the DSM currently recognized by HHSC; and

(G) a description of the amount of medication available to the individual, if applicable.

(4) The discharge summary must be sent to the individual's:

(A) designated LMHA, LBHA, or LIDDA, as applicable; and

(B) providers to whom the individual was referred.

(5) Documentation of refusal. If the individual, or the individual's LAR if applicable, [or the individual's caregivers] refuse to participate in the discharge planning, the circumstances of the refusal must be documented in the individual's record.

(l) An LMHA or LBHA must provide continuity of care services designed to support joint discharge planning efforts in accordance with Texas Health and Safety Code §534.0535.

[(l) Care after discharge. An individual discharged from an SMHF or facility with a CPB is eligible for:]

[(1) community transitional services for 90 days if referred to an LMHA or LBHA; or]

[(2) ongoing services.]

§306.202. Special Considerations for Discharge Planning.

(a) Three Admissions Within 180 Days. An individual admitted to a state hospital [an SMHF] or [a facility with a] CPB three times within 180 days is considered at risk for future admission to inpatient services. To prevent the potentially unnecessary admissions to an inpatient facility, the designated LMHA or LBHA must:

(1) during discharge planning, review the individual's previous recovery or treatment plans to determine the effectiveness of the clinical services received;

(2) include in the recovery or treatment plan:

(A) non-clinical supports, such as those provided by a mental health peer specialist or recovery support peer specialist [coach], identified to support the individual's ongoing recovery; and

(B) recommendations for services and interventions from the individual's current or previous care plan [plan(s)] that support the individual's strengths and goals and prevent unnecessary admission to a state hospital [an SMHF] or [facility with a] CPB;

(3) determine the availability and level of care, including type, ["type,] amount, scope, and duration [duration"] of clinical and non-clinical supports, such as those provided by a mental health peer specialist or recovery support peer specialist [coach], that promote ongoing recovery and prevent unnecessary admission to a state hospital [an SMHF] or [facility with a] CPB; and

(4) consider appropriateness of the individual's continued stay in the state hospital [SMHF] or [facility with a] CPB.

(b) Discharge Planning Specialists. Pursuant to Texas Health and Safety Code §534.053, each state hospital must designate at least one employee to deliver continuity of care services for individuals who are determined medically appropriate for discharge from the facility. The state hospital must concentrate the provision of continuity of care services for individuals who have been:

(1) admitted to and discharged from a state hospital three or more times during a 30-day period; or

(2) in the state hospital for longer than 365 consecutive days.

(c) [(b)] Nursing Facility Referral or Admission.

(1) In accordance with 42 CFR Part 483, Subpart C, and as described in Chapter 554, Subchapter BB of this title [40 TAC Chapter 19, Subchapter BB] (relating to Nursing Facility Responsibilities Related to Preadmission Screening and Resident Review (PASRR)), a nursing facility must coordinate with the referring entity to ensure the referring entity screens the individual for admission to the nursing facility before the nursing facility admits the individual.

(2) As the referring entity, the state hospital [SMHF] or [facility with a] CPB must complete a PL1 Screening [PASRR Level I Screening] and forward the completed form in accordance with §303.301 of this title (relating to Referring Entity Responsibilities Related to the PASRR Process).

(3) The LMHA, [or] LBHA, or LIDDA must conduct a PE [PASRR Level II Evaluation] in accordance with Chapter 303 of this title (relating to Preadmission Screening and Resident Review (PASRR)).

(4) If a nursing facility admits an individual while on pass or furlough [an ATP], the designated LMHA or LBHA must conduct and document, including justification for its recommendations, the activities described in paragraphs (5) and (6) of this subsection.

(5) The designated LMHA or LBHA must make at least one in-person [face-to-face] contact with the individual at the nursing facility while on pass or furlough [an ATP]. The contact must consist of:

(A) a review of the individual's record at the nursing facility; and

(B) discussions with the individual, the individual's [and] LAR[,] if applicable [any], the nursing facility staff, and other staff who provide care to the individual regarding:

(i) the individual's needs and the care the individual is receiving;

(ii) the ability of the nursing facility to provide the appropriate care;

(iii) the provision of mental health services, if needed by the individual; and

(iv) the individual's adjustment to the nursing facility.

(6) Before the end of the initial pass or furlough [ATP] period described in §306.205(a) [§306.206(b)(2)] of this subchapter (relating to Pass or Furlough from a State Hospital or Facility with a Contracted Psychiatric Bed [Absence for Trial Placement]), the designated LMHA or LBHA must recommend to the state hospital [SMHF] or [facility with a] CPB one of the following:

(A) discharging the individual if the LMHA or LBHA determines that:

(i) the nursing facility is capable and willing to provide appropriate care to the individual after discharge;

(ii) any mental health services needed by the individual are being provided to the individual while residing in the nursing facility; and

(iii) the individual, and the individual's LAR[~~,~~] if applicable [~~any~~], agrees to the nursing facility admission;

(B) extending the individual's pass or furlough [~~ATP~~] period in accordance with §306.205(a)(2) [~~§306.206(b)(3)~~] of this subchapter;

(C) returning the individual to the state hospital [~~SMHF~~] or [~~facility with a~~] CPB in accordance with §306.205 of this subchapter (relating to Pass or Furlough from a State Hospital [~~Mental Health Facility~~] or a Facility with a Contracted Psychiatric Bed); or

(D) initiating involuntary admission to the state hospital [~~SMHF~~] or [~~facility with a~~] CPB in accordance with §306.176 (relating to Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [~~Authorized by an LMHA or LBHA or for a State Mental Health Facility~~] for Emergency Detention) and §306.177 (relating to Admission Criteria Under Order of Protective Custody or Court-ordered Inpatient Mental Health Services) of this subchapter.

(d) [~~(c)~~] Assisted Living.

(1) A state hospital [~~An SMHF~~], [~~facility with~~] a CPB, an LMHA, or an LBHA may only [~~not~~] refer an individual to an assisted living facility that is [~~not~~] licensed under [~~the~~] Texas Health and Safety Code[~~,~~] Chapter 247.

(2) As required by Texas Health and Safety Code §247.063(b), if a state hospital, [~~an SMHF, facility with~~] a CPB, an LMHA, or an LBHA gains knowledge of an assisted living facility not operated or licensed by the state, the state hospital [~~SMHF~~], [~~facility with a~~] CPB, LMHA, or LBHA must report [~~reports~~] the name, address, and telephone number of the facility to HHSC Complaint and Incident Intake at 1-800-458-9858.

(e) [~~(d)~~] Minors.

(1) To the extent permitted by medical privacy laws, the state hospital [~~SMHF~~] or [~~facility with a~~] CPB and designated LMHA or LBHA must make a reasonable effort to involve a minor's LAR or the LAR's designee in the treatment and discharge planning process.

(2) A minor committed to or placed in a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB under Texas Family Code[~~,~~] Chapter 55, Subchapter C or D, shall be discharged in accordance with the Texas Family Code[~~,~~] Chapter 55, Subchapter C or D as applicable.

(f) [~~(e)~~] An individual suspected of having an ID. If a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB suspects an individual has an ID, the state hospital [~~the SMHF~~] or [~~facility with a~~] CPB must notify the designated LMHA or LBHA CoC liaison [~~continuity of care worker~~] and the designated LIDDA to:

(1) assign a LIDDA continuity of care worker to the individual; and

(2) conduct an assessment in accordance with Chapter 304 of this title [~~40 TAC Chapter 5, Subchapter D~~](relating to Diagnostic Assessment).

(g) [~~(f)~~] Criminal Code.

(1) Texas Code of Criminal Procedure[~~,~~] Chapter 46B[~~: Incompetency to stand trial~~].

(A) An individual committed to a state hospital [~~The SMHF~~] or [~~facility with a~~] CPB [~~must discharge an individual committed~~] under Texas Code of Criminal Procedure[~~,~~] Article 46B.102 may only be discharged by order of the committing court under [~~(relating to Civil Commitment Hearing: Mental Illness), in accordance with~~] Texas Code of Criminal Procedure, Article 46B.107 [~~(relating to Release of Defendant after Civil Commitment)~~].

(B) An individual committed to a state hospital [~~The SMHF~~] or [~~facility with a~~] CPB [~~must discharge an individual committed~~] under Texas Code of Criminal Procedure [~~,~~] Article 46B.073 must be discharged and transferred [~~(relating to Commitment for Restoration to Competency)~~], in accordance with Texas Code of Criminal Procedure Article 46B.081 through[~~,~~] Article 46B.083 [~~(relating to Supporting Commitment Information Provided by Facility or Program)~~].

(C) For an individual committed under Texas Code of Criminal Procedure[~~,~~] Chapter 46B, discharged and returned to the committing court, the state hospital [~~SMHF~~] or [~~facility with a~~] CPB, within 24 hours after discharge, must notify the following of the discharge:

(i) the individual's designated LMHA or LBHA; and

(ii) the TCOOMMI.

(2) Texas Code of Criminal Procedure[~~,~~] Chapter 46C: Insanity defense. An individual committed to a state hospital [~~An SMHF~~] or [~~facility with a~~] CPB under Texas Code of Criminal Procedure Chapter 46C may only be discharged by [~~must discharge an individual acquitted by reason of insanity and committed to an SMHF or facility with a CPB under Texas Code of Criminal Procedure, Chapter 46C, only upon~~] order of the committing court in accordance with Texas Code of Criminal Procedure[~~,~~] Article 46C.253 or Article 46C.268.

(h) [~~(g)~~] Offenders with special needs following discharge from a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB. The LMHA or LBHA must comply with the requirements as defined by the LMHA's and LBHA's TCOOMMI contract for offenders with special needs.

(1) An LMHA or LBHA that receives a referral for an offender with special needs in the MH priority population from a county or city jail at least 24 hours before the individual's release must complete one of the following actions:

(A) if the offender with special needs is currently receiving LMHA or LBHA services, the LMHA or LBHA must [~~LMHA~~]:

(i) notify [~~notifies~~] the offender with special needs of the referral from a county or city jail [~~jail's referral~~];

(ii) arrange an in-person [~~arranges a face-to-face~~] contact between the offender with special needs and a QMHP-CS to occur within 15 days after the individual's release; and

(iii) ensure [~~ensures~~] that the QMHP-CS, at the in-person [~~face-to-face~~] contact, reassesses [~~re-assesses~~] the individual and arranges for appropriate services, including transportation needs at the time of release;[~~.~~]

(B) if the individual is not currently receiving LMHA or LBHA services from the LMHA or LBHA that is notified of the referral, the LMHA or LBHA must [~~LMHA~~]:

(i) ensure [~~ensures~~] that at the in-person [~~face-to-face~~] contact required in subparagraph (A) of this paragraph, the

QMHP-CS conducts a pre-admission assessment in accordance with §301.353(a) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization); and

(ii) comply [complies] with §306.161(b) of this subchapter (relating to Screening and Assessment), as applicable [appropriate]; or

(C) if the LMHA or LBHA is unable to [does not] conduct an in-person [a face-to-face] contact with the individual required in paragraph (1)(A) of this subsection, the LMHA or LMHA must document the reasons for not doing so in the individual's record.

(2) If an LMHA or LBHA is notified of the anticipated release from prison or a state jail of an offender with special needs in the MH priority population who is currently taking psychoactive medications [medication(s)] for a mental illness and who will be released with a 30-day supply of the psychoactive medications [medication(s)], the LMHA or LBHA must arrange an in-person [a face-to-face] contact required in paragraph (1)(A) of this subsection between the individual and QMHP-CS within 15 days after the individual's release.

(A) If the offender with special needs is released from state prison or state jail after hours or the LMHA or LBHA is otherwise unable to schedule the in-person [face-to-face] contact required in paragraph (2) of this subsection before the individual's release, the LMHA or LBHA must make [makes] a good faith effort to locate and contact the individual. If the designated LMHA or LBHA is unable to [does not] have an in-person [a face-to-face] contact with the individual within 15 days after being released, the LMHA or LBHA must document the reasons for not doing so in the individual's record.

(B) At the in-person [face-to-face] contact required in paragraph (2) of this subsection:

(i) the QMHP-CS with appropriate supervision and training must perform an assessment in accordance with §301.353(a) of this title and comply with §306.161(b) and (c) of this subchapter, as applicable [appropriate]; and

(ii) if the LMHA or LBHA determines that the offender with special needs should receive services immediately, the LMHA or LBHA must arrange for the individual to meet with a physician or designee authorized by state law to prescribe medication before the individual requires a refill of the prescription.

(C) If the LMHA or LBHA is unable to [does not] conduct an in-person [a face-to-face] contact with the offender with special needs required in paragraph (2) of this subsection, the LMHA or LBHA must document the reasons for being unable to do [for not doing] so in the individual's record.

(3) If the offender with special needs is on parole or probation, the state hospital [SMHF] or [facility with a] CPB must notify a representative of TCOOMMI before the discharge of the individual known to be on parole or probation.

§306.203. Discharge of an Individual Voluntarily Receiving Inpatient Treatment.

(a) A state hospital [An SMHF] or [facility with a] CPB must discharge an individual voluntarily receiving treatment if the administrator or designee of the state hospital [SMHF] or [facility with a] CPB concludes that the individual can no longer benefit from inpatient services based on the physician's determination, as delineated in Division 5 of this subchapter (relating to Discharge and Absences from a State Hospital [Mental Health Facility] or a Facility with a Contracted Psychiatric Bed).

(b) If a written request for discharge is made by an individual voluntarily receiving treatment, or the individual's LAR if applicable:

(1) the state hospital [SMHF] or [facility with a] CPB must discharge the individual in accordance with Texas Health and Safety Code §572.004; and

(2) the individual, or the individual's LAR if applicable, must sign, date, and document [signs, dates, and documents] the time on the discharge request.

(c) In accordance with Texas Health and Safety Code §572.004, if an individual informs a staff member of a state hospital [an SMHF] or [facility with a] CPB of the individual's desire to leave the state hospital [SMHF] or [facility with a] CPB, the state hospital [SMHF] or [facility with a] CPB must:

(1) as soon as possible, assist the individual in documenting [creating] the written request and obtaining the necessary signature; and

(2) within four hours after a written request is made known to the state hospital [SMHF] or [facility with a] CPB, notify:

(A) the treating physician; or

(B) another physician who is a state hospital [an SMHF] or [facility with a] CPB staff member, if the treating physician is not available during that time period.

(d) Results of physician notification required by subsection (c)(2) [(c)(3)] of this section.

(1) In accordance with Texas Health and Safety Code §572.004(c) and (d):

(A) a state hospital [an SMHF] or [facility with a] CPB, based on a physician's determination, must discharge an individual within the four-hour time period described in subsection (c)(2) of this section; or

(B) if the physician who is notified in accordance with subsection (c)(2) of this section has reasonable cause to believe that the individual may meet the criteria for court-ordered inpatient mental health services or emergency detention, the physician must examine the individual as soon as possible, but no later than 24 hours, after the request for discharge is made known to the state hospital [SMHF] or [facility with a] CPB.

(2) Reasonable cause to believe that the individual may meet the criteria for court-ordered inpatient mental health services or emergency detention.

(A) If a physician does not examine an individual who may meet the criteria for court-ordered inpatient mental health services or emergency detention within 24 hours after the request for discharge is made known to the state hospital [SMHF] or [the facility with a] CPB, the facility must discharge the individual.

(B) If a physician, in accordance with Texas Health and Safety Code §572.004(d), examines the individual as described in paragraph (1)(B) of this subsection and determines that the individual does not meet the criteria for court-ordered inpatient mental health services or emergency detention, the state hospital [the SMHF] or [the facility with a] CPB must discharge [discharges] the individual upon completion of the examination.

(C) If a physician, in accordance with Texas Health and Safety Code §572.004(d), examines the individual as described in paragraph (1)(B) of this subsection and determines that the individual meets

the criteria for court-ordered inpatient mental health services or emergency detention, the state hospital [SMHF] or [the facility with a] CPB, by 4:00 p.m. on the next business day, must:

(i) if the state hospital or [SMHF or facility with a] CPB intends to detain the individual, require the physician or designee, [to file an application and obtain a court order for further detention of the individual] in accordance with Texas Health and Safety Code §572.004(d), to[, the physician]:

(I) file [files] an application for court-ordered inpatient mental health services or emergency detention and obtains a court order for further detention of the individual;

(II) notify [notifies] the individual, and the individual's LAR if applicable, of such intention; and

(III) document [documents] in the individual's record the reasons for the decision to detain the individual; or

(ii) discharge [discharges] the individual.

(e) In accordance with Texas Health and Safety Code §572.004(i), after a written request from a minor individual admitted under §306.175(a)(1)(B) of this subchapter (relating to Voluntary Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [Authorized by an LMHA or LBHA or for a State Mental Health Facility]), the state hospital [SMHF] or [facility with a] CPB must:

(1) notify the minor's parent, managing conservator, or guardian of the request and:

(A) if the minor's parent, managing conservator, or guardian objects to the discharge, the minor continues [treatment as a patient] receiving voluntary treatment; or

(B) if the minor's parent, managing conservator, or guardian does not object to the discharge, the minor individual is discharged and released to the minor's LAR; and

(2) document the request in the minor's record.

(f) In accordance with Texas Health and Safety Code §572.004(f)(1), a state hospital [an SMHF] or [facility with a] CPB is not required to complete the requirements described in this section if the individual documents and signs [makes] a written statement withdrawing the request for discharge.

§306.204. Discharge of an Individual Involuntarily Receiving Treatment.

(a) Discharge from emergency detention.

(1) Except as provided by §306.178 of this subchapter (relating to Voluntary Treatment Following Involuntary Admission) and in accordance with Texas Health and Safety Code §573.021(b) and §573.023(b), a state hospital [an SMHF] or [facility with a] CPB must immediately discharge [discharges] an individual under emergency detention if:

(A) the state hospital [SMHF] administrator, administrator of the [facility with a] CPB, or designee concludes, based on a physician's determination, the individual no longer meets the criteria in §306.176(c)(1) of this subchapter (relating to Admission Criteria for a State Hospital or a Facility with a Contracted Psychiatric Bed [Authorized by an LMHA or LBHA or for a State Mental Health Facility] for Emergency Detention); or

(B) except as provided in paragraph (2) of this subsection:

(i) 48 hours has elapsed from the time the individual was presented to the state hospital [the SMHF] or [facility with a] CPB; and

(ii) the state hospital [SMHF] or [facility with a] CPB has not obtained a court order for further detention of the individual.

(2) In accordance with Texas Health and Safety Code §573.021(b), if the 48-hour period described in paragraph (1)(B)(i) of this subsection ends on a Saturday, Sunday, or legal holiday, or before 4:00 p.m. on the next business day after the individual was presented to the state hospital [SMHF] or [facility with a] CPB, the state hospital [SMHF] or [facility with a] CPB may detain [detains] the individual until 4:00 p.m. on such business day.

(b) Discharge under order of protective custody. Except as provided by §306.178 of this subchapter and in accordance with Texas Health and Safety Code §574.028, a state hospital [an SMHF] or [facility with a] CPB must immediately discharge [discharges] an individual under an order of protective custody if:

(1) the state hospital [SMHF] administrator, administrator of the [facility with a] CPB [administrator], or designee determines that, based on a physician's determination, the individual no longer meets the criteria described in Texas Health and Safety Code §574.022(a);

(2) the state hospital [SMHF] administrator, administrator of the [facility with a] CPB [administrator], or designee does not receive notice that the individual's continued detention is authorized after a probable cause hearing held within the time period prescribed by Texas Health and Safety Code §574.025(b);

(3) a final order for court-ordered inpatient mental health services has not been entered within the time period prescribed by Texas Health and Safety Code §574.005; or

(4) an order to release the individual is issued in accordance with Texas Health and Safety Code §574.028(a).

(c) Discharge under court-ordered inpatient mental health services.

(1) Except as provided by §306.178 of this subchapter and in accordance with Texas Health and Safety Code §574.085 and §574.086(a), a state hospital [an SMHF] or [facility with a] CPB must immediately discharge [discharges] an individual under a temporary or extended order for inpatient mental health services if:

(A) the order for inpatient mental health services expires; or

(B) the state hospital [SMHF] administrator, administrator of the [facility with a] CPB, or designee concludes that, based on a physician's determination, the individual no longer meets the criteria for court-ordered inpatient mental health services.

(2) In accordance with Texas Health and Safety Code §574.086(b), before discharging an individual in accordance with paragraph (1) of this subsection, the state hospital [SMHF] administrator, administrator of the [facility with a] CPB, or designee must consider [considers] whether the individual should receive court-ordered outpatient mental health services in accordance with a modified order described in Texas Health and Safety Code §574.061.

(3) In accordance with Texas Health and Safety Code §574.081, at the time an individual receiving court-ordered inpatient mental health services is furloughed or discharged from a state hospital or [facility with a] CPB, the state hospital or [a facility with a] CPB must provide and pay [is responsible for providing or paying]

for psychoactive medication and any other medication prescribed to counteract adverse side effects of psychoactive medication. This requirement also applies for a patient on a pass.

(A) A state hospital or [facility with a] CPB is only required to provide or pay for these medications if funding to cover the cost of the medications is available to be paid to the facility for this purpose from HHSC.

(B) The state hospital or [facility with a] CPB must provide or pay for the medications in an amount sufficient to last until the individual can see a physician, or provider with prescriptive authority, but the state hospital or [facility with a] CPB is not required to provide or pay for more than a seven-day supply.

(C) The state hospital or [facility with a] CPB must inform an individual if funding is not available to provide or pay for the medications upon pass, furlough, or discharge, and if[. If] funding is not available, the individual's designated LMHA or LBHA is responsible for providing psychoactive medications as provided in §306.207(2)(A) of this division (relating to Post Discharge or Furlough [Absence for Trial Placement]: Contact and Implementation of the Recovery or Treatment Plan), if applicable.

(4) An individual [Individuals] committed under Texas Code of Criminal Procedure[,] Chapter 46B or 46C may only be discharged as provided by §306.202(f) of this division (relating to Special Considerations for Discharge Planning).

(d) Discharge packet. A state hospital [An SMHF] administrator, administrator of a [facility with a] CPB, or designee must forward [forwards] a discharge packet, as provided in §306.201(h) of this division (relating to Discharge Planning), of any individual committed under the Texas Code of Criminal Procedure to the jail and the LMHA or LBHA in accordance with state and federal privacy laws.

§306.205. Pass or Furlough from a State Hospital [Mental Health Facility] or a Facility with a Contracted Psychiatric Bed.

(a) An individual who is under consideration for discharge as described in §306.203 of this division (relating to Discharge of an Individual Voluntarily Receiving Treatment) or §306.204(c) of this division (relating to Discharge of an Individual Involuntarily Receiving Treatment) may leave the state hospital or CPB while on pass or furlough if the state hospital or CPB and the designated LMHA or LBHA agree that a pass or furlough will be beneficial in implementing the individual's recovery or treatment plan. The designated LMHA or LBHA is responsible for monitoring the individual while the individual is on pass or furlough. [In accordance with Texas Health and Safety Code §574.082, an SMHF administrator, administrator of a facility with a CPB, or designee may, in coordination with the designated LMHA or LBHA, authorize absences for an individual involuntarily admitted under court order for inpatient mental health services.]

(1) If an individual on an involuntary commitment under Texas Health and Safety Code Chapter 574 is [individual's] authorized for a pass or furlough, the state hospital [absence is to exceed 72 hours, the SMHF] or [facility with a] CPB notifies the committing court of the individual's absence.

(2) The state hospital or CPB may extend an initial pass or furlough if:

(A) requested by the designated LMHA or LBHA; and

(B) the extension is clinically justified.

(3) A furlough that exceeds 60 days must be approved by:

(A) the state hospital administrator or designee, or the administrator of the CPB or designee; and

(B) the designated LMHA or LBHA executive director or designee

(4) [(2)] The state hospital [SMHF] or [facility with a] CPB must [may] not authorize a pass or furlough [an absence] that exceeds the expiration date of the individual's order for inpatient mental health services.

(b) The administrator of a state hospital or CPB may contact a peace officer as described under Texas Health and Safety Code §574.083 if:

(1) an individual is absent without authority from a state hospital or CPB;

(2) the individual has violated the conditions of a pass or furlough; or

(3) the individual's condition has deteriorated to the extent that the individual's continued absence under pass or furlough is not appropriate.

[(b) In accordance with Texas Health and Safety Code §574.083, an SMHF or facility with a CPB detains or readmits an individual if the SMHF administrator, administrator of the facility with a CPB, or the administrator's designee issues a certificate or affidavit establishing that the individual is receiving court-ordered inpatient mental health services and:]

[(1) the individual is absent without authority from the SMHF or facility with a CPB;]

[(2) the individual has violated the conditions of the absence; or]

[(3) the individual's condition has deteriorated to the extent that the individual's continued absence from the SMHF or facility with a CPB is inappropriate and there is a question of competency or willingness to consent to return, then the designated LMHA or SMHF must initiate involuntary admission in accordance with Texas Health and Safety Code, Chapter 573 or 574.]

(c) If the individual is detained in a nonmedical facility by a peace officer, the LMHA or LBHA must ensure the individual receives proper care and medical attention in accordance with Texas Health and Safety Code §574.083.

(d) [(c)] In accordance with Texas Health and Safety Code §574.084, an individual's furlough [authorized absence that exceeds 72 hours] may be revoked only after an administrative hearing held in accordance with this subsection.

(1) The state hospital [SMHF] or [facility with a] CPB must conduct [conducts] a hearing by a hearing officer who is a mental health professional not directly involved in treating the individual.

(2) The state hospital [SMHF] or [facility with a] CPB must:

(A) hold [holds] an informal hearing within 72 hours after the individual returns to the facility;

(B) provide [provides] the individual, or the individual's LAR if applicable, and facility staff members an opportunity to present information supporting the state hospital's or CPB's [their] position; and

(C) provide [provides] the individual, or the individual's LAR if applicable, the option to select another person or staff member to serve as the individual's advocate.

(3) Within 24 hours after the conclusion of the hearing, the hearing officer must determine if:

(A) revocation of the furlough is justified because:

(i) the individual was absent without authority from the facility;

(ii) the individual violated the conditions of the furlough; or

(iii) the individual's condition deteriorated to the extent the individual's continued furlough was inappropriate; or

[(A) determines if the individual violated the conditions of the authorized absence, the authorized absence was justified, or the individual's condition deteriorated to the extent the individual's continued absence was inappropriate; and]

(B) the furlough was justified.

(4) [(B)] The hearing office must render [renders] the final decision in writing, including the basis for the hearing officer's decision, and place the decision in the individual's file.

(5) [(4)] If the hearing officer's decision does not revoke the furlough [authorized absence], the individual may leave the state hospital [SMHF] or [facility with a] CPB pursuant to the conditions of the furlough [absence].

(6) [(5)] The state hospital [SMHF] or [facility with a] CPB must ensure [ensures] the individual's record includes a copy of the hearing officer's report.

(e) [(d)] Only [Except in medical emergencies, only] the committing criminal court may grant a pass or furlough from a state hospital [absences from a SMHF] or [facility with a] CPB for individuals committed under Texas Code of Criminal Procedure[,] Chapter 46B or 46C.

§306.207. Post Discharge or Furlough[Absence for Trial Placement]: Contact and Implementation of the Recovery or Treatment Plan.

(a) The designated LMHA or LBHA must:

(1) contact an [is responsible for contacting the] individual following discharge or furlough [ATP] from a state hospital [an SMHF] or [a facility with a] CPB; [and for implementing]

(2) implement the individual's recovery or treatment plan within seven days after discharge in accordance with this section; and

(3) ensure the successful transition of the individual determined by the state hospital or CPB to be medically appropriate for discharge in accordance with Texas Health and Safety Code §534.0535.

(b) [(1)] LMHA or LBHA contact after discharge or furlough [ATP].

(1) [(A)] The designated LMHA or LBHA must contact an individual in person or using audiovisual technology [makes face-to-face contact with an individual] within seven days after discharge or furlough [ATP] of an individual who is:

(A) [(i)] discharged or on furlough [ATP] from a state hospital [an SMHF] or [facility with a] CPB and referred to the LMHA or LBHA for services or supports as indicated in the recovery or treatment plan;

(B) [(ii)] discharged from an LMHA or LBHA-network provider of inpatient services and referred to the LMHA or LBHA for services or supports as indicated in the recovery or treatment plan;

(C) [(iii)] discharged from an alternate provider of inpatient services and receiving LMHA or LBHA services from the designated LMHA or LBHA at the time of admission and who, upon discharge, is referred to the LMHA or LBHA for services or supports as indicated in the recovery or treatment plan;

(D) [(iv)] discharged from the LMHA's or LBHA's crisis stabilization unit or any overnight crisis facility and referred to the LMHA or LBHA for services or supports as indicated in the discharge plan; or

(E) [(v)] an offender with special needs discharged from a state hospital [an SMHF] or [facility with a] CPB returning to jail.

(2) [(B)] During the contact required by paragraph (1)(A) [At the face-to-face contact after discharge required by subparagraph (A)] of this paragraph, the designated LMHA or LBHA must:

(A) [(i)] reassess [re-assesses] the individual;

(B) [(ii)] ensure [ensures] the provision of the services and supports specified in the individual's recovery or treatment plan by making the services and supports available and accessible as determined by the individual's level of care; and

(C) [(iii)] assist [assists] the individual in accessing the services and supports specified in the individual's recovery or treatment plan.

(3) [(C)] The designated LMHA or LBHA must develop [develops] or review [reviews] an individual's recovery or treatment plan in accordance with §301.353(e) of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization) and consider [considers] treatment recommendations in the state hospital's [SMHF] or [facility with a] CPB's discharge plan within ten business days after the [face-to-face] contact required by paragraph (1)(A) [subparagraph (A)] of this paragraph.

(4) [(D)] The designated LMHA or LBHA must make [makes] a good faith effort to [locate and] contact an individual as required by paragraph (1)(A) [who fails to appear for a face-to-face contact required by subparagraph (A)] of this paragraph. If the designated LMHA or LBHA does not have the required [a face-to-face] contact with the individual, the LMHA or LBHA must document [documents] the attempts made and reasons the [face-to-face] contact did not occur in the individual's record.

(c) [(2)] For an individual whose recovery or treatment plan must identify [identifies] the designated LMHA or LBHA as responsible for providing or paying for the individual's psychoactive medications, the designated LMHA or LBHA must ensure [is responsible for ensuring]:

(1) [(A)] the provision of psychoactive medications for the individual; and

(2) [(B)] the individual has an appointment with a physician or designee authorized by state law to prescribe medication before the earlier of the following events:

(A) [(i)] the individual's supply of psychoactive medication from the state hospital [SMHF] or [facility with a] CPB has been depleted; or

(B) [(ii)] the 15th day after the individual is on furlough [ATP] or discharged from the state hospital [SMHF] or [facility with a] CPB.

(d) [(3)] The designated LMHA or LBHA must document [documents] in an individual's record the LMHA's or LBHA's activities described in this section, and the individual's responses to those activities.

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

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Karen Ray
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26 TAC §306.206

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The repeal affects Texas Government Code §531.0055.

§306.206. Absence for Trial Placement.

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

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DIVISION 6. TRAINING

26 TAC §306.221

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The amendment affects Texas Government Code §531.0055.

§306.221. Screening and Intake Assessment Training Requirements at a State Hospital [~~Mental Health Facility~~] and a Facility with a Contracted Psychiatric Bed.

(a) Screening training. As required by Texas Health and Safety Code §572.0025(e), a state hospital [~~an SMHF~~] or [~~facility with a~~] CPB staff member whose responsibilities include conducting a screening described in Division 3 of this subchapter (relating to Admission to a State Hospital [~~Mental Health Facility~~] or a Facility with a Contracted Psychiatric Bed--Provider Responsibilities) must receive at least eight hours of training in the state hospital's [~~SMHF's~~] or [~~facility with a~~] CPB's screening.

(1) The screening training must provide instruction regarding:

(A) obtaining relevant information about the individual, including information about finances, third-party coverage or insurance benefits, and advance directives;

(B) explaining, orally and in writing, the individual's rights described in 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services);

(C) explaining, orally and in writing, the state hospital's [~~SMHF's~~] or [~~facility with a~~] CPB's services and treatment as the services and treatment [~~they~~] relate to the individual;

(D) explaining, orally and in writing, the existence, purpose, telephone number, and address of the protection and advocacy system established in Texas, pursuant to Texas Health and Safety Code §576.008; and

(E) determining whether an individual comprehends the information provided in accordance with subparagraphs (B) - (D) of this paragraph.

(2) Up to six hours of the following training may count toward the screening training required by this subsection:

(A) 25 TAC §417.515 (relating to Staff Training in Identifying, Reporting, and Preventing Abuse, Neglect, and Exploitation); and

(B) 25 TAC §404.165 (relating to Staff Training in Rights of Persons Receiving Mental Health Services).

(b) Intake assessment training. As required by Texas Health and Safety Code §572.0025(e), if a state hospital's [~~an SMHF~~] or [~~facility with a~~] CPB's internal policy permits an assessment professional to determine whether a physician should conduct an examination on an individual requesting voluntary admission, the

assessment professional must receive at least eight hours of training in conducting an intake assessment pursuant to this subchapter.

(1) The intake assessment training must provide instruction regarding assessing and diagnosing in accordance with §301.353 of this title (relating to Provider Responsibilities for Treatment Planning and Service Authorization).

(2) An assessment professional must receive intake training:

(A) before conducting an intake assessment; and

(B) annually throughout the professional's employment or association with state hospital [~~the SMHF~~] or [~~facility with a~~] CPB.

(c) Documentation of training. A state hospital [~~An SMHF~~] or [~~facility with a~~] CPB must document that each staff member and each assessment professional whose responsibilities include conducting the screening or intake assessment have successfully completed the training described in subsections (a) and (b) of this section, including:

(1) the date of the training;

(2) the length of the training session; and

(3) the name of the instructor.

(d) Performance in accordance with training. Each staff member and each assessment professional whose responsibilities include conducting the screening or intake assessment must perform the assessments in accordance with the training required by this section.

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

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SUBCHAPTER H. BEHAVIORAL HEALTH SERVICES--TELECOMMUNICATIONS

26 TAC §§306.361, 306.363, 306.365, 306.367, 306.369

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and §531.008 which requires the Executive Commissioner of HHSC to establish a division for administering state facilities, including state hospitals and SSLCs; Health and Safety Code §533.014 which requires the Executive Commissioner of HHSC to adopt rules relating to LMHA treatment responsibilities, §533.0356 which allows the Executive Commissioner to adopt rules governing LBHAs, §533A.0355 which requires the Executive Commissioner of HHSC to adopt rules establishing the roles and responsibilities of LIDDAs, §534.052 which requires the Executive Commissioner of HHSC to adopt rules necessary and appropriate to ensure the adequate provision of community-based services through LMHAs, §534.0535 which requires the Executive Commissioner of HHSC to adopt rules that require continuity of services and planning for patient care between HHSC facilities and LMHAs, and §552.001 which provides HHSC with authority to operate the state hospitals.

The new sections affect Texas Government Code §531.0055.

§306.361. Purpose.

The purpose of this subchapter is to establish methods and parameters of service delivery for individuals receiving general revenue-funded behavioral health services that HHSC determines are clinically effective and cost effective in accordance with Texas Government Code §531.02161.

§306.363. Application.

This subchapter applies to:

(1) LMHAs;

(2) LBHAs;

(3) substance use intervention providers;

(4) substance use treatment providers; and

(5) subcontracted providers of LMHAs, LBHAs, substance use intervention providers, and substance use treatment providers.

§306.365. Definitions.

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

(1) Audio-only technology--A synchronous interactive, two-way audio communication that uses only sound and that conforms to privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include audiovisual or in-person communication.

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

(3) CFR--Code of Federal Regulations.

(4) HHSC--Texas Health and Human Services Commission or its designee.

(5) HIPAA--The Health Insurance Portability and Accountability Act, 42 U.S.C. §1320d et seq.

(6) Individual--A person seeking or receiving services under this subchapter.

(7) In person--Within the physical presence of another person. In person does not include interacting with an individual through audiovisual or audio-only communication.

(8) LAR--Legally authorized representative. A person authorized by state law to act on behalf of an individual.

(9) LBHA--Local behavioral health authority. An entity designated as the local behavioral health authority by HHSC in accordance with Texas Health and Safety Code §533.0356.

(10) LMHA--Local mental health authority. An entity designated as the local mental health authority by HHSC in accordance with Texas Health and Safety Code §533.035(a).

(11) Provider--A person or entity that contracts to deliver services under this subchapter with:

(A) HHSC;

(B) an LMHA;

(C) an LBHA; and

(D) a substance use treatment provider.

§306.367. General Provisions.

(a) A provider may deliver services as permitted under this subchapter, if such delivery is permitted under the provider's state license, permit, or other legal authorization.

(b) If a behavioral health service has a procedure code that is billable in Medicaid, but the service is funded through general revenue, providers must adhere to:

(1) the Texas Medicaid Provider Procedures Manual and the Behavioral Health and Case Management Services Handbook posted on the Texas Medicaid and Healthcare Partnership website;

(2) the Texas Medicaid Provider Procedures Manual and Telecommunications Services Handbook posted on the Texas Medicaid and Healthcare Partnership website; and

(3) other Medicaid guidance concerning delivery of behavioral health services by audiovisual technology and audio-only technology.

(c) A provider may deliver behavioral health services that do not have a procedure code billable in Medicaid either in person, by audiovisual technology, or by audio-only technology.

(d) A provider delivering behavioral health services by audiovisual technology or audio-only technology as permitted under this subchapter must:

(1) deliver behavioral health services in person or use audiovisual technology rather than audio-only technology, whenever possible;

(2) offer the option of in person service delivery and not require an individual to receive services through audiovisual technology or audio-only technology;

(3) defer to the needs of the individual receiving services, allowing the method of service delivery to be accessible, person-centered and family-centered, and driven primarily by the individual's choice rather than provider convenience;

(4) only deliver the service by audiovisual technology and audio-only technology if agreed to by the individual, or the individual's LAR if applicable;

(5) determine that providing the service by audiovisual technology or audio-only technology is clinically appropriate and safe;

(6) deliver services in compliance with state standards set forth in Texas Health and Safety Code §533.035(d) and §533.0356(h), Texas Health and Safety Code Chapter 464, and in accordance with applicable HHSC rules; and

(7) maintain the confidentiality of protected health information as required by 42 CFR Part 2, 45 CFR Parts 160 and 164, Texas Occupations Code Chapter 159, Texas Health and Safety Code Chapter 611, and other applicable federal and state law.

(e) A provider must ensure any software or technology used complies with all applicable state and federal requirements, including HIPAA confidentiality and data encryption requirements, and with the United States Department of Health and Human Services rules implementing HIPAA confidentiality and data encryption requirements.

§306.369. Documentation Requirements.

(a) A provider must accurately document the services rendered and identify the method of service delivery. Documentation requirements for behavioral health services delivered by audiovisual technology or audio-only technology are the same as for service delivery in person.

(b) Prior to delivering a behavioral health service by audio-only technology, a provider must:

(1) obtain informed consent from the individual, or the individual's LAR if applicable, except when doing so is not feasible or could result in death or injury to the individual;

(2) if applicable, document in the individual's medical record that informed consent was obtained verbally; and

(3) document the reason why the provider delivered services by audio-only technology.

(c) Providers must adhere to documentation requirements in accordance with publications and conditions described in §306.367(b) of this subchapter (relating to General Provisions) if the general revenue-funded behavioral health service has a procedure code that is billable in Medicaid.

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

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CHAPTER 307. BEHAVIORAL HEALTH PROGRAMS

SUBCHAPTER C. JAIL-BASED COMPETENCY RESTORATION PROGRAM

26 TAC §§307.101, 307.103, 307.105, 307.107, 307.109, 307.111, 307.113, 307.115, 307.117, 307.119, 307.121, 307.123, 307.125, 307.127, 307.129, 307.131

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §307.101, concerning Purpose; §307.103, concerning Application; §307.105, concerning Definitions; §307.107, concerning Program Eligibility Requirements; §307.109, concerning Service Standards; §307.111, concerning Provider Staff Member Training; §307.113, concerning Policies and Procedures; §307.115, concerning Individual Eligibility; §307.117, concerning Admission; §307.119, concerning Rights of Individuals Receiving JBCR Services; §307.121, concerning Treatment Planning; §307.123, concerning Competency Restoration Education; §307.125, concerning Procedures for Determining Competency Status in a JBCR Program; §307.127, concerning Preparation for Discharge from a JBCR Program; §307.129, concerning

Outcome Measures; and §307.131, concerning Compliance with Statutes, Rules, and Other Documents.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement Senate Bill 49, 87th Legislature, Regular Session, 2021, which amended Texas Code of Criminal Procedure (CCP) Chapter 46B concerning procedures regarding defendants who are or may be individuals with a mental illness or intellectual disability. The amended rules in this proposal align the existing rules with CCP Chapter 46B by removing references to the pilot program, defining when the initial competency restoration period and an extension begin, updating requirements for a jail-based competency restoration (JBCR) psychiatrist or psychologist, and allowing JBCR programs to continue competency restoration services after 60 days if the individual has not yet restored under certain circumstances. The amended rules require new JBCR policies and procedures to ensure consistency in staff training and program operations and expands upon the policies and procedures for development of a safety plan. The proposal also updates cross-references and terminology for clarity and makes minor grammatical and editorial changes for accuracy, understanding, and uniformity.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §307.101 removes information about pilot and county-based programs due to the expiration of CCP Article 46B.090. The terms "jail-based competency restoration," "intellectual disability," and "substance use disorder" are replaced with their respective acronyms as minor editorial changes.

The proposed amendment to §307.103 replaces "LMHA or LBHA subcontractor" with "or a subcontractor of an LMHA or LBHA" as an editorial change. The proposed amendment removes references to other entities delivering jail-based competency restoration services due to the expiration of CCP Article 46B.090, and adds language clarifying that the subchapter applies to all JBCR programs implemented by counties regardless of their funding source.

The proposed amendment to §307.105 adds a definition for Extension; amends the definitions for Competency restoration, IST--Incompetent to stand trial, JBCR--Jail-based competency restoration, and JBCR program; and deletes the Local unit of general purpose government definition to align with Texas Code of Criminal Procedure Chapter 46B. The proposed amendment deletes the following definitions as they are no longer used in the rule text: Provider, Specially trained jailer, and State mental health facility, and deleted the following definitions as they did not need to be defined: Subcontractor and Texas Commission on Jail Standards. The proposed amendment adds or amends the following definitions to clarify and align with other rules: Business day, CFR--Code of Federal Regulations, Competency restoration training module, Day, Good standing, ID--intellectual disability, In-patient mental health facility, Legally authorized representative, LIDDA--Local intellectual and developmental disability authority, LMHA--Local mental health authority, Mental illness, Non-clinical services, OCR--outpatient competency restoration, Program staff member, QMHP-CS--Qualified mental health professional-community services, Safety plan, SUD--Substance use disorder, TAC--Texas Administrative Code, and Treatment team. The proposed amendment renumbers the definitions to account for the new definitions and changes made to existing definitions.

The proposed amendment to §307.107 revises the title to "JBCR Program Eligibility Requirements," updates the cross-reference in subsection (a), removes reference to the pilot program, and removes paragraphs (1) and (2) related to the pilot program to reflect repeal of Texas Code of Criminal Procedure Article 46B.090, relating to the JBCR pilot program. The proposed amendment to subsection (b) removes the reference to "county-based" and Texas Code of Criminal Procedure Article 46B.091. Proposed new subsection (c) clarifies the requirement that the LMHA or LBHA must contract with a county or counties to provide JBCR services. Through the proposed amendment, previous subsection (c) becomes subsection (d), and the proposed amendment updates the cross-reference to 25 TAC Chapter 412.

The proposed amendment to §307.109 removes subsection (a) related to the JBCR pilot program, and subsection (b) becomes assumed subsection (a). The proposed amendment adds the language in former subparagraph (A) to paragraph (1). The proposed amendment removes reference to "county-based" and clarifies that services must be provided by "licensed professionals, QMHP-CSs, or QIDPs as permitted by their professional license or certification." The proposed amendment adds new paragraph (5) to align with Article 46B.091, requiring that the program's JBCR must operate in the jail in a designated space that is separate from the space used for the general population of the jail, and subsequent paragraphs are renumbered. The proposed amendment clarifies in paragraph (7) that treatment should be provided to individuals as clinically indicated; adds new paragraph (8) to align with Article 46B.091, requiring JBCR programs to supply clinically appropriate psychoactive medications in accordance with Texas Code of Criminal Procedure Article 46B.086 or Texas Health and Safety Code Chapter 574; and adds new paragraph (9) clarifying the requirement that JBCR programs assess individuals for suicidality and homicidality and develop a safety plan.

The proposed amendment to §307.111 revises the title to "JBCR Program Staff Member Training" and corrects cross-references in subsection (a)(1) - (3) and (b)(1). The proposed amendment to subsection (b)(3) replaces HHSC's Office of the Ombudsman with the Department of Family and Protective Services for reporting abuse, neglect, and exploitation.

The proposed amendment to §307.113 adds new paragraph (1) requiring policies and procedures for maintaining a list of each program staff member providing JBCR, including position and credentials, reporting structure, and responsibilities. The proposed amendment also adds new paragraph (2) regarding maintaining program staff member training records to ensure accurate and consistent program oversight. Previous paragraph (1) becomes paragraph (3). Proposed amendments to paragraph (3) clarify that program eligibility is determined by the JBCR program and updates the cross-reference. Proposed new paragraph (5) specifies what a safety plan must document to ensure accurate record keeping of prevention and management of crises. Proposed amendments to paragraph (6) replace "ability to monitor" with "process to assess, evaluate" to align with Chapter 46B requirements and add cross-references. Proposed amendments to paragraph (7) replace "ensures ongoing" with "coordinates with the jail provider to address continuity of" to clarify what is required of the provider and updates the cross reference. Proposed new paragraph (8) adds required policies and procedures for educating an individual about the individual's rights while participating in the JBCR program; proposed new paragraph (9) adds required policies and procedures for coordinating with the court concerning the JBCR program's ability

to provide services to a new participant within 72 hours after admission; and proposed new paragraph (10) adds required policies and procedures for accommodating individual needs through adaptive materials and approaches, as needed.

The proposed amendment to §307.115 removes original subsection (a), as it related to the court determination of incompetency and proposes new subsection (a) to clarify the requirements relating to screening individuals for admission to the JBCR program if an OCR program is available. Proposed amendments to subsection (b) clarify requirements that JBCR screening must occur before the JBCR program makes a recommendation to the court regarding the individual's eligibility for the JBCR program if an OCR program is not available. Previous subsection (c) becomes subsection (b).

The proposed amendment to §307.117 adds new subsection (a) requiring a JBCR program to admit an individual to JBCR upon receipt of a court order requiring the individual to participate in JBCR under Texas Code of Criminal Procedure Chapter 46B, Subchapter D. The proposed amendment also implements S.B. 49 by adding new subsection (b) to specify when the initial competency restoration period begins. Previous subsection (a) becomes amended subsection (c) and clarifies that a participant must be served within 72 hours of admission to the JBCR program. Previous subsection (b) becomes subsection (d), and the proposed amendment for subsection (d) makes a minor grammatical edit and updates the statutory reference.

The proposed amendment to §307.119 revises the title to "Rights of Individuals Receiving JBCR" and updates the cross-reference in paragraph (1).

The proposed amendment to §307.121 clarifies language and adds a cross-reference to assumed subsection (a), makes a minor grammatical edit to paragraph (7), amends paragraph (8) to replace substance use disorder with the acronym "SUD," and proposes new paragraph (9) requiring the treatment plan to include specific non-clinical services and supports needed by the individual after discharge to capture all areas of individual needs to be assessed when developing the treatment plan.

The proposed amendment to §307.123 clarifies that required accommodations include "accommodations for language barriers and disabilities" in subsection (c) and removes the required review of progress in subsection (d) to implement S.B. 49 amendments to CCP Chapter 46B.

The proposed amendment to §307.125 updates the requirements of the JBCR psychiatrist or psychologist for re-evaluating an individual's competency to align with the S.B. 49 amendments to Article 46B.091. The proposed amendment to subsection (a) requires that the psychiatrist or psychologist must evaluate an individual's competency and report to the court as required by CCP Article 46B.079. Proposed amendments to subsection (b) address the requirements when the psychologist or psychiatrist believes the individual has restored to competency or is unlikely to restore to competency in the foreseeable future. Proposed new subsection (c) requires the JBCR program to continue to serve a participant if the participant has not restored to competency by the 60th calendar day unless notified that space is available at a facility or OCR program, as appropriate, and the required timeframes remain for the individual's commitment. Proposed new subsection (d) requires that the JBCR program coordinate with the court and county jail to ensure that the individual is transferred to the appropriate facility or program. Proposed new subsection (e) requires the JBCR program return the individual to court for further proceedings if the individual has not restored at the end of the period authorized under the Texas Code of Criminal Procedure.

The proposed amendment to §307.127 clarifies the responsibility of the treatment team to provide continuity of care and supports after an individual is either restored to competency, is determined unlikely to restore to competency in the foreseeable future, does not restore to competency after completion of the JBCR program, or is transferred to a facility or OCR program after 60 days in the JBCR program. Proposed amendments to subsections (a) and (b) include editorial changes to clarify the lists of discharge settings.

The proposed amendment to §307.129 adds new subsection (a) to clarify that "competency as determined by the JBCR psychiatrist or psychologist" refers to the clinical opinion of the psychiatrist or psychologist provided under CCP Articles 46B.079(b) and 46B.091. Previous assumed subsection (a) becomes subsection (b). The proposed amendment in subsection (b) revises language to clarify what data must be reported to HHSC. The proposed new subparagraphs (C), (D) and (E) require JBCR programs to report the date the individual was ordered to JBCR, the date the first JBCR service was provided, and whether the court granted an extension. The proposed amendment clarifies language in relabeled subparagraphs (F) - (H) that JBCR programs should report calendar days and report the competency as determined by the JBCR program's psychiatrist or psychologist. The proposed amendment adds new subparagraph (I) to report the number of individuals charged with a felony and not restored to competency, revises subparagraph (J) and adds new subparagraph (K) to report the number of individuals charged with a felony or a misdemeanor who are restored to competency, and revises language in relabeled subparagraphs (L) - (O) for clarification and consistency with terminology. The proposed amendments revise subparagraph (M) to include number of individuals for consistency with the other data points and add new subparagraph (P) to report the number of individuals whose charges were dismissed before completion of the JBCR program. The proposed amendment also revises subsection (b)(2) to clarify language, remove reference to "pilot program or county-based JBCR," update a cross-reference, and add a new cross-reference.

The proposed amendment to §307.131 moves the reference to Texas Human Resources Code Chapter 48 from subsection (b)(8) to subsection (a)(2) and renumbers the subsequent paragraphs. The proposed amendment updates the title to the cross-reference in paragraph (3)(A) and references to rules in Title 25 that have transferred to Title 26. Proposed amendment to subsection (b) updates the HIPAA cross-reference, removes paragraph (b)(4), and renumbers the subsequent paragraphs. Paragraphs (b)(5) and (b)(6) include proposed amendments to statutory references to more accurately reflect requirements for JBCR programs.

The proposed amendments to §§307.105, 307.111, and 307.113, §§307.117 - 307.125, §307.129, and §307.131 replace "provider" with "program" to maintain uniformity and improve clarity.

The proposed amendments to §§307.101 - 307.109, §307.113, and §307.119 replace "JBCR services" with "JBCR" to maintain consistency and improve clarity.

The proposed amendments to §§307.101, 307.121, and 307.129 replace "JBCR program" with "JBCR" to maintain consistency and improve clarity.

HHSC made minor grammatical and editorial changes throughout the subchapter for accuracy and understanding.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new regulations;

(6) the proposed rules will expand existing regulations;

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

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

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

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities because there is no requirement to alter current business practices.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

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

PUBLIC BENEFIT AND COSTS

Trina Ita, Interim Deputy Executive Commissioner for Behavioral Health Services, has determined that for each year of the first five years the rules are in effect, the public benefit will be aligning rules with statute. There is no anticipated cost for compliance with the proposed amendments since there is no requirement to alter current business practices, and there are no new fees imposed.

Trey Wood, Chief Financial Officer, has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rule because there is no requirement to alter current business practices and no new fees or costs will be imposed on those required to comply.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 23R078" in the subject line.

STATUTORY AUTHORITY

The proposed amendments are authorized by the Texas Code of Criminal Procedure Chapter 46B, relating to Incompetency to Stand Trial, Article 46B.091, requiring the Executive Commissioner of HHSC to adopt rules as necessary for a county to develop and implement a JBCR program, and Texas Government Code §531.0055 which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services system.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

§307.101. Purpose.

The purpose of this subchapter is to provide standards for JBCR [~~jail-based competency restoration services in pilot and county-based programs,~~] as required by the Texas Code of Criminal Procedure[~~,~~] Chapter 46B, relating to Incompetency to Stand Trial. JBCR includes [~~The programs include~~]:

(1) mental health services;

(2) ID [~~intellectual disability~~] services;

(3) co-occurring psychiatric and SUD [~~substance use disorder~~] treatment services;

(4) competency restoration education in the county jail for an individual found IST [~~incompetent to stand trial~~]; and

(5) discharge planning services.

§307.103. Application.

This subchapter applies to an LMHA, LBHA, or a subcontractor of an LMHA or LBHA [~~subcontractor, a private provider, and a local unit of general purpose government or city unit of government or a subcontractor of the unit of government~~] delivering JBCR [~~jail-based competency restoration services~~] authorized by the Texas Code of Criminal Procedure[~~,~~] Chapter 46B, regardless of the funding source for the JBCR.

§307.105. Definitions.

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

(1) Business day--Any day except a Saturday, Sunday, or legal holiday listed in Texas Government Code §662.021.

(2) CFR--Code of Federal Regulations.

(3) [(1)] Competency restoration--The treatment or [and] education process for restoring an individual's ability to consult with the individual's attorney with a reasonable degree of rational understanding, including [and] a rational and factual understanding of the court proceedings and charges against the individual as defined in the Texas Code of Criminal Procedure Article 46B.001.

(4) [(2)] Competency restoration training module[(training module)]--An HHSC-reviewed training module used by program [provider] staff members to provide legal education to an individual receiving competency restoration services.

(5) [(3)] Court--A court of law presided over by a judge, judges, or a magistrate in civil and criminal cases.

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

(7) Extension--As described in Texas Code of Criminal Procedure Article 46B.080(d), an extension begins on the later of:

(A) the date the court enters the order under Article 46B.080(a); or

(B) the date competency restoration services begin pursuant to the order entered under Article 46B.080(a).

(8) Good standing--Entities eligible to contract with HHSC pursuant to HHSC procurement and contract rules and guidelines.

(9) [(4)] HHSC--Texas Health and Human Services Commission or its designee.

(10) [(5)] ID--Intellectual disability. Consistent with Texas Health and Safety Code[,] §591.003, significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior as defined in §304.102 of this title (relating to Definitions) and originating before age 18.

(11) [(6)] Individual--A person receiving services under this subchapter.

(12) [(7)] Inpatient mental health facility--The term has the meaning assigned in Texas Health and Safety Code §571.003. [A mental health facility providing 24-hour residential and psychiatric services and is:]

[(A) a facility operated by HHSC;]

[(B) a private mental hospital licensed by HHSC;]

[(C) a community center, facility operated by or under contract with a community center or other entity HHSC designates to provide mental health services;]

[(D) a local mental health authority or a facility operated by or under contract with a local mental health authority;]

[(E) an identifiable part of a general hospital in which diagnosis, treatment, and care for an individual with mental illness is provided and is licensed by HHSC; or]

[(F) a hospital operated by a federal agency.]

(13) [(8)] IST--Incompetent to stand trial. The term has the meaning described in Texas Code of Criminal Procedure Article 46B.003. [A situation when an individual does not have:]

[(A) sufficient present ability to consult with the individual's lawyer with a reasonable degree of rational understanding; or]

[(B) a rational as well as factual understanding of the proceedings against the individual.]

(14) [(9)] JBCR--Jail-based competency restoration. Competency restoration services [conducted] in a county jail setting provided in a designated space separate from the space used for the general population of the county jail.

(15) [(A)] JBCR program-- [County-based program--]A jail-based competency restoration program developed and implemented by a county or [joint] counties in accordance with the Texas Code of Criminal Procedure[,] Article 46B.091.

[(B) Pilot program--A jail-based competency restoration pilot program implemented in accordance with the Texas Code of Criminal Procedure, Article 46B.090.]

(16) [(10)] LBHA--Local behavioral health authority. An entity designated as the local behavioral health authority by HHSC in accordance with Texas Health and Safety Code §533.0356.

(17) Legally authorized representative--A person authorized by state law to act on behalf of an individual as an agent under a Medical Power of Attorney under Texas Health and Safety Code Chapter 166, or a Declaration for Mental Health Treatment under Texas Civil Practice and Remedies Code Chapter 137.

(18) [(11)] LIDDA--Local intellectual and developmental disability authority. An entity designated as the local intellectual and developmental disability authority by HHSC in accordance with Texas Health and Safety Code §533A.035(a) [, §533A.035].

(19) [(12)] LMHA--Local mental health authority. An entity designated as the local mental health authority by [the executive commissioner of] HHSC in accordance with Texas Health and Safety Code[,] §533.035(a).

[(13) Local unit of general purpose government--The government of a county, municipality, township, Indian tribe, or other unit of government (other than a state) which is a unit of general government as defined in 13 United States Code §184.]

(20) [(14)] LPHA--Licensed practitioner of the healing arts. A person who is:

(A) a physician;

(B) a physician assistant;

(C) an advanced practice registered nurse;

(D) a licensed psychologist;

(E) a licensed professional counselor;

(F) a licensed clinical social worker; or

(G) a licensed marriage and family therapist.

(21) [(15)] Mental illness--An illness, disease, or condition as defined by Texas Health and Safety Code §571.003. [(other than a sole diagnosis of epilepsy, dementia, substance use disorder, or ID) that:]

[(A) substantially impairs an individual's thought, perception of reality, emotional process, or judgment; or]

[(B) grossly impairs an individual's behavior as demonstrated by recent disturbed behavior.]

[(16) Provider--An entity that contracts with HHSC or a county to provide JBCR program services.]

(22) Non-clinical services--Services that support an individual's care but do not provide direct diagnosis, treatment, or care for the individual.

(23) OCR--Outpatient competency restoration. As defined in Chapter 307, Subchapter D of this title (relating to Outpatient Competency Restoration), a community-based program with the specific objective of attaining restoration to competency pursuant to Texas Code of Criminal Procedure Chapter 46B.

(24) [(17)] Program [Provider] staff member--An employee or person with whom the program [provider] contracts or subcontracts for the provision of JBCR [program services]. A program [provider] staff member includes specially trained security officers, all licensed and credentialed staff, and other people [persons] directly contracted or subcontracted to provide JBCR [services] to an individual.

(25) [(18)] QIDP--Qualified intellectual disability professional as defined in 42 CFR §483.430(a).

(26) [(19)] QMHP-CS--Qualified mental health professional-community services. As defined in Chapter 301 [412], Subchapter G[,] of this title (relating to Mental Health Community Services Standards).

(27) [(20)] Residential care facility--A state supported living center or the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF-IID) component of the Rio Grande State Center.

(28) Safety plan--An individualized written plan to prevent or manage crises.

(29) [(21)] Serious injury--An injury determined by a physician to require medical treatment by a licensed medical professional (e.g., physician, dentist, physician's assistant, or advance practice nurse) or requires medical treatment in an emergency department or licensed hospital.

(30) [(22)] Significantly sub-average general intellectual functioning--Consistent with Texas Health and Safety Code[,] §591.003, measured intelligence on standardized general intelligence tests of two or more standard deviations (not including standard error of measurement adjustments) below the age-group mean for the test used.

[(23) Specially trained jailer--A person appointed or employed as a county jailer assigned to work for the JBCR provider.]

[(24) State mental health facility--A state hospital or a state center with an inpatient psychiatric component.]

[(25) Subcontractor--A person or entity that contracts with the provider of JBCR program services.]

[(26) Texas Commission on Jail Standards--The regulatory agency for all county jails and privately operated municipal jails in the state, as established in the Texas Government Code, Chapter 511.]

(31) SUD--Substance use disorder. The use of one or more substances, including alcohol, which significantly and negatively impacts one or more major areas of life functioning, and which meets the criteria for substance use disorder as described in the HHSC-recognized edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(32) TAC--Texas Administrative Code.

(33) Treatment team--A group of treatment providers, including a psychiatrist and LPHA; the individual; and the individual's legally authorized representative, if any, who work together in a coordinated manner to provide competency restoration services to the individual.

§307.107. JBCR Program Eligibility Requirements.

(a) A [The] JBCR [pilot] program must meet the standards set forth in the Texas Code of Criminal Procedure[,] Article 46B.091. [46B.090, and upon operation of program services, the provider of the JBCR pilot program must be:]

[(1) an LMHA:]

[(A) in good standing with HHSC; and]

[(B) that demonstrates a history of successful competency restoration outcomes; or]

[(2) a private provider or a local unit of general purpose government or city unit of government, or a subcontractor of the unit of government:]

[(A) certified by a nationwide nonprofit organization that accredits health care organizations and programs;]

[(B) that maintains the accreditation in subparagraph (A) of this paragraph while under contract with HHSC to provide competency restoration services under this subchapter;]

[(C) that demonstrates a history of successful JBCR program outcomes; and]

[(D) has previously provided JBCR services for one or more years.]

(b) A [The county-based] JBCR program must [meet the standards set forth in the Texas Code of Criminal Procedure, Article 46B.091 and upon operation of program services, the provider of the county-based JBCR program must be]:

(1) be an LMHA or LBHA in good standing with HHSC; or

(2) a subcontractor of an LMHA or LBHA in good standing with HHSC.

(c) An LMHA or LBHA must contract with the county to provide JBCR.

(d) [(c)] An LMHA or LBHA that provides JBCR [contracts with a county to provide jail-based competency restoration services] must comply with the rules found in 25 TAC Chapter 412, Subchapter B [of this title] (relating to Contracts Management for Local Authorities) and the contract management and oversight requirements of the Texas Comptroller of Public Accounts.

§307.109. Service Standards.

[(a) A JBCR pilot program must:]

[(1) use a multidisciplinary treatment team to provide clinical treatment:]

[(A) focused on the objective of restoring the individual to competency to stand trial; and]

[(B) similar to the clinical treatment provided as part of a competency restoration program at an inpatient mental health facility;]

[(2) employ or contract for the services of at least one psychiatrist;]

[(3) use QMHP-CSs or QIDPs to provide JBCR program services; and]

[(4) provide weekly competency restoration hours commensurate to the treatment hours provided as part of a competency restoration program at an inpatient mental health facility.]

[(b)] A [county-based] JBCR program must:

(1) use a multidisciplinary treatment team focused on the objective of restoring the individual to competency to stand trial; [:]

[(A) focused on the objective of restoring the individual to competency to stand trial; and]

[(B) similar to other competency restoration programs;]

(2) employ or contract for the services of at least one psychiatrist;

(3) [use QMHP-CSs or QIDPs to] provide JBCR through licensed professionals, QMHP-CSs, or QIDPs as permitted by their professional license or credentials [program services];

(4) provide weekly competency restoration hours commensurate to the treatment hours provided as part of a competency restoration program at an inpatient mental health facility;

(5) provide JBCR in a designated space in the jail, separate from the space used for the general population of the jail;

(6) [(5)] ensure coordination of general health care;

(7) [(6)] provide mental health treatment, SUD [ID services, and substance use disorder] treatment, and referral to ID services to individuals, as clinically indicated [necessary], for competency restoration; [and]

(8) [(7)] supply clinically appropriate psychoactive medications for purposes of administering court-ordered medication to individuals as applicable and in accordance with Texas Code of Criminal Procedure Article 46B.086 or Texas Health and Safety Code §574.106; and [through contract, obligate a subcontractor to comply with this subchapter.]

(9) assess individuals for suicidality and homicidality and develop a safety plan based on the needs of the individual.

§307.111. JBCR Program [Provider] Staff Member Training.

(a) A JBCR program [provider] must recruit, train, and maintain qualified program [provider] staff members with documented competency in accordance with Chapter 301 [412], Subchapter G, Division 2 of this title (relating to Organizational Standards), specifically:

(1) §301.327(e) [§412.314(e)] of this title (relating to Access to Mental Health Community Services);

(2) §301.329 [§412.315] of this title (relating to Medical Records System); and

(3) §301.331 [§412.316] of this title (relating to Competency and Credentialing).

(b) Before providing services, a JBCR program [provider] must train each program [provider] staff member and ensure demonstrated competence in:

(1) 25 TAC Chapter 404, Subchapter E [Chapter 404, Subchapter E of this title] (relating to Rights of Persons Receiving Mental Health Services);

(2) 40 TAC Chapter 4, Subchapter C (relating to Rights of Individuals with an Intellectual Disability);

(3) identifying, preventing, and reporting abuse, neglect, and exploitation in accordance with the Texas Commission on Jail Standards or [the] HHSC [Office of the Ombudsman] as set forth in applicable state laws and rules; and

(4) using a protocol for preventing and managing aggressive behavior, including preventative de-escalation intervention strategies.

§307.113. Policies and Procedures.

A JBCR program [provider] must develop and implement written policies and procedures for:

(1) maintaining a list of each program staff member providing JBCR, including:

(A) position and credentials;

(B) reporting structure; and

(C) responsibilities;

(2) maintaining program staff member training records;

(3) [(1)] describing JBCR eligibility as determined by the JBCR program, intake and assessment, and treatment planning as described in §307.121 [§416.86] of this subchapter (relating to Treatment Planning), and transition and discharge processes to include coordination and continuity of care planning with an LMHA, LBHA, or LIDDA, or an LMHA, LBHA, or LIDDA subcontractor;

(4) [(2)] describing how an individual is assessed for:

(A) suicidality and homicidality;

(B) the degree of suicidality and homicidality; [and]

(C) the development of a safety [an individualized suicide and homicide prevention] plan;

(5) developing a safety plan that must document:

(A) warning signs, including thoughts, images, changes in mood and behavior, or situations that may prompt a crisis;

(B) internal coping strategies that distract from crisis thoughts and urges;

(C) a process for communicating safety concerns and recommended precautions to the jail relating to an individual participating in JBCR;

(D) the process for identifying and addressing suicidal and homicidal means;

(6) [(3)] outlining a JBCR program's process to assess, evaluate, [provider staff member's ability to monitor] and report to the court an individual's restoration to competency status and readiness for return to court as specified in the Texas Code of Criminal Procedure Articles 46B.077(b) and [, Article] 46B.079; [and]

(7) [(4)] addressing how a program [provider] staff member coordinates with the jail medical provider to address continuity of [ensures ongoing] care, treatment, and overall therapeutic environment during evenings and weekends, including responding to behavioral health crisis or physical health crisis consistent with §301.351(a) [§412.321(a)] and (e) of this title (relating to Crisis Services);[.]

(8) educating an individual about the individual's rights while participating in JBCR;

(9) coordinating with the court concerning the JBCR program's ability to provide services to a new participant within 72 hours after admission in accordance with §307.117 of this title and Texas Code of Criminal Procedure Article 46B.073(d); and

(10) accommodating individual needs through adaptive materials and approaches as needed, including accommodations for language barriers and disabilities.

§307.115. Individual Eligibility.

(a) If there is an OCR program available to serve the individual, a JBCR program must collaborate with the OCR program to screen the individual for OCR services. The individual must be deemed ineligible for OCR in accordance with Chapter 307, Subchapter D of this title (relating to Recommendation Regarding Outpatient Competency Restoration Program Admission) before a JBCR program makes a recommendation to the court regarding the individual's eligibility for JBCR.

(b) If there is not an OCR program available to serve the individual, a JBCR program must screen the individual to determine if JBCR is appropriate and make a recommendation to the court regarding the individual's eligibility for JBCR.

[(a) To be eligible to participate in a JBCR program, the court must determine the individual as IST pursuant to the Texas Code of Criminal Procedure, Chapter 46B.]

[(b) An LMHA, LBHA, or an LMHA or LBHA subcontractor must:]

[(1) screen an individual for outpatient competency restoration; and]

[(2) determine an individual ineligible for those services before the individual is admitted into the JBCR program.]

[(c) If an outpatient competency restoration provider is not within the LMHA's or LBHA's local service area or contracted to provide outpatient competency restoration services for the area to participate in screening an individual for outpatient competency restoration services, the JBCR provider must admit the individual to the JBCR program, if eligible.]

§307.117. Admission.

(a) A JBCR program must admit an individual to JBCR upon receipt of a court order requiring the individual to participate in JBCR under Texas Code of Criminal Procedure Chapter 46B, Subchapter D.

(b) In accordance with Texas Code of Criminal Procedure Article 46B.0735, the initial competency restoration period begins on the later of:

(1) the date the individual is:

(A) ordered to participate in OCR services; or

(B) committed to a mental health facility, residential care facility, or JBCR; or

(2) the date competency services begin.

(c) [(a)] When a JBCR program [provider] determines an individual is eligible for [a] JBCR, the program[: (1) the provider] must ensure the individual will receive competency restoration services no later than 72 hours after admission to [arriving at] the JBCR program.[; or]

[(2) the provider must inform the court that the JBCR program is at capacity, and immediately report the individual's name to HHSC for placement on the Clearinghouse, which HHSC uses to track the list of pending admissions of criminal code commitments for nonviolent offenses.]

(d) [(b)] A JBCR program [provider] must, when necessary, seek a court order for psychoactive medications in accordance with Texas Health and Safety Code[,] §574.106 or [and] the Texas Code of Criminal Procedure Article 46B.086 [, Chapter 46B].

§307.119. Rights of Individuals Receiving JBCR [Services].

A [provider of] JBCR program [services] must:

(1) inform the individual receiving JBCR [services] of the individual's rights in accordance with 25 TAC Chapter 404, Subchapter E [of this title] (relating to Rights of Persons Receiving Mental Health Services) or 40 TAC Chapter 4, Subchapter C (relating to Rights of Individuals with an Intellectual Disability), as applicable;

(2) provide the individual with a copy of the rights handbook published for an individual receiving mental health services or an individual with an ID; and

(3) explain to the individual receiving JBCR [services] how to initiate a complaint and how to contact:

(A) the HHS Office of the Ombudsman for complaints against the JBCR program [provider];

(B) the Texas Commission on Jail Standards for complaints against the county jail; and

(C) the Texas protection and advocacy system.

§307.121. Treatment Planning.

Within five days after admission to [the] JBCR [program], based on an individual's competency evaluation and JBCR program [provider] assessment, the JBCR program [provider] must develop the individual's treatment plan in accordance with 25 TAC Chapter 404, Subchapter E (relating to Rights of Persons Receiving Mental Health Services) and Chapter 301, Subchapter G of this title (relating to Mental Health Community Services Standards) to include the individual's:

(1) [the individual's] strengths, to assist the individual in:

(A) overcoming barriers to achieving a factual and rational understanding of legal proceedings; and

(B) consulting with the individual's lawyer with a reasonable degree of rational understanding;

(2) [the individual's] trauma history;

(3) physical health concerns or issues;

(4) medication and medication management;

(5) level of family and community support;

(6) mental health concerns or issues;

(7) ID concerns or issues; [and]

(8) SUD [substance use disorder] or co-occurring psychiatric and SUD [substance use disorder] concerns or issues; and[.]

(9) specific non-clinical services and supports needed by the individual after discharge, including:

(A) housing assistance;

(B) food assistance;

(C) governmental benefits;

(D) clothing resources; and

(E) other supplemental supports.

§307.123. Competency Restoration Education.

(a) A JBCR program [provider] must submit the competency restoration training module for HHSC review.

(b) A JBCR program [Each individual] must educate individuals using [be educated in] multiple learning formats, which may include:

(1) discussion;

(2) written text;

(3) video; and

(4) experiential methods, such as role-playing or mock trial.

(c) A JBCR program [provider] must ensure an individual with accommodation needs receives adapted materials and approaches as needed, including accommodations for language barriers and disabilities.

[(d) Not later than the 14th day after the date on which an individual's competency restoration services begin, the provider must review the individual's progress towards attaining competency in accordance with the Texas Code of Criminal Procedure, Chapter 46B.]

§307.125. Procedures for Determining Competency Status in a JBCR Program.

(a) A JBCR program [The] psychiatrist or psychologist who has the qualifications described by Texas Code of Criminal Procedure Article 46B.022 must evaluate the individual's competency and report to the court as required by Article 46B.079. [for a JBCR pilot program, or psychiatrist or psychologist for a county-based JBCR program, must conduct at least two full psychiatric or psychological evaluations for each individual. The psychiatrist or psychologist must:]

[(1) conduct the first evaluation no later than the 21st day after the date JBCR program services began;]

[(2) conduct the second evaluation no later than the 55th day after the date JBCR program services began; and]

[(3) subsequent to evaluations completed in paragraphs (1) and (2) of this subsection, promptly submit a separate report for each psychiatric or psychological evaluation to the court.]

(b) A JBCR program psychiatrist or psychologist must promptly send a report to the court, if at any time during an individual's commitment for JBCR, the JBCR psychiatrist or psychologist determines the individual is: [At any time during the commitment for JBCR services consistent with the Texas Code of Criminal Procedure, Article 46B.091(h), but no later than the 60th day after the date JBCR services begin, the psychiatrist for a JBCR pilot program, or psychiatrist or psychologist for a county-based JBCR program, must determine if the individual is restored to competency, is unlikely to be restored to competency in the foreseeable future, or has not been restored to competency but will likely be restored in the foreseeable future. If the psychiatrist or psychologist determines the individual:]

(1) [is] restored to competency; or [, the psychiatrist or psychologist must send a report to the court demonstrating this determination;]

(2) [is] unlikely to be restored to competency in the foreseeable future.[, the psychiatrist or psychologist must send a report to the court demonstrating this determination, and coordinate with provider staff members, the court, and the county jail to ensure the transfer or release of the individual pursuant to the court's action to:]

[(A) proceed under the Texas Code of Criminal Procedure, Chapter 46B, Subchapter E or Subchapter F; or]

[(B) release the defendant on bail under the Texas Code of Criminal Procedure, Chapter 17; or]

[(3) has not been restored to competency but will likely be restored in the foreseeable future, if the individual is charged with:]

[(A) a felony offense, the psychiatrist or psychologist must coordinate with provider staff members, the court, and the county jail to ensure the transfer of the individual to the first available mental health facility or residential care facility for the remainder of the commitment period; or]

[(B) a misdemeanor offense, the psychiatrist or psychologist must coordinate with provider staff members, the court, and the county jail to ensure the transfer or release of the individual pursuant to the court's action to:]

[(i) order a single extension under the Texas Code of Criminal Procedure, Article 46B.080 and transfer of the individual to the first available mental health facility or residential care facility;]

[(ii) proceed in accordance with the Texas Code of Criminal Procedure, Chapter 46B, Subchapter E or Subchapter F;]

[(iii) release the defendant on bail in accordance with the Texas Code of Criminal Procedure, Chapter 17; or]

[(iv) dismiss the charges in accordance with the Texas Code of Criminal Procedure, Article 46B.010.]

(c) If the JBCR program psychiatrist or psychologist determines that the individual has not restored to competency by the end of the 60th calendar day after the date the individual began receiving JBCR, the JBCR program must continue to provide competency restoration services to the individual for the period authorized under Texas Code of Criminal Procedure Chapter 46B, Subchapter D, including any extension ordered under Article 46B.080, unless the JBCR program is notified that space at a mental health facility or residential care facility or an OCR program appropriate for the individual is available and:

(1) for an individual charged with a felony, not less than 45 calendar days are remaining in the initial restoration period; or

(2) an individual charged with a felony or misdemeanor, an extension has been ordered under Article 46B.080 and not less than 45 calendar days are remaining under the extension order.

(d) After receipt of a notice under subsection (c) of this section, the JBCR program must coordinate with the court and the county jail to ensure the transfer of the individual without unnecessary delay to the appropriate mental health facility, residential care facility, or OCR program for the remainder of the period permitted by Texas Code of Criminal Procedure Article 46B.073(b), including any extension that may be ordered under Article 46B.080 if an extension has not previously been ordered under that article.

(e) If the individual is not transferred, as referenced in subsection (d) of this section, and if the JBCR program psychiatrist or psychologist determines that the individual has not been restored to competency by the end of the period authorized under Texas Code of Criminal Procedure Chapter 46B, Subchapter D, the individual must be returned to the court for further proceedings.

§307.127. Preparation for Discharge from a JBCR Program.

(a) At any time an individual is restored to competency, the treatment team [psychiatrist or psychologist] must [collaborate with provider staff members to] coordinate the individual's continuity of care [continued services] and supports after discharge from the JBCR program to their discharge setting, including:

(1) the county jail;

(2) the LMHA;

(3) the LBHA;

(4) the LIDDA; [or]

(5) other community [another] mental health provider; or[.]

(6) the care of a responsible person.

(b) If the individual is determined to be [charged with a misdemeanor or felony and the individual is] unlikely to restore [be restored] to competency in the foreseeable future or is not restored after completing the JBCR program, the treatment team [psychiatrist or psychologist] must [collaborate with provider staff members to] coordinate the individual's continuity of care [continued services] and supports after discharge from the JBCR program to their discharge setting, including:

(1) a mental health facility;

(2) a residential care facility;

(3) the LMHA;

(4) the LBHA;

(5) the LIDDA;

(6) other community [another] mental health provider; or

(7) the care of a responsible person.

(c) If an individual is not restored to competency by the 60th day and is being transferred to a facility or OCR program, the JBCR treatment team [psychiatrist or psychologist] must[, if the individual is charged with: (1) a felony,] coordinate with discharge setting [provider] staff members to link the individual for continuity of care [continued services] and supports post discharge from the JBCR program to:

(1) [(A)] a mental health facility; [or]

(2) [(B)] a residential care facility; or

(3) an OCR program.

[(2) a misdemeanor, coordinate with provider staff members to link the individual for continued services and supports post discharge from the JBCR program to:]

[(A) the county jail,]

[(B) a mental health facility;]

[(C) a residential care facility;]

[(D) the LMHA;]

[(E) the LBHA;]

[(F) the LIDDA; or]

[(G) another mental health provider.]

§307.129. Outcome Measures.

(a) For the purposes of this section, "competency as determined by the JBCR psychiatrist or psychologist" refers to the clinical opinion of the psychiatrist or psychologist provided under Texas Code of Criminal Procedure Articles 46B.079(b) and 46B.091, as applicable.

(b) A JBCR program [provider] must collect and report the following data for an individual admitted to a JBCR program, using HHSC's designated automation system [to HHSC on]:

(1) individual outcomes:

(A) the number of individuals on felony charges;

(B) the number of individuals on misdemeanor charges;

(C) date individual was ordered to JBCR;

(D) date of first JBCR service provided;

(E) whether the court granted an extension;

(F) [(C)] the average number of calendar days for an individual charged with a felony to be restored to competency, as determined by the JBCR psychiatrist or psychologist;

(G) [(D)] the average number of calendar days for an individual charged with a misdemeanor to be restored to competency, as determined by the JBCR psychiatrist or psychologist;

(H) [(E)] the number of individuals charged with a misdemeanor and not restored to competency, as determined by the JBCR psychiatrist or psychologist[for whom an extension was sought];

(I) the number of individuals charged with a felony and not restored to competency, as determined by the JBCR psychiatrist or psychologist;

(J) [(F)] the number of individuals charged with a misdemeanor and restored to competency, as determined by the JBCR psychiatrist or psychologist;

(K) the number of individuals charged with a felony and restored to competency, as determined by the JBCR psychiatrist or psychologist;

(L) [(G)] the average length of time between determination of non-restorability by the JBCR psychiatrist or psychologist and transfer to an inpatient [a state] mental health facility, [or] residential care facility, or OCR program pursuant to Texas Code of Criminal Procedures Article 46B.091(j-1);

(M) [(H)] the number [percentage] of individuals restored to competency as determined by the JBCR psychiatrist or psychologist in 60 calendar days or less;

(N) [(I)] the number of individuals [jail inmates] found IST who were found ineligible [screened out of or deemed inappropriate] for JBCR based on the JBCR program screening and the reason why; [and]

(O) [(J)] the number of individuals not restored to competency and who were transferred to an inpatient [a state] mental health facility or residential care facility; and

(P) the number of individuals whose charges were dismissed before completion of JBCR; and

(2) administrative outcomes, in a format specified by HHSC, for the JBCR program, including:

(A) the costs associated with operating the JBCR [pilot program or county-based JBCR] program; and

(B) the number of:

(i) reported and confirmed cases of abuse, neglect, and exploitation;

(ii) reported and confirmed cases of rights violations;

(iii) restraints and seclusions used;

(iv) emergency medications used;

(v) serious injuries; and

(vi) deaths, in accordance with 25 TAC §415.272 [of this title] (relating to Documenting, Reporting, and Analyzing Restraint or Seclusion) or Chapter 405, Subchapter K (relating to Deaths

of Individuals Served by Community Mental Health Centers), as applicable.

§307.131. Compliance with Statutes, Rules, and Other Documents.

(a) In addition to any applicable federal or state law or rule, a JBCR program [~~provider~~] must comply with:

(1) Texas Health and Safety Code[~~,~~] Chapter 574 (relating to Court-Ordered Mental Health Services);

(2) Texas Human Resources Code Chapter 48 (relating to Investigations and Protective Services for Elderly Persons and Persons with Disabilities);

(3) [~~(2)~~] 25 TAC:

(A) Chapter 405, Subchapter K (relating to Deaths of Individuals Served by Community Mental Health Centers) [~~(relating to Deaths of Persons Served by TXMHMR Facilities or Community Mental Health and Mental Retardation Centers)~~];

(B) Chapter 414 (relating to Rights and Protections of Persons Receiving Mental Health Services) [~~Chapter 411, Subchapter N (relating to Standards for Services to Individuals with Co-occurring Psychiatric and Substance Use Disorders (COPSD))~~];

[~~(C) Chapter 414, Subchapter I (relating to Consent to Treatment with Psychoactive Medication--Mental Health Services);~~]

[~~(D) Chapter 414, Subchapter K (relating to Criminal History and Registry Clearances);~~]

[~~(E) Chapter 414, Subchapter L (relating to Abuse, Neglect, and Exploitation in Local Authorities and Community Centers);~~]

(C) [~~(F)~~] Chapter 415, Subchapter A (relating to Prescribing of Psychoactive Medication); and

(D) [~~(G)~~] Chapter 415, Subchapter F (relating to Interventions in Mental Health Services); and

(4) [~~(3)~~] 26 TAC: [~~37 TAC Part 9 (relating to Texas Commission on Jail Standards).~~]

(A) Chapter 301, Subchapter G (relating to Mental Health Community Services Standards); and

(B) Chapter 306, Subchapter A (relating to Standards for Services to Individuals with Co-occurring Psychiatric and Substance Use Disorders (COPSD)).

(b) Concerning confidentiality, a JBCR program [~~provider~~] must comply with the Health Insurance Portability and Accountability Act, 42 U.S.C. §1320d et seq [~~of 1996 (HIPAA)~~] and other applicable federal and state laws, including:

(1) 42 CFR Part 2 and Part 51, Subpart D;

(2) 45 CFR Parts 160 and 164, and Part 1326, Subpart C [~~§1386.22~~];

(3) Texas Health and Safety Code[~~,~~] Chapter 81, Subchapter F;

[~~(4) Texas Health and Safety Code, Chapter 241, Subchapter G;~~]

(4) [~~(5)~~] Texas Health and Safety Code[~~,~~] Chapters 181, 595, and 611;

(5) [~~(6)~~] Texas Health and Safety Code[~~,~~] §§533.009, [~~533.035(a), 572.004,~~] 576.005, 576.007, and 614.017;

(6) [~~(7)~~] Texas Government Code[~~,~~] Chapters 552 and 559[~~, and §531.042~~];

[~~(8) Texas Human Resources Code, Chapter 48;~~]

(7) [~~(9)~~] Texas Occupations Code[~~,~~] Chapter 159; and

(8) [~~(10)~~] Texas Business and Commerce Code[~~,~~] §521.053.

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

Filed with the Office of the Secretary of State on August 28, 2024.

TRD-202404039
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 593-0168

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CHAPTER 350. EARLY CHILDHOOD INTERVENTION SERVICES

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to the Texas Administrative Code (TAC), Title 26, Chapter 350, Subchapter A, concerning General Rules, §350.103, §350.107; Subchapter B, concerning Procedural Safeguards and Due Process Procedures, §350.209, §350.225; Subchapter C, concerning Staff Qualifications, §350.303, §350.309, §350.312, §350.313, §350.315; Subchapter D, concerning Case Management for Infants and Toddlers with Developmental Disabilities, §350.403, §350.404, §350.405, §350.406, §350.407, §350.411, §350.415; Subchapter E, concerning Specialized Rehabilitative Services, §350.501, §350.507; Subchapter F, concerning Public Outreach, §350.605, §350.607, §350.609, §350.611, §350.613, §350.615, §350.617; Subchapter G, concerning Referral, Pre-Enrollment, and Developmental Screening, §350.704, §350.706, §350.707, §350.708, §350.709; Subchapter H, concerning Eligibility, Evaluation, and Assessment, §350.805, §350.807, §350.809, §350.811, §350.813, §350.815, §350.817, §350.821, §350.823, §350.825, §350.829, §350.833, 350.835, §350.837; Subchapter J, concerning Individualized Family Service Plan (IFSP), §350.1003, §350.1004, §350.1007, §350.1009, §350.1015, 350.1017, §350.1019; Subchapter K, concerning Service Delivery, §350.1104, §350.1108, §350.1111; Subchapter L, concerning Transition, §350.1203, §350.1207, 350.1209, §350.1211, §350.1213, §350.1215, §350.1217, §350.1219, §350.1221; Subchapter M, concerning Child and Family Outcomes, §350.1307, §350.1309; and Subchapter N, concerning Family Cost Share System, §350.1405, §350.1411, §350.1413, §350.1431, and §350.1433.

The Executive Commissioner of HHSC also proposes the repeal of 26 TAC Subchapter A, concerning General Rules, §350.101; Subchapter B, concerning Procedural Safeguards and Due Process Procedures; §350.201; Subchapter C, concerning Staff Qualifications; §350.301; Subchapter F, concerning Public Outreach, §350.601; Subchapter G, concerning Referral, Pre-Enrollment, and Developmental Screening, §350.701; Subchapter H, concerning Eligibility, Evaluation, and Assessment, §350.801; Subchapter J, concerning Individualized Family Service Plan (IFSP); §350.1001, Subchapter K, concerning Service Delivery, §350.1101; Subchapter L, concerning Transition, §350.1201, Subchapter M, concerning Child and Family

Outcomes, §350.1301; and Subchapter N, concerning Family Cost Share System, §350.1401.

BACKGROUND AND PURPOSE

The purpose of the proposal is to amend rules as they relate to Early Childhood Intervention (ECI) to increase administrative efficiencies and improve processes for ECI subrecipients. This proposal also aims to repeal rules that are no longer needed.

The proposed changes also contain non-substantive changes that will improve readability, consistency, and understanding, as well as align language with HHSC rulemaking standards.

The proposed amendments and repeals are the result of the HHSC ECI program conducting a review of current rules, as required by Texas Government Code Section 2001.039, relating to 4-year reviews, and seeking input from current ECI subrecipients and stakeholders to identify ways to improve the long-term sustainability of the program. These proposed rules will address a number of areas including minimum staff qualifications, programmatic requirements, and additional needs identified by current subrecipients. Additionally, this rule project has allowed the ECI program to amend language related to immunizations to align with House Bill 44, 88th Texas Legislature, Regular Session, 2023, which amends Texas Government Code Chapter 531 by adding §531.02119.

There is no anticipated fiscal impact to state government from implementation of the proposed rules. All changes are to provide clarity and align rules with contract and federal requirements, or to allow administrative efficiencies for ECI subrecipients.

SECTION-BY-SECTION SUMMARY

The proposed amendments to 26 TAC Chapter 350 replace "contractor" with "subrecipient" throughout the chapter to align with ECI contracts, "early childhood intervention" with "ECI," and the "Texas Health and Human Services Commission" with "HHSC."

The proposed repeal of §350.101, Purpose, deletes the rule because the language is provided in the Code of Federal Regulations (CFR) and is not necessary to restate in rule.

The proposed amendment to §350.103, Definitions, amends existing definitions to clarify grammar and align with HHSC rulemaking standards and adds definitions for commonly used phrases and acronyms used throughout ECI rules that were not previously defined. The paragraphs are renumbered to account for the amendment, addition, and deletion of terms. The terms "Assessment," "Child," "Child Find," Complaint," "Comprehensive Needs Assessment," "Co-visits," "Days," "Developmental Delay," "Developmental Screenings," "Early Childhood Intervention Program," "Early Childhood Intervention Services," "EIS," "Evaluation," "Group Services," "HHSC," "HHSC ECI," "IFSP," "IFSP Services," "IFSP Team," "Interdisciplinary Team," "LPHA," "Native Language," "Natural Environments," "Parent," "Personally Identifiable Information," "Pre-Enrollment," Primary Referral Sources," "Public Agency," "Qualifying Medical Diagnosis," "Referral Date," "Routine Caregiver," "Service Coordinator," "Surrogate Parent," and "Telehealth services" are amended.

The terms "CFR," "DFPS," "ECI," "ECSE," "Face-to-face," "IDEA Part C," "IFSP services pages," "MOU," "SEA," "SRS," "SST," "Subrecipient," "TAC," "TEA," and "USC" are added as new terms.

The term "TCM" was moved from §350.403, relating to Case Management, to this section.

The term "ECI Professional" is deleted from its current location and moved up to follow alphabetization. The term is also amended for clarity.

The terms "Condition with a High Probability of Resulting in Developmental Delay," and "Contractor" are deleted.

The proposed amendment to §350.107, Health Standards for Early Childhood Intervention Services, amends language related to immunizations to align with House Bill (H.B.) 44, 88th Texas Legislature, Regular Session, 2023. H.B. 44 prohibits providers who participate in Medicaid or the child health plan program from refusing to provide health care services based solely on the recipient's failure to obtain a vaccine or immunization.

The proposed repeal of §350.201, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.209, Parent Rights in the Individualized Family Service Plan (IFSP) Process, removes the acronym from the title to align with HHS rulemaking standards. The amendment to §350.209 also makes non-substantive language revisions to align with HHSC rulemaking standards.

The proposed amendment to §350.225, Amendment of Records at Parent's Request, makes non-substantive language revisions to align with HHSC rulemaking standards.

The proposed repeal of §350.301, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.303, Definitions, amends existing definitions to clarify grammar and align with HHSC rulemaking standards. The amendment also adds definitions for commonly used phrases and acronyms used throughout ECI rules that were not previously defined. The terms "Criminal Background Check," "Dual Relationships," "Early Intervention Specialist (EIS) Active Status," "Early Intervention Specialist (EIS) Inactive Status," "EIS Registry," "Individualized Professional development Plan (IPDP)," "Professional Boundaries," "Service Coordinator Active Status," and "Service Coordinator Inactive Status" are amended. The term "EIS past due status" is added as new and the paragraphs are renumbered to account for the addition and amendment of terms.

The proposed amendment to §350.309, Minimum Requirements for All Direct Service Staff, adds new subsection (a) for terms used in this section, which includes "Consultation," "Record Review," and "Observation." These definitions were relocated from new subsection (f)(1) through (3) to avoid repetition. Language was also added to new (c)(1) and new (e) to clarify who qualifies as staff employed by the Local Education Agency (LEA). The proposed amendment also makes non-substantive language, grammar edits, revises an incorrect citation, revises cross references to accurately reflect reference changes, and renumbers the section to account for the addition of the subsection.

The proposed amendment to §350.312, Licensed Practitioner of the Healing Arts (LPHA), removes the acronym from the title to align with HHSC rulemaking standards. The proposed amendment also makes non-substantive revisions to improve clarity.

The proposed amendment to §350.313, Early Intervention Specialist (EIS), removes the acronym from the title to align with HHSC rulemaking standards and makes non-substantive grammar and language revisions throughout the section to align with HHSC rulemaking standards. The amendment to subsection (a)

reduces barriers related to hiring early intervention specialists (EISes) and allows for administrative efficiencies related to updating degree and curriculum information through ongoing collaboration with subrecipients and institutes of higher education. Requirements related to qualifying and related degrees, coursework, and previous experience are being removed from TAC and posted on the HHSC website to allow the program more flexibility in adding or removing certain degrees or courses when appropriate.

New subsection (b) adds clarification on the requirements for being credentialed as an EIS. New subsection (c) adds clarification on requirements for the re-certification of an EIS. New subsection (d) corrects TAC cross-references. New subsection (e) adds clarification on the requirements for an EIS on active status, past due status, and inactive status. This proposed amendment provides clarification on the activities requiring EIS active status. New subsection (f) clarifies how active status can be regained when an EIS goes on past due status or inactive status. New subsection (g) covers the requirement discussed in old subsection (e). New subsection (h) covers the requirement discussed in old subsection (f).

The proposed amendment to §350.315, Service Coordinator, makes non-substantive language and grammar revisions for clarification and to align with HHSC rulemaking standards. The amendment removes duplicative language in subsection (b) that is in §350.403 and adds a cross-reference. References are updated in new subsections (c) and (e). The proposed amendment to new subsection (f) provides clarification on the requirements for active status and inactive status for service coordinators.

The proposed amendment to §350.403, Definitions, revises existing definitions and grammar to enhance clarity and align with HHSC rulemaking standards. The amendment to §350.403 also adds definitions for commonly used phrases and acronyms used throughout ECI rule that were not previously defined. The terms "Case management," Monitoring and assessment," and "Texas Health Steps" are amended. The terms "Developmental disability," "Service coordinator," and "TCM" are deleted.

The proposed amendment to §350.404, Recipient Eligibility for Early Childhood Intervention (ECI) Case Management Services, removes the acronym from the title in alignment with HHSC rulemaking standards. The amendment also makes non-substantive revisions to clarify existing language and align rule with rulemaking standards and updates a title to a reference.

The proposed amendment to §350.405, Case Management Services, makes non-substantive revisions to clarify existing language and align with HHSC rulemaking standards. Subsection (a) is added to provide that case management services may be provided via telehealth with written consent of the parent, but case management services must still be provided even if the parent declines to consent to telehealth services. New subsection (b) removes the case management definition that is repetitive of §350.403. New subsection (c) clarifies that targeted case management (TCM) should be offered to all children and families regardless of Medicaid enrollment and makes non-substantive language revisions for clarification. New subsections (d) and (e) add clarification for targeted case management (TCM) requirements.

The proposed amendment to §350.406, Parent Refusal, makes non-substantive language and grammar revisions to add clarity and to align with HHSC rulemaking standards.

The proposed amendment to §350.407, Medicaid Service Limitations, makes non-substantive language and grammar revisions to add clarity and separates the first paragraph into a subsection (a) and (b).

The proposed amendment to §350.411, Assignment of Service Coordinator, makes non-substantive language and grammar revisions to add clarity and to align with HHSC rulemaking standards.

The proposed amendment to §350.415, Documentation, makes non-substantive language and grammar revisions to add clarity and to align with HHSC rulemaking standards.

The proposed amendment to §350.501, Specialized Rehabilitative Services, makes language and grammar revisions to support clarity and consistency relating to referencing various ECI therapies and professionals. The amendment simplifies language to remove duplication across subsections, renumbers as necessary, and corrects outdated citations in (a)(2)(C)(ii) and (a)(3)(C). The removal of old subsection (c) and (e) removes duplicative language.

The proposed amendment to §350.507, Due Process, makes non-substantive revisions to grammar and language to provide clarity and align with HHSC rulemaking standards.

The proposed repeal of §350.601, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.605, Definitions, removes the definition for "Central directory" because the term is no longer used in this section, renumbers the paragraphs, and makes minor edits to "Public awareness" and "Public outreach."

The proposed amendment to §350.607, Public Outreach, corrects a minor grammar error.

The proposed amendment to §350.609, Child Find, makes minor grammar revisions to add clarification and align with HHSC rulemaking standards. The amendment moves language in subsection (d) to (a) and re-numbers the section accordingly to improve clarity on the requirement to document how HHSC ECI policy changes are communicated to referral sources.

The proposed amendment to §350.611, Public Awareness, makes non-substantive grammar and language revisions to improve clarity. The amendment to subsection (d) removes an outdated resource reference to improve accuracy.

The proposed amendment to §350.613, Publications, removes a reference to the ECI Graphics Manual and replaces it with a requirement for subrecipients to comply with graphics standards required by HHSC ECI to improve clarity on the requirement.

The proposed amendment to §350.615, Interagency Coordination, makes non-substantive grammar revisions and replaces defined terms with their associated acronyms. The amendment to subsection (c) replaces "auditory and visual impairment services" with "services for children who are deaf or hard of hearing or blind or visually impaired" to align with the person-first respectful language initiative.

The proposed amendment to §350.617, Public Outreach Contact, Planning, and Evaluation, makes non-substantive grammar revisions and abbreviates terms to their defined acronyms. The amendment to subsection (b) fixes a cross-reference in alignment with a rule revision. Language from subsection (d)(4) is relocated to create new subsection (e) for clarity.

The proposed repeal of §350.701, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.704, Referral Requirements, makes non-substantive grammar changes to align with HHSC rulemaking standards. The amendment to subsection (c) removes unnecessary citations and corrects acronyms.

The proposed amendment to §350.706, Referrals Received While the Child is in the Hospital, makes non-substantive grammar changes to align with the HHSC rulemaking standards. The amendment to subsection (b) also makes non-substantive revisions and re-arranges language to provide clarity. These changes clarify requirements for the interdisciplinary team that determines eligibility and helps to clarify the difference between the eligibility evaluation team and the IFSP team.

The proposed amendment to §350.707, Child Referred with an Out-of-State IFSP, updates the title to "Child Referred with an Out-of-State Individualized Family Service Plan" and replaces defined terms with their associated acronym.

The proposed amendment to §350.708, Pre-Enrollment Activities, makes minor language changes to align with ECI contracts and to establish consistency with acronym use.

The proposed amendment to §350.709, Optional Developmental Screenings, makes non-substantive language and organization changes to improve clarity. New subsections (d) and (e) are amended to clarify requirements per the memorandum of understanding (MOU) between HHSC ECI and the Department of Family and Protective Services by matching the language in the MOU.

The proposed repeal of §350.801, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.805, Definitions, amends existing definitions to clarify grammar and align with HHSC Rulemaking standards. The term "Adjusted Age" is amended and adds a definition for the new term "Chronological age."

The proposed amendment to §350.807, Eligibility, makes non-substantive language and grammar edits to improve clarity. New subsection (a) is added to provide clarification on federal requirements. Subsection (f) is added to stress the requirement to provide prior written notice. Existing subsection (c) is removed to reduce repetition between rules and federal regulations.

The proposed amendment to §350.809, Initial Eligibility Criteria, clarifies terminology and makes non-substantive grammar revisions to align with HHSC rulemaking standards. Amendments also align language with the person first respectful language initiative. A reference is added to paragraph (3)(C) to provide detail about the qualitative determination.

The proposed amendment to §350.811, Eligibility Determination Based on Medically Diagnosed Condition That Has a High Probability of Resulting in Developmental Delay, changes the title of the rule to "Qualifying Medical Diagnosis" improve clarity and align with commonly used terminology. Subsection (a) is edited for clarity. Old subsection (b) is deleted to remove duplicative language.

The proposed amendment to §350.813, Determination of Hearing and Auditory Status, changes the title of the rule to "Deaf or Hard of Hearing." Non-substantive clarifying edits are made to improve clarity and align language with the person-first respectful language initiative. New subsection (a) provides the requirements for determination of a child's eligibility for ECI services based on a child who is deaf or hard of hearing. New subsection (c) is added to clarify when a hearing screening tool may be used for a child who is eligible based on a qualifying medical diagnosis or meeting the definition of blind or visually impaired. Language from old subsections (c)(1) and (c)(2) is relocated to new subsection (e). New subsections (f) and (g) provide information for referring a child to the LEA.

The proposed amendment to §350.815, Determination of Vision Status, changes the title to "Blindness or Visual Impairment." New subsection (a) provides the requirements for determination of a child's eligibility for ECI services based on blindness or visual impairment. Non-substantive grammar edits are made to subsections (b) and (d) to improve clarity. New subsection (c) describes when a vision screening tool may be used. The amendment to new subsection (e) aligns language with the person-first respectful language initiative and makes non-substantive grammar edits to improve clarity. Language is added to provide the actions a subrecipient should take when a child is eligible based on blindness or visual impairment. Language from deleted subsection (d) is added to subsection (e)(2).

The proposed amendment to §350.817, Eligibility Determination Based on Developmental Delay, changes the title to "Developmental Delay." The amendment removes paragraph (3) in subsection (a) to remove redundancy throughout the chapter. Additional edits are made to grammar and organization to improve clarity. New paragraph (4) is added to provide requirements for children with a chronological or adjusted age of zero months or younger.

The proposed amendment to §350.821, Qualitative Determination of Developmental Delay, make non-substantive revisions to language and grammar, as well as the organization of the rule, to improve clarity.

The proposed amendment to §350.823, Continuing Eligibility Criteria, make non-substantive revisions to language and grammar, as well as the organization of the rule, to improve clarity. References to §350.813 and §350.815 of this subchapter are added to provide clarification on the requirements for the appropriate certified teacher or teachers who should be on the interdisciplinary team.

The proposed amendment to §350.825, Eligibility Statement, re-organizes information and make non-substantive revisions to language and grammar to improve clarity. The subsections are renumbered to account for the reorganization.

The proposed amendment to §350.829, Review of Nutrition Status, adds clarifying language and makes minor grammar edits to align with HHSC rulemaking standards.

The proposed amendment to §350.833, Autism Screening, adds clarifying information related to referrals and screening for autism spectrum disorder and makes non-substantive language and grammar edits to improve clarity and align with rulemaking standards. New subsection (e) clarifies the need for written parental consent to refer a child to their health care provider to complete the Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) and the follow-up interview. New subsection (f) clarifies the subrecipient's responsibility to obtain written parental consent to complete the M-CHAT-R and the follow-up interview if the child is not screened by their provider or is unable to receive the screening in a timely manner. The section

is renumbered to account for the addition of new subsections (e) and (f).

The proposed amendment to §350.835, Contractor Oversight, changes the title to "Subrecipient Oversight." Non-substantive clarifying edits and minor grammar edits are made to align with HHSC rulemaking standards.

The proposed amendment to §350.837, Needs Assessment, makes non-substantive revisions to remove duplicative language and improve clarity and to align with HHSC rulemaking standards.

The proposed repeal of §350.1001, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.1003, Definitions, amends existing definitions to align with HHSC rulemaking standards. The terms "Functional Ability," "IFSP Goals," and "Periodic Review" are amended.

The proposed amendment to §350.1004, Individualized Family Service Plan (IFSP) Development, removes the acronym from the rule title to align with HHSC rulemaking standards. The amendment also makes non-substantive grammar and language revisions to improve clarity and align with HHSC rulemaking standards.

The proposed amendment to §350.1007, Interim Individualized Family Service Plan (IFSP), removes the acronym from the rule title to align with HHSC rulemaking standards. The amendment also makes non-substantive grammar and language revisions to improve clarity and align with HHSC rulemaking standards.

The proposed amendment to §350.1009, Participants in Initial and Annual Individualized Family Service Plan (IFSP) Meetings, removes the acronym from the rule title to align with HHSC rulemaking standards. The amendment makes non-substantive grammar, language, and organization revisions to improve clarity and align with HHSC rulemaking standards. The amendment to subsection (a) and deletion of subsection (b) is to remove duplicative language.

The proposed amendment to §350.1015, Content of the IFSP, removes the acronym from the rule title and spells out "IFSP" to align with HHSC rulemaking standards. The amendment clarifies existing language and makes grammar edits to align with HHSC rulemaking standards. Edits to subsections (b) and (d) revise an incorrect cross-reference.

The proposed amendment to §350.1017, Periodic Reviews, makes non-substantive clarifying grammar and language edits. The amendment to subsection (f) corrects a cross-reference.

The proposed amendment to §350.1019, Annual Meeting to Evaluate the IFSP, removes and spells out the acronym in the title to align with HHSC rulemaking standards. Edits to subsection (a) clarify requirements for the annual meeting to evaluate the IFSP after determination of continuing eligibility. Subsection (b)(1)(C) removes (i) through (iii) because they are listed in the referenced rule, §350.1307. The amendment to the section makes non-substantive language and grammar edits to enhance clarity and reduce duplication and updates references.

The proposed repeal of §350.1101, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.1104, Early Childhood Intervention Services Delivery, makes non-substantive language, grammar, and organization revisions to improve clarity.

The proposed amendment to §350.1108, State Funded Respite Services, makes a non-substantive grammar revision to the title of the rule to align with HHSC rulemaking standards. The amendment to the section makes non-substantive clarifying grammar revisions. Subsection (c)(3) removes specific language related to the hourly limit of respite services to reduce barriers. This information will be posted on the HHSC ECI website.

The proposed amendment to §350.1111, Service Delivery Documentation Requirements, makes non-substantive clarifying edits to language and grammar.

The proposed repeal of §350.1201, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.1203, Definitions, makes non-substantive language and grammar revisions to enhance clarity and align with HHSC rulemaking standards. The terms "Community Transition Meeting," "LEA Notification," "LEA Notification Opt Out," "LEA Transition Conference," "Limited Personally Identifiable Information," and " Transition Planning" are amended.

The proposed amendment to §350.1207, Transition Planning, makes non-substantive revisions to language and grammar to enhance clarity and align with HHSC rulemaking standards.

The proposed amendment to §350.1209, SEA Notification, removes the acronym in the title and spells out the term to align with HHSC rulemaking standards. The amendment makes non-substantive revisions to add acronyms for terms that are defined and separate existing language into subsections to enhance clarity.

The proposed amendment to §350.1211, Local Education Agency (LEA) Notification of Potential Eligibility for Special Education Services, removes and spells out the acronym in the title and revises the title to "Local Education Agency Notification of Potential Eligibility for Early Childhood Special Education Services" to align with HHSC rulemaking standards. The amendment to subsections (a) and (b) and subsequently, subsection (d), adds clarity.

The proposed amendment to §350.1213, LEA Notification Opt Out, changes the title to "The Family's Right to Opt Out of the Local Education Agency Notification." The amendment makes non-substantive clarifying edits and renumbers the subsections accordingly.

The proposed amendment to §350.1215, Reporting Late LEA Notifications, removes and spells out the acronym to align with HHSC rulemaking standards. The paragraph is split into new subsections (a) and (b) and edits are made for clarification.

The proposed amendment to §350.1217, LEA Transition Conference, removes and spells out the acronym to align with HHSC rulemaking standards. The amendment makes non-substantive clarifying edits. The deletion of subsection (a) removes duplicative language.

The proposed amendment to §350.1219, Transition to LEA Services, removes and spells out the acronym to align with HHSC rulemaking standards. The amendment makes non-substantive clarifying edits.

The proposed amendment to §350.1221, Transition Into the Community, updates the title to "Transition Into Community Supports and Services." The amendment makes non-substantive clarifying edits and aligns with the person-first respectful language initiative.

The proposed repeal of §350.1301, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.1307, Child Outcomes, makes non-substantive clarifying edits.

The proposed amendment to §350.1309, Family Outcomes, makes non-substantive clarifying edits.

The proposed repeal of §350.1401, Purpose, deletes the rule because the language is provided in CFR and is not necessary to restate in rule.

The proposed amendment to §350.1405, Definitions, makes non-substantive language and grammar edits to improve clarity. The terms "Ability to Pay," "Adjusted Income," "Allowable Deductions," "CHIP," "Dependent," "Family Cost Share System," "Federal Poverty Guidelines," "Gross Income," "Inability to Pay," "Maximum Charge," "Out-of-Pocket," "Sliding Fee Scale," and "Third-Party Payor" are amended.

The proposed amendment to §350.1411, Early Childhood Intervention Services Provided with No Out-of-Pocket Payment from the Parent, makes non-substantive clarifying edits and aligns with the person-first respectful language initiative.

The proposed amendment to §350.1413, Individualized Family Service Plan (IFSP) Services Subject to Out-of-Pocket Payment from the Family, removes the acronym in the title to align with HHSC rulemaking standards and changes the title to "Individualized Family Service Plan Services Subject to Out-of-Pocket Payment." The amendment makes non-substantive clarifying edits and updates a cross-reference.

The proposed amendment to §350.1431, Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI) Sliding Fee Scale, removes the acronyms in the title to align with HHSC rulemaking standards. The proposed amendment makes non-substantive grammar revisions. Existing subsection (c) is renumbered as new subsection (b) and amended to remove a sentence that no longer applies, as all children and families currently enrolled in ECI have enrolled after September 1, 2015, and updates the citation to the figure.

Figure 26 TAC §350.1431(c) is now located in new subsection (b). The table is amended for clarity and to update a formatting error.

The proposed amendment to §350.1433, Billing Families for IFSP Services, removes and spells out the acronym to align with HHSC rulemaking standards.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new regulations;

(6) the proposed rules will expand existing regulations;

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

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to protect the health, safety, and welfare of the residents of Texas; do not impose a cost on regulated persons; are amended to reduce the burden or responsibilities imposed on regulated persons by the rules; and are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Rob Ries, Deputy Executive Commissioner for Family Health Services, has determined that for each year of the first five years the rules are in effect, the public benefit will be improved ECI services for infants and toddlers with developmental delays or disabilities by addressing barriers in recruitment of ECI professionals for ECI subrecipients. The rules will also benefit the public through improving clarity of processes and procedures, ultimately reducing confusion and complications for ECI subrecipients.

Trey Wood has also determined that for the first five years the rules are in effect, there are no anticipated economic costs to persons who are required to comply with the proposed rules because there are no changes in ECI processes or procedures, therefore there are no changes in how required persons comply with the rules.

TAKINGS IMPACT ASSESSMENT

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

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to ECI.Policy@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R028" in the subject line.

SUBCHAPTER A. GENERAL RULES

26 TAC §350.101

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.101. Purpose.

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

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Karen Ray

Chief Counsel

Health and Human Services Commission

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26 TAC §350.103, §350.107

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.103. Definitions.

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

(1) Assessment--As defined in 34 CFR §303.321(a)(2)(ii), the ongoing procedures used by appropriate qualified personnel [~~throughout the period of a child's eligibility for early childhood intervention (ECI) services~~] to assess the child's individual strengths and needs and determine the appropriate services to meet those needs throughout the period of a child's eligibility for ECI services.

(2) Child--An infant or toddler under the age of three. [~~toddler, from birth through 35 months, as defined in 34 CFR §303.21.~~]

(3) Child find [~~Find~~]--As described in 34 CFR §§303.115, 303.302, and 303.303, activities and strategies designed to locate and identify, as early as possible, infants and toddlers with developmental delay.

(4) CFR--Code of Federal Regulations. The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

(5) [~~(4)~~] Complaint--A formal written allegation submitted to HHSC [~~the Texas Health and Human Services Commission (HHSC)~~] stating that a requirement of IDEA Part C [~~the Individuals with Disabilities Education Act (IDEA)~~] or an applicable federal or state regulation has been violated.

(6) [~~(5)~~] Comprehensive needs assessment [~~Needs Assessment~~]--The process [~~Conducted by an interdisciplinary team as defined in paragraph (25) of this section as a part of the Individualized Family Services Plan (IFSP) development process, the process~~] for identifying a child's unique strengths and needs, and the family's resources, concerns, and priorities in order to develop an IFSP. The comprehensive needs assessment: [~~The comprehensive assessment process gathers information across developmental domains regarding the child's abilities to participate in the everyday routines and activities of the family.~~]

(A) is conducted by an interdisciplinary team as defined in paragraph (29) of this section; and

(B) gathers information across developmental domains regarding the child's abilities to participate in the everyday routines and activities of the family.

[~~(6) Condition with a High Probability of Resulting in Developmental Delay--A medical diagnosis known and widely accepted within the medical community to result in a developmental delay over the natural course of the diagnosis.~~]

(7) Consent--As defined in 34 CFR §303.7 and meeting all requirements in 34 CFR §303.420.

[~~(8) Contractor--A local private or public agency with proper legal status and governed by a board of directors or governing authority that accepts funds from HHSC to administer an early childhood intervention program.~~]

(8) [~~(9)~~] Co-visits--When two or more ECI professionals [~~service providers~~] deliver different services to the child during the same period of time. Co-visits are provided when a child will receive greater benefit from services being provided at the same time, rather than individually.

(9) [~~(10)~~] Days--Calendar days, except for LEA [~~local education agency (LEA)~~] services, which are defined as "school days."

(10) [~~(11)~~] Developmental delay [~~Delay~~]--As defined in Texas Human Resources Code §73.001(3) and determined to be sig-

nificant in compliance with the criteria and procedures in Subchapter H of this chapter (relating to Eligibility, Evaluation, and Assessment).

(11) [(12)] Developmental screenings [Screenings]--General screenings provided by the ECI [early childhood intervention] program to assess the child's need for further evaluation.

(12) DFPS--Department of Family and Protective Services. The state agency that provides family reunification services for families. These services are provided to families and children to protect the children from abuse and neglect and help the family reduce the risk of abuse and neglect.

(13) ECI--Early Childhood Intervention.

(14) ECI professional--An individual employed by or under the direction of an ECI program who meets the requirements of qualified personnel as defined in 34 CFR §303.13(c) and §303.31, and who is knowledgeable in child development and developmentally appropriate behavior, possesses the requisite education and experience, and demonstrates competence to provide ECI services.

(15) [(13)] ECI program [Early Childhood Intervention Program]--In addition to the definition of early intervention service program as defined in 34 CFR §303.11, a program operated by a subrecipient of HHSC ECI [the contractor] with the express purpose of implementing a system to provide ECI [early childhood intervention] services to children with developmental delays and their families.

(16) [(14)] ECI services [Early Childhood Intervention Services]--Individualized IDEA Part C [early childhood intervention] services determined by the IFSP team to be necessary to support the family's ability to enhance their child's development. ECI [Early childhood intervention] services are further defined in 34 CFR §303.13 and §303.16 and §350.1105 of this chapter (relating to Capacity to Provide Early Childhood Intervention Services).

[(15) ECI Professional--An individual employed by or under the direction of an HHSC Early Childhood Intervention Program contractor who meets the requirements of qualified personnel as defined in 34 CFR §303.13(c) and §303.31, and who is knowledgeable in child development and developmentally appropriate behavior, possesses the requisite education and experience, and demonstrates competence to provide ECI services.]

(17) ECSE--Early Childhood Special Education. The state and federally mandated program for young children with disabilities ages three to five under IDEA Part B, Section 619.

(18) [(16)] EIS--Early intervention specialist [Intervention Specialist]. A credentialed professional who meets specific educational requirements established by HHSC ECI in §350.313(a) of this chapter (relating to Early Intervention Specialist[(EIS)]) and has specialized knowledge in early childhood cognitive, physical, communication, social-emotional, and adaptive development.

(19) [(17)] Evaluation--The procedures used by qualified personnel to determine a child's initial and continuing eligibility for ECI [early childhood intervention] services that comply with the requirements described in 34 CFR §303.21 and §303.321.

(20) Face-to-face--The delivery of ECI services in-person or via telehealth.

(21) [(18)] FERPA--Family Educational Rights and Privacy Act of 1974, 20 USC §1232g, as amended, and implementing regulations at 34 CFR Part 99. Federal law that outlines privacy protection for parents and children enrolled in the ECI program. FERPA includes rights to confidentiality and restrictions on disclosure of personally identifiable information, and the right to inspect records.

(22) [(19)] Group services [Services]--ECI [Early childhood intervention] services provided at the same time to no more than four children and their parent or parents or routine caregivers per ECI professional [service provider] to meet the developmental needs of the individual infant or toddler.

(23) [(20)] HHSC--Texas Health and Human Services Commission. [The entity designated as the lead agency by the governor under the Individuals with Disabilities Education Act, Part C.]

(A) HHSC has the final authority and responsibility for the administration, supervision, and monitoring of programs and activities under this system.

(B) HHSC has the final authority for the obligation and expenditure of funds and compliance with all applicable laws and rules.

(24) [(21)] HHSC ECI--[The] Texas Health and Human Services Commission Early Childhood Intervention [Services]. The entity designated as the lead agency, as defined by 34 CFR §303.22. HHSC ECI is [state program] responsible for maintaining and implementing the statewide IDEA Part C system. [early childhood intervention system required under the Individuals with Disabilities Education Act, Part C, as amended in 2004.]

(25) IDEA Part C--The Individuals with Disabilities Education Act, Part C, as amended in 2004.

(26) [(22)] IFSP--Individualized Family Service Plan as defined in 34 CFR §303.20. A written plan of care for providing ECI [early childhood intervention] services and other medical, health, and social services to an eligible child and the child's family when necessary to enhance the child's development. The IFSP is considered complete when the parent has signed the IFSP and received a copy.

(27) [(23)] IFSP services [Services]--The individualized ECI [early childhood intervention] services listed in the IFSP that have been determined by the IFSP team to be necessary to enhance an eligible child's development.

(28) IFSP services pages--The standardized form designated by HHSC ECI that constitutes the required final pages of the IFSP used to record ECI services planned for the child.

(29) [(24)] IFSP team [Team]--An interdisciplinary team that meets the requirements in 34 CFR §303.24(b) and works collaboratively to develop, review, modify, and approve the IFSP. The IFSP team includes, at a minimum, the child's parent and at least two ECI professionals from different disciplines or professions. [It includes the parent; the service coordinator; all ECI professionals providing services to the child, as planned on the IFSP; certified Teachers of the Deaf and Hard of Hearing, as appropriate; and certified Teachers of Students with Visual Impairments, as appropriate.]

(A) At least one of the ECI professionals must be the family's assigned service coordinator.

(B) At least one of the ECI professionals must be an LPHA.

(C) At least one ECI professional must have been involved in conducting the evaluation. This may be the LPHA or another professional.

(D) If the LPHA attending the IFSP meeting did not conduct the evaluation, the subrecipient must ensure that the most recent observations and conclusions of the LPHA who conducted the evaluation were communicated to the LPHA attending the initial IFSP meeting and incorporated into the IFSP.

(E) Other team members may participate by other means acceptable to the team.

(30) [~~(25)~~] Interdisciplinary team [~~Team~~]--In addition to the definition of multidisciplinary team as defined in 34 CFR §303.24, a team that consists of at least two ECI professionals from different disciplines and the child's parent.

(A) One of the ECI professionals must be an LPHA. [~~a Licensed Practitioner of the Healing Arts (LPHA).~~]

(B) The team may include representatives of the LEA.

(C) Professionals on the team shall share a common perspective regarding infant and toddler development and developmental delay [~~and work collaboratively to conduct evaluation, assessment, IFSP development, and to provide intervention~~].

(D) Professionals on the team must work collaboratively to:

(i) conduct the evaluation and assessment;

(ii) develop the IFSP; and

(ii) provide ECI services.

(31) [~~(26)~~] LEA--Local educational agency as defined in 34 CFR §303.23.

(32) [~~(27)~~] LPHA--Licensed practitioner of the healing arts [~~Practitioner of the Healing Arts~~]. A licensed physician, registered nurse, licensed physical therapist, licensed occupational therapist, licensed speech language pathologist, licensed professional counselor, licensed clinical social worker, licensed psychologist, licensed dietitian, licensed audiologist, licensed physician assistant, licensed marriage and family therapist, licensed intern in speech language pathology, licensed behavior analyst, or advanced practice registered nurse who is an employee or a subcontractor of an ECI subrecipient. [~~contractor.~~] LPHA responsibilities are further described in §350.312 of this chapter (relating to Licensed Practitioner of the Healing Arts). [~~Arts (LPHA)).~~]

(33) [~~(28)~~] Medicaid--The medical assistance entitlement program administered by HHSC.

(34) MOU--Memorandum of understanding. A written document evidencing the understanding or agreement of two or more parties regarding the subject matter of the agreement.

(35) [~~(29)~~] Native language [~~Language~~]--As defined in 34 CFR §303.25.

(A) When used with respect to an individual who is limited English proficient (as that term is defined in IDEA Part B, Section 602(18)), [~~section 602(18) of the Individuals with Disabilities Education Act),~~] native language means:

(i) the language normally used by that individual, or, in the case of a child, the language normally used by the parents of the child; and

(ii) for evaluations and assessments conducted pursuant to 34 CFR §303.321(a)(5) and (a)(6), the language normally used by the child, if determined developmentally appropriate for the child by qualified personnel conducting the evaluation or assessment.

(B) When used with respect to an individual who is deaf or hard of hearing, blind or visually impaired, or for an individual with no written language, "native language" means the mode of communication that is normally used by the individual (such as sign language, braille, or oral communication).

(36) [~~(30)~~] Natural environments [~~Environments~~]--As defined in 34 CFR §303.26, settings that are natural or typical for a same-aged infant or toddler without a disability. A natural environment[~~,~~] may include the home or community settings, include [~~includes~~] the daily activities of the child and family or caregiver, and must be consistent with the provisions of 34 CFR §303.126.

(37) [~~(31)~~] Parent--As defined in 20 USC §1401(23) [~~§1401~~] and 34 CFR §303.27.

(38) [~~(32)~~] Personally identifiable information [~~Identifiable Information~~]--As defined in 34 CFR §99.3 and 34 CFR §303.29.

(39) [~~(33)~~] Pre-enrollment [~~Pre-Enrollment~~]--All family-related activities from the time the referral is received up until the time the parent signs the initial IFSP.

(40) [~~(34)~~] Primary referral sources [~~Referral Sources~~]--As defined in 34 CFR §303.303(c).

(41) [~~(35)~~] Public agency [~~Agency~~]--HHSC and any other state agency or political subdivision of the state that is responsible for providing ECI [~~early childhood intervention~~] services to eligible children under IDEA [~~the Individuals with Disabilities Education Act,~~] Part C.

(42) [~~(36)~~] Qualifying medical diagnosis [~~Medical Diagnosis~~]--A diagnosed medical condition that has a high probability of developmental delay as determined by HHSC, as described in §350.811 of this chapter (relating to Qualifying Medical Diagnosis).[~~Eligibility Determination Based on Medically Diagnosed Condition That Has a High Probability of Resulting in Developmental Delay).~~]

(43) [~~(37)~~] Referral date [~~Date~~]--The date the child's name and sufficient information to contact the family was obtained by the subrecipient. [~~contractor.~~]

(44) [~~(38)~~] Routine caregiver [~~Caregiver~~]--An adult who:

(A) has written authorization from the parent to participate in ECI [~~early childhood intervention~~] services with the child, even in the absence of the parent;

(B) participates in the child's daily routines;

(C) knows the child's likes, dislikes, strengths, and needs; and

(D) may be the child's relative, childcare provider, or other person who regularly cares for the child.

(45) SEA--State educational agency as defined by 34 CFR §303.3(b).

(46) [~~(39)~~] Service coordinator [~~Coordinator~~]--An employee or subcontractor of an ECI subrecipient [~~The contractor's employee or subcontractor~~] who:

(A) meets all applicable requirements in Subchapter C of this chapter (relating to Staff Qualifications);

(B) is assigned to be the single contact point for the family;

(C) is responsible for providing case management services as described in §350.405 of this chapter (relating to Case Management Services); and

(D) is from the profession most relevant to the child's or family's needs or is otherwise qualified to carry out all applicable responsibilities.

(47) SRS--Specialized rehabilitative services. Rehabilitative services outlined in §350.501 of this chapter (relating to

Specialized Rehabilitative Services) that promote age-appropriate development by correcting deficits and teaching compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions.

(48) SST--Specialized skills training. As defined by 34 CFR 303.13(b)(14). SST seeks to reduce the child's functional limitations across developmental domains, including strengthening the child's cognitive skills, positive behaviors, and social interactions.

(49) Subrecipient--A local private or public agency with proper legal status and governed by a board of directors or governing authority that accepts funds from HHSC to administer an ECI program.

(50) [(40)] Surrogate parent [Parent]--A person assigned to act as a surrogate for the parent in compliance with IDEA Part C [the Individuals with Disabilities Education Act, Part C] and this chapter.

(51) TAC--Texas Administrative Code. A compilation of all state agency rules in Texas.

(52) TCM--Targeted case management. Case management activities that meet criteria in §350.405(c) of this subchapter and are reimbursable by Medicaid when provided to Medicaid-enrolled children who are eligible for ECI.

(53) TEA--Texas Education Agency. The state agency that oversees primary and secondary public education. It is headed by the commissioner of education.

(54) [(41)] Telehealth services--Health care [Healthcare] services, other than telemedicine medical services, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient who is located at a different physical location than the health professional using synchronous audio-visual telecommunications or information technology.

(55) USC--United States Code. The official codification of the general and permanent federal statutes of the United States.

§350.107. Health Standards for Early Childhood Intervention Services.

(a) The subrecipient [contractor] must implement written policies and procedures that cover the following areas:

(1) administration of medication, if applicable;

(2) infectious disease prevention and management, [management] including:

(A) adherence to universal precautions as defined by the Centers for Disease Control of the United States Public Health Service;

(B) compliance with the Texas Communicable Disease Prevention and Control Act, Texas Health and Safety Code[,] Chapter 81; and

(C) immunization guidelines [and requirements] as specified by the Texas Department of State Health Services.

(b) The subrecipient [contractor] must follow all federal and state laws [law] and regulations regarding providing services and maintaining records for families and children with Human Immunodeficiency Virus [HIV] or other communicable diseases. [disease.]

(c) The subrecipient must not refuse to provide ECI services to a child based solely on the family's refusal or failure to obtain a vaccine or immunization for a particular infectious or communicable disease. The subrecipient is not in violation of this rule if the subrecipient adopts a policy requiring children receiving group services to be vaccinated or immunized against a particular infection or communicable disease if the policy provides an exemption from each required vaccination or immunization based on:

(1) a reason of conscience, including a sincerely held religious belief, observance, or practice, that is incompatible with the administration of the vaccination or immunization; or

(2) a recognized medical condition for which the vaccination or immunization is contraindicated.

[(c) Children who participate in any ECI group activities must have immunizations as recommended by the Texas Department of State Health Services. The contractor must inform the family of the importance of immunizations and assist the family with obtaining immunizations if necessary. An exception may be made if medical or religious reasons prevent immunizations. If so, documentation must be maintained, and the family must be notified that the child may be excluded from group activities if a contagious outbreak occurs.]

(d) The subrecipient must accept oral or written requests for an exemption.

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

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Karen Ray
Chief Counsel
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SUBCHAPTER B. PROCEDURAL SAFEGUARDS AND DUE PROCESS PROCEDURES

26 TAC §350.201

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.201. Purpose.

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

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26 TAC §350.209, §350.225

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.209. Parent Rights in the Individualized Family Service Plan [~~(IFSP)~~] Process.

The subrecipient [~~contractor~~] must explain the contents of the IFSP to the parent or parents and obtain informed written consent from a parent before providing any ECI [~~early childhood intervention~~] services. A [~~The~~] parent has the right to:

(1) be present and participate in the development of the IFSP;

(2) have decisions about ECI [~~early childhood intervention~~] services made based on the individualized needs of the child and family;

(3) receive a full explanation of the IFSP, including the identified strengths and needs of the child and family, priorities of the family, the developmental goals for the child and the recommended services to meet those goals, and any identified service coordination and case management goals;

(4) consent to some, but not all, ECI [~~early childhood intervention~~] services;

(5) receive all IFSP services for which the parent gives consent;

(6) request an administrative hearing or file a complaint with HHSC [~~the Texas Health and Human Services Commission~~] if the parent does not agree with the other IFSP team members;

(7) indicate disagreement in writing in the parent's native language with a part of the IFSP, even if [~~though~~] the parent consents to ECI [~~early childhood intervention~~] services;

(8) have the IFSP written in the parent's native language, as defined in §350.103 of this chapter (relating to Definitions), or mode of communication; and

(9) receive a complete copy of the IFSP in a timely manner.

§350.225. Amendment of Records at Parent's Request.

(a) A parent who believes that information in records collected, maintained, or used under this section is inaccurate, misleading, [~~inaccurate or misleading~~] or a violation of [~~violates~~] the privacy or other rights of the child, may request that the subrecipient [~~the contractor which maintains the information to~~] amend the information.

(b) The subrecipient [~~contractor~~] decides whether to amend the information in accordance with the request no more than [~~within~~] 30 days after the request is made.

(c) If, after review of the request, the subrecipient [~~contractor~~] decides the information is inaccurate, misleading, [~~misleading~~] or otherwise in violation of the privacy or other rights of the child, it amends the record accordingly and informs the parent in writing.

(d) If the subrecipient [~~contractor~~] refuses to amend the information in accordance with the request, it informs the parent of the refusal, and advises the parent of the right to a hearing conducted in accordance with the requirements of [~~the~~] FERPA.

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

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SUBCHAPTER C. STAFF QUALIFICATIONS

26 TAC §350.301

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.301. Purpose.

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

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26 TAC §§350.303, 350.309, 350.312, 350.313, 350.315

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of

services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.303. Definitions.

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

(1) Criminal background check [Background Check]--Review of fingerprint-based criminal history record information.

(2) Dual relationships [Relationships]--When the person providing ECI [early childhood intervention] services engages in activities with the family that go beyond his or her professional boundaries.

(3) EIS active status--Refers to the current standing of an EIS who has maintained a current credential by fulfilling all necessary initial credentialing and renewal requirements by their respective due dates. An EIS is considered active upon completion of the current orientation to HHSC ECI and remains on active status by completing initial credentialing requirements and continuing education requirements as defined in §350.313 of this subchapter (relating to Early Intervention Specialist). [Early Intervention Specialist (EIS) Active Status--When an EIS is employed or subcontracting with a contractor and holds a current active credential.]

(4) EIS inactive status--Refers to the current standing of an EIS who is [Early Intervention Specialist (EIS) Inactive Status--When an EIS is] not employed or subcontracting with an ECI program [a contractor] or does not hold a current active credential.

(A) An EIS is considered on long-term inactive status when they are on inactive status for 48 months or more since the date the EIS credential was removed from their record or the date their employment was terminated.

(B) An EIS is considered on short-term inactive status when they are on inactive status for less than 48 months since the date the EIS credential was removed from their record or the date their employment was terminated.

(5) EIS past due status--Refers to the current standing of an EIS whose credential has lapsed.

(A) An EIS is considered on past due status when:

(i) the EIS fails to complete initial credentialing or renewal activities by the designated due date; or

(ii) the EIS transfers from another ECI program and fails to complete the orientation to HHSC ECI within 30 days after their hire date, unless the EIS has documentation that they have completed the current orientation module.

(B) An EIS is considered on long-term past due status when they are on past due status for 48 months or more since their credential lapsed.

(C) An EIS is considered on short-term past due status when they are on past due status for less than 48 months since their credential lapsed.

(6) [(5)] EIS Registry--A system used by HHSC ECI to maintain current required EIS information submitted by ECI programs. [contractors. HHSC ECI designates Early Intervention Specialists. The EIS credential is only valid within the Texas IDEA Part C system.]

(7) [(6)] IPDP--Individualized Professional Development Plan. [Individualized Professional Development Plan (IPDP)--] The training and technical assistance plan developed when a staff person begins employment at an ECI program. [contractor. The IPDP can include but is not limited to orientation training, EIS credentialing activities, service coordination training, and other training or professional development required by the program or HHSC ECI.]

(8) [(7)] Professional boundaries [Boundaries]--Financial, physical, and emotional limits to the relationship between the ECI professional providing ECI [early childhood intervention] services and the family.

(9) [(8)] Service coordinator active status--Refers to the current standing of a service coordinator who is [Coordinator Active Status--When a service coordinator is] employed by or subcontracting with an ECI program [a contractor] and is current with continuing education requirements specified by HHSC ECI.

(10) [(9)] Service coordinator inactive status--Refers to the current standing of a service coordinator who [Coordinator Inactive Status--When a service coordinator] is not employed by or subcontracting with an ECI program [a contractor] or is not current with continuing education requirements specified by HHSC ECI.

§350.309. Minimum Requirements for All Direct Service Staff.

(a) For the purposes of this section, the following terms are defined as follows.

(1) Consultation--Evaluation and development of staff knowledge, skills, and abilities in the context of case-specific problem solving.

(2) Record review--A review of documentation in child records to evaluate compliance with the requirements of this chapter, and quality, accuracy, and timeliness of documentation. It also includes feedback to staff to identify areas of strength and areas that need improvement.

(3) Observation--Watching staff interactions with children and families and providing guidance and feedback about the interaction.

(b) [(a)] The subrecipient [contractor] must comply with HHSC ECI [the Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI)] requirements related to health regulations for all direct service staff. The subrecipient [contractor] must comply with 2 CFR Part 3485 [34 CFR Part 85] and Texas Health and Safety Code Chapter 81.

(c) [(b)] The subrecipient [contractor] must comply with HHSC ECI requirements related to initial training requirements for direct service staff. Before providing services, all staff must:

(1) with the exception of teachers of the deaf or hard of hearing, teachers of students with visual impairment, and certified orientation and mobility specialists, complete orientation training as required by HHSC ECI; [ECI. This requirement does not apply to staff employed by the Local Education Agency (LEA);]

(2) hold current certification in first-aid and cardiopulmonary resuscitation for children and infants; and

(3) complete universal precautions training that aligns with recommendations from the Centers for Disease Control and Prevention.

(d) [(c)] The subrecipient [contractor] must comply with HHSC ECI requirements related to continuing education requirements

for direct service staff. All staff providing ECI [early childhood intervention] services to children and families must maintain current certification in first aid and cardiopulmonary resuscitation for children and infants.

(e) [(d)] With the exception of teachers of the deaf or hard of hearing, teachers of students with visual impairments, and certified orientation and mobility specialists, the subrecipient [The contractor] must verify that all newly employed staff: [staff, except staff employed by the LEA:]

(1) are qualified in terms of education and experience for their assigned scopes of responsibilities;

(2) are competent to perform the job-related activities before providing ECI [early childhood intervention] services; and

(3) complete orientation training as required by HHSC ECI before providing ECI [early childhood intervention] services.

(f) [(e)] The subrecipient [contractor] must comply with HHSC ECI requirements related to supervision of direct service staff. A subrecipient [contractor] must implement a system of supervision and oversight that consists of consultation, record review, and observation from a qualified supervisor. [The intent of supervision is to provide oversight and direction to staff.] Supervisor qualifications are further described in §350.313(d) [§350.313(c)] and §350.315(e) [§350.315(d)] of this subchapter (relating to Early Intervention Specialist [(EIS)] and Service Coordinator, respectively).

[(1) Consultation means evaluation and development of staff knowledge, skills, and abilities in the context of case-specific problem solving.]

[(2) Record review means a review of documentation in child records to evaluate compliance with the requirements of this chapter, and quality, accuracy, and timeliness of documentation. It also includes feedback to staff to identify areas of strength and areas that need improvement.]

[(3) Observation means watching staff interactions with children and families to provide guidance and feedback and providing guidance and feedback about the observation.]

(g) [(f)] The subrecipient [contractor] must follow all training requirements mandated [defined] by HHSC ECI.

§350.312. Licensed Practitioner of the Healing Arts [(LPHA)].

(a) The LPHA participates in eligibility determination as part of the interdisciplinary team and provides necessary clinical knowledge for the IFSP team to plan and implement individualized services focused on helping families to support their children with attaining developmental goals [individualized, goal oriented services] within an interdisciplinary approach.

(b) The LPHA is responsible for:

(1) documenting [LPHA's responsibility is to document] the child's progress towards the IFSP goals; [outcomes,]

(2) recommending [recommend] to the team modifications to the plan as needed; [needed,] and

(3) providing assessments [provide re-assessments] or ongoing therapy services as planned on the IFSP.

(c) The [A] LPHA is required to sign the IFSP and in doing so acknowledges the planned services are reasonable and necessary.

(d) The LPHA must provide [provides] ongoing monitoring and assessment of the IFSP, at least once every six months as part of the periodic review, in order to provide a professional opinion as to the effectiveness of services.

§350.313. Early Intervention Specialist [(EIS)].

(a) The subrecipient [The contractor] must comply with HHSC ECI [the Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI)] requirements related to minimum qualifications for an EIS.

(1) An individual who meets one of the following criteria is eligible for EIS credentialing. [An EIS must meet one of the following criteria:]

(A) Be [be] registered as an EIS before September 1, 2011. [2011;]

(B) Hold [hold] a bachelor's or graduate degree from an accredited university with: [with a bachelor or graduate degree specialization in:]

(i) academic transcripts reflecting the successful completion of required coursework for an EIS, designated by HHSC ECI; or [early childhood development;]

(ii) three years of experience within the last ten years working for an IDEA Part C program in the United States or a United States territory providing special instruction, as defined in 34 CFR §303.13(b)(14), or SST, as defined in §350.501(a)(4) of this chapter (relating to Specialized Rehabilitative Services), to infants and toddlers with developmental delays or disabilities and their families.

[(ii) early care and early childhood;]

[(iii) early childhood special education; or]

[(iv) human development and family studies;]

(C) If an individual lacks some of the required coursework referenced in paragraph (1)(B)(i) of this subsection, they may complete applicable contact hours of continuing education:

(i) up to the maximum amount set by HHSC ECI; and

(ii) that meets HHSC ECI requirements.

[(C) hold a bachelor's or graduate degree from an accredited university in a field related to early childhood intervention. For each of the following fields, transcripts of degree coursework must reflect successful completion of at least nine semester course credit hours relevant to early childhood intervention and three semester course credit hours that focus on early childhood development or early childhood special education. Related fields include:]

[(i) psychology;]

[(ii) social work;]

[(iii) counseling;]

[(iv) special education (without early childhood emphasis); and]

[(v) sociology;]

[(D) hold a bachelor's or graduate degree from an accredited university in a field unrelated to early childhood intervention. For fields unrelated to early childhood intervention, transcripts of degree coursework must reflect successful completion of at least 15 semester course credit hours relevant to early childhood intervention and three semester course credit hours that focus on early childhood development or early childhood special education; or]

[(E) hold a bachelor's or graduate degree from an accredited university with three years of experience within the last ten years working for an Individuals with Disabilities Education Act, Part C program in the United States or a United States territory providing special instruction, as defined in 34 CFR §303.13(b)(14), or specialized skills training, as defined in §350.501(a)(4) of this chapter, to infants and toddlers with developmental delays or disabilities and their families.]

[(2) If an EIS has not completed three of the required hours of semester course credit relevant to early childhood intervention provided in paragraph (1)(C) and (D) of this subsection, the EIS must complete forty clock hours of continuing education that is relevant to early childhood intervention within three years prior to employment as an EIS. If the contractor hires an EIS who does not have the necessary hours, the EIS must complete these hours no more than 30 days after the EIS's hire date.]

[(3) If an EIS has not completed the required three hours of semester course credit in early childhood development or early childhood special education provided in paragraph (1)(C) and (D) of this subsection, the EIS must complete forty clock hours of continuing education in early childhood development or early childhood special education within three years prior to employment as an EIS. If the contractor hires an EIS who does not have the necessary hours, the EIS must complete these hours no more than 30 days after the EIS's hire date.]

[(4) Coursework or previous training in early childhood development or early childhood special education is required to ensure that an EIS understands the development of infants and toddlers because the provision of specialized skills training for which an EIS is solely responsible depends on significant knowledge of typical child development. Therefore, the content of the three hours of coursework described in paragraph (1)(C) and (D) of this subsection, and the forty clock hours of continuing education described in paragraph (2) of this subsection must relate to the growth, development, and education of the young child and may include courses or training in:]

[(A) child growth and development;]

[(B) child psychology;]

[(C) children with special needs; or]

[(D) typical language development.]

(b) The subrecipient must comply with HHSC ECI requirements related to initial credentialing for an EIS.

(1) An EIS must read and sign the EIS code of ethics prior to the creation of an employee record on the EIS Registry.

(2) An EIS must complete the current orientation to ECI training, as designated by HHSC ECI, and develop an IPDP with their supervisor within 30 days after the EIS's hire date.

(3) An EIS must complete the EIS IPDP no more than one year after their hire date.

(c) The subrecipient [(b) The contractor] must comply with HHSC ECI requirements related to the biennial renewal of the EIS credential. [continuing education for an EIS.]

(1) Every two years after obtaining the EIS credential, an [An] EIS must complete a minimum of:

(A) [(1) a minimum of] 20 contact hours of continuing professional education (CPE) that has been approved by their supervisor [approved continuing education every two years]; and

(B) [(2) an additional] three contact hours of CPE [continuing education] in ethics that has been approved by their supervisor. [every two years.]

(d) [(c)] The subrecipient [contractor] must comply with HHSC ECI requirements related to supervision of an EIS.

(1) The subrecipient [contractor] must provide supervision for an EIS [supervision] as defined in §350.309(f) [§350.309(e)] of this subchapter [chapter] (relating to Minimum Requirements for All Direct Service Staff) as required by HHSC ECI.

(2) An EIS supervisor must:

(A) have two years of experience providing ECI services, or two [2] years of experience supervising staff who provide ECI [other early childhood intervention] services to children and families; and

(B) meet the minimum requirements in subsection (a) of this section. [be an active EIS or hold a bachelor's degree or graduate degree from an accredited university with a specialization in:]

[(i) child development, special education, psychology, social work, sociology, nursing, rehabilitation counseling, human development, or related field; or]

[(ii) an unrelated field and have at least 18 hours of semester course credit in child development.]

(e) [(d)] Requirements for EIS active status, EIS past due status, [status] and EIS inactive status are as follows.

(1) Only an EIS with active status is allowed to provide ECI [early childhood intervention] services to children and families.

(2) An EIS on past due status or inactive status may not perform any ECI services. [activities requiring the EIS active status.]

(A) [(2)] An EIS goes on past due [inactive] status when:

(i) the EIS fails to complete initial credentialing or renewal activities by the designated due date; or

(ii) the EIS transfers from another ECI program and fails to complete the orientation to ECI within 30 days after their hire date, unless the EIS has documentation that they have completed the current orientation module.

[(A) the EIS fails to submit the required documentation by the designated deadline.]

[*(i)* Orientation to ECI training must be completed within 30 days, from the EIS's start date.

(ii) If an EIS is required to submit the clock hours described in subsection (a)(2) or (a)(3) of this section, the clock hours must be completed no more than 30 days after the EIS's hire date.]

[*(iii)* If an EIS is transferring from another program, the Orientation to ECI training must be completed within 30 days from the EIS's start date unless the EIS has documentation he or she has completed the current Orientation module.]

[*(iv)* All credentialing activities (Final Individualized Professional Development Plan) must be completed within one year from the EIS's start date.]

[*(v)* If, due to exceptional circumstances, an EIS is unable to submit documentation of completion of credentialing activities by the designated due date, the EIS's supervisor must contact the HHSC ECI EIS credentialing specialist as soon as he or she is aware the due date will not be met. The credentialing specialist and his or her

supervisor will work with the EIS's supervisor and the EIS to determine an appropriate course of action.]

(B) An EIS goes on inactive status when the EIS is no longer employed by a subrecipient or has the EIS credential removed from their record in the Texas Kids Intervention Database System.

[(B) the EIS fails to submit documentation of required continuing education and ethics training by the designated deadline. An EIS may return to active status from inactive status by submitting the required documentation in accordance with subsection (b) of this section.]

(C) If, due to exceptional circumstances, an EIS is unable to submit documentation of completion of credentialing activities by the designated due date, the EIS's supervisor must contact the HHSC ECI EIS credentialing specialist as soon as he or she is aware the due date will not be met. The credentialing specialist and his or her supervisor will work with the EIS's supervisor and the EIS to determine an appropriate course of action.

[(C) the EIS is no longer employed by a contractor. An EIS may return to active status from inactive status by:]

[*(i)* submitting 10 contact hours of continuing education for each year of inactive status; and]

[*(ii)* submitting documentation of three contact hours of ethics training within the last two years.]

[(3) An EIS who has been on inactive status for longer than 48 months from his or her first missed continuing education submission date must complete all credentialing activities, including the current Orientation to ECI and EIS Individualized Personnel Development Plan.]

[(4) EIS active status is considered reinstated after the information is entered into the EIS Registry and is approved by HHSC ECI.]

[(e) The contractor must comply with HHSC ECI requirements related to ethics for an EIS. An EIS who violates any of the standards of conduct in §350.314 of this subchapter (relating to EIS Code of Ethics) is subject to the contractor's disciplinary procedures. Additionally, the contractor must complete an EIS Code of Ethics Incident Report in the EIS Registry.]

(f) Requirements for reinstating EIS active status are as follows.

(1) An EIS who has been on short-term past due status or short-term inactive status must submit the required contact hours of continuing professional education and ethics training for their missed renewal dates.

(2) An EIS who has been on long-term past due status or long-term inactive status must complete all initial credentialing activities in subsection (b) of this section.

(3) EIS active status is considered reinstated after the information is entered into the EIS Registry and is approved by HHSC ECI.

[(f) Contractors must contact the HHSC ECI state office when hiring a new EIS to verify if an EIS Code of Ethics Incident Report has been recorded in the EIS Registry.]

(g) The subrecipient must comply with HHSC ECI requirements related to ethics for an EIS.

(1) The subrecipient must establish and maintain disciplinary procedures that apply to all EISs upon violations of standards of conduct in §350.314 of this subchapter (relating to EIS Code of Ethics).

(2) An EIS who violates any of the standards of conduct is subject to the subrecipient's disciplinary procedures.

(3) The subrecipient must complete an EIS Code of Ethics Incident Report in the EIS Registry when an EIS violates any of the standards of conduct.

(h) Subrecipients must contact HHSC ECI when hiring a new EIS to verify if an EIS Code of Ethics Incident Report has been recorded in the EIS Registry.

§350.315. Service Coordinator.

(a) The subrecipient must [Early Childhood Intervention (ECI) case management may only be provided by an employee or subcontractor of an ECI contractor. The contractor must] comply with HHSC [the Texas Health and Human Services Commission (HHSC)] ECI requirements related to minimum qualifications for service coordinators.

(b) ECI service coordination, case management, and TCM as defined by §350.103 of this chapter (relating to Definitions) may only be provided by a service coordinator who is employed by or subcontracts with an ECI subrecipient.

(1) A service coordinator must meet one of the following criteria:

(A) be a licensed professional in a discipline relevant to early childhood intervention;

(B) be an EIS [Early Intervention Specialist (EIS)] or meet the qualifications for an EIS as defined in §350.313 of this subchapter (relating to Early Intervention Specialist); [subchapter;]

(C) be a registered nurse [Registered Nurse] (with a diploma, an associate's, bachelor's, or advanced degree) licensed by the Texas Board of Nursing; or

(D) hold a bachelor's degree or graduate degree from an accredited university with coursework that is relevant to ECI service coordination, as designated by HHSC ECI. [a specialization in:]

[*(i)* child development, special education, psychology, social work, sociology, nursing, rehabilitation counseling, or human development or a related field; or]

[*(ii)* an unrelated field with at least 18 hours of semester course credit in child development or human development.]

(2) Before performing service coordination, case management, or TCM [case management] activities, a service coordinator must complete HHSC ECI-required [ECI required] case management training and develop an IPDP with their supervisor. [that includes, at a minimum, content which results in:]

[(A) knowledge and understanding of the needs of infants and toddlers with disabilities and their families;]

[(B) knowledge of the Individuals with Disabilities Education Act, Part C;]

[(C) understanding of the scope of early childhood intervention services available under the early childhood intervention program and the medical assistance program; and]

[(D) understanding of other state and community resources and supports necessary to coordinate care.]

(3) A service coordinator must complete all assigned activities on the service coordinator's IPDP no more than one year after

[Individualized Professional Development Plan within one year from] the service coordinator's start date.

(4) A service coordinator must effectively communicate in the family's native language or use an interpreter or translator.

(c) [(b)] A service coordinator who was employed as a service coordinator by a subrecipient [contractor] before March 1, 2012, [2012] and who does not meet the requirements of subsection (b)(1) [(a)(1)] of this section, [section] may continue to serve as a service coordinator at the subrecipient's [contractor's] discretion.

(d) [(c)] The subrecipient [contractor] must comply with HHSC ECI requirements related to continuing education for service coordinators. A service coordinator must complete:

(1) three contact hours of training in ethics every two years;

(2) an additional three contact hours of training specifically relevant to case management every year; and

(3) if the service coordinator does not hold a current license or credential that requires continuing professional education, an additional seven contact hours of [approved] continuing education approved by their supervisor every year.

(e) [(d)] The subrecipient [contractor] must comply with HHSC ECI requirements related to supervision of service coordinators.

(1) A subrecipient's [contractor's] supervision of service coordinators must meet the requirements outlined in §350.309(f) [§350.309(e)] of this subchapter (relating to Minimum Requirements for All Direct Service Staff).

(2) An individual employed by or subcontracting with a subrecipient must meet the following criteria to supervise a service coordinator. [(2) A contractor's ECI program staff member who meets the following criteria is qualified to supervise a service coordinator:]

(A) A service coordinator supervisor must meet the minimum requirements in subsections (b) and (c) of this section. [has completed all service coordinator training as required in subsection (a)(2) and (a)(3) of this section;]

(B) A service coordinator supervisor must have two years of experience providing case management in an ECI program or another applicable community-based program. [has two years of experience providing case management in an ECI program or another applicable community-based organization; and]

[(C) is an active EIS or holds a bachelor's degree or graduate degree from an accredited university with a specialization in:]

[(i) child development, special education, psychology, social work, sociology, nursing, human development or a related field; or]

[(ii) an unrelated field with at least 18 hours of semester course credit in child development or human development.]

(f) [(e)] Requirements for service coordinator active status and inactive status are as follows.

(1) A service coordinator is on active [inactive] status when all of the requirements in subsections (b) and (c) of this section have been approved by their [the service coordinator fails to complete required training activities by the designated deadlines in subsections (a) and (c) of this section. Service coordinator active status is reinstated after the required training activities are completed and approved by the service coordinator's] supervisor.

(2) A service coordinator goes on inactive status when: [is on inactive status when the service coordinator is no longer employed by a contractor.]

(A) the service coordinator fails to complete required training activities by the designated deadlines; or [(A) A service coordinator returns to active status when the service coordinator:]

[(i) is employed by an ECI program within 24 months or less from the last day of employment;]

[(ii) submits 10 clock hours of continuing education for every year of inactive status; and]

[(iii) submits documentation of three clock hours of ethics training completed within the last two years and not used to meet previous training requirements.]

(B) the service coordinator is no longer employed by or subcontracting with a subrecipient.

[(B) A service coordinator who has been on inactive status for longer than 24 months must complete the training requirements outlined in subsections (a)(2) and (a)(3) of this section.]

(3) If a service coordinator has been inactive for less than 48 months, active status is reinstated after the required training activities are completed and approved by the service coordinator's supervisor.

(4) A service coordinator who has been on inactive status for 48 months or longer must complete the training requirements outlined in subsections (b)(2) and (b)(3) of this section.

(g) [(f)] The subrecipient [contractor] must comply with HHSC ECI requirements related to ethics of service coordinators. Service coordinators must meet the established rules of conduct and ethics training required by their license or credential. A service coordinator who does not hold a license or credential must meet the rules of conduct and ethics established in §350.314 of this subchapter (relating to EIS Code of Ethics).

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

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Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 424-6580

SUBCHAPTER D. CASE MANAGEMENT FOR INFANTS AND TODDLERS WITH DEVELOPMENTAL DISABILITIES

26 TAC §§350.403 - 350.407, 350.411, 350.415

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state

agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.403. Definitions.

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

(1) Case management--In compliance with §350.405 of this subchapter (relating to Case Management Services), case management means services provided to assist an eligible child and their family in gaining access to the rights and procedural safeguards under IDEA Part C [~~the Individuals with Disabilities Education Act (IDEA), Part C,~~] and to needed medical, social, educational, developmental, and other appropriate services. Case management services may be provided via telehealth with the prior written consent of the parent. If the parent declines to consent to telehealth services, case management must still be provided.

[~~(2) Developmental disability--Children from birth to age three who have substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services are not provided.~~]

(2) [~~(3)~~] Monitoring and assessment--Activities and contacts as described in §350.405 of this subchapter that are necessary to ensure that the IFSP, [~~individualized family service plan (IFSP),~~] as described in Subchapter J of this chapter (relating to Individualized Family Service Plan[~~(IFSP)~~]), is effectively implemented and that the planned services adequately address the needs of the child.

[~~(4) Service coordinator--An employee or person under the direction of an Early Childhood Intervention (ECI) contractor who meets the criteria described in Subchapter C of this chapter (relating to Staff Qualifications).~~]

[~~(5) Targeted case management--Case management activities that are reimbursable by Medicaid when provided to Medicaid-enrolled children who are eligible for ECI.~~]

(3) [~~(6)~~] Texas Health Steps--The name adopted by the state [~~State~~] of Texas for the federally mandated Early and Periodic Screening, Diagnosis, and Treatment [~~(EPSDT)~~] program.

§350.404. [~~Recipient~~] Eligibility for Early Childhood Intervention [~~(ECI)~~] Case Management Services.

To [~~In order to~~] receive ECI case management services, the child [~~recipient~~] must meet the criteria established in Subchapter H of this chapter (relating to Eligibility, Evaluation, and Assessment), [~~Eligibility), have an identified need for case management,~~] and the family must agree to receive services.

§350.405. Case Management Services.

(a) Case management services may be provided via telehealth with the prior written consent of the parent. If the parent declines to consent to telehealth services, case management must still be provided.

(b) [~~(a)~~] All case management activities must be documented in the child's record. Case management activities include: [~~Case management means services provided to assist an eligible child and their family in gaining access to the rights and procedural safeguards under IDEA Part C, and to needed medical, social, educational, developmental, and other appropriate services. Case management includes:~~]

(1) coordinating the performance of evaluations and assessments;

(2) facilitating and participating in the development, review, and evaluation of the IFSP [~~individualized family service plan~~] in accordance with Subchapter J of this chapter (relating to Individualized Family Service Plan); [~~Plan (IFSP)) which is based upon:~~]

[~~(A) the child's applicable history;~~]

[~~(B) the parent's input;~~]

[~~(C) input from others providing services and supports to the child and family; and~~]

[~~(D) the results of all evaluations and assessments;~~]

(3) supporting families to meet their needs by: [~~assisting families in:~~]

(A) assisting families with identifying unmet needs;

(B) assisting families with identifying available providers of services and supports;

(C) making appropriate referrals and facilitating applications for services and supports; [~~application;~~] and

(D) assisting with initial and ongoing contact to obtain services from medical, social, and educational providers to address identified needs and achieve goals specified in the IFSP;

(4) following up with families and providers of services and supports to assist the child with timely access to services, and discussing [~~discuss~~] the status of referrals to determine whether [~~if~~] the services have met the child's identified needs, and whether [~~if~~] ongoing assistance to ensure continued access will be necessary;

(5) monitoring and assessment of the delivery [~~of~~] and effectiveness of services at least every six months after the IFSP is developed. This process must: [~~that:~~]

[~~(A) occurs at least once every six months, or more frequently as needed;~~]

(A) be [~~(B) is~~] individualized and clearly related to the needs of the child and family;

(B) collect [~~(C) collects~~] information from family members, ECI professionals, [~~service providers,~~] and other entities and individuals who provide services [~~service~~] or supports to the child and family to assess whether [~~if~~]:

(i) services are being provided in accordance with the child's IFSP;

(ii) services are adequate to meet the child's and family's needs;

(iii) all ECI professionals [~~service providers~~] are effectively collaborating to address the child's and family's needs; and

(iv) parents and routine caregivers are able to use the interventions being presented;

(6) adjusting the IFSP [~~and service arrangements~~] if new needs, ineffectiveness, or barriers to services are identified;

(7) assisting the parent or routine caregiver in advocating for the child;

(8) coordinating with medical and other health providers to ensure services are effective in meeting the child's and family's needs; and

(9) facilitating the child's transition to ECSE [preschool] or other appropriate community services and supports.

(c) [(b)] TCM is case management that meets the following criteria. [Medicaid reimbursement is available for the provision of targeted case management if the following criteria are met:]

(1) The [the] contact occurs with the parent or routine caregiver. [caregiver;]

(2) The [the] contact occurs face-to-face [face to face] or by telephone. [telephone;]

(3) Contacts made in one day total [the contact is of] at least eight minutes in duration. [duration;]

(4) The [the] desired outcome of the contact is of direct benefit to a child who is eligible for ECI services. [services; and]

(5) During [during] the contact the service coordinator performs a case management activity as described in subsection (a) of this section.

(d) [(c)] TCM must be offered to all families and documented in a child's record, regardless of the child's Medicaid enrollment. [Non-billable case management contacts must be documented in a child's record. These contacts occur when:]

(e) Case management activities not defined as TCM occur when the service coordinator performs a case management activity as defined in subsection (a) of this section; and

(1) the contact is with individuals other than a parent or routine caregiver;

(2) the desired outcome of the contact is not of direct benefit to a child who is eligible for ECI services; [and]

(3) the contact is less than eight minutes in duration; or

[(3) during the contact the service coordinator performs a case management activity as defined in subsection (a) of this section.]

(4) the contact does not occur face-to-face or by telephone.

§350.406. Parent Refusal.

(a) A parent may refuse case management provided by the subrecipient. [ECI contractor.] If the parent refuses case management activities, the service coordinator must:

(1) document the parent's choice in the child's record;

(2) provide the [IDEA Part C] required ECI services during the pre-enrollment period, including scheduling and coordinating screenings, evaluations, and assessments;

(3) coordinate the development, review, and evaluation of the IFSP, [Individualized Family Service Plan (IFSP),] including any reviews, revisions, and the annual IFSP; and

(4) provide and obtain all the accompanying required notices and consents.

(b) When the parent refuses case management services, the subrecipient [ECI contractor] must not submit a claim for TCM [case management] to Medicaid.

§350.407. Medicaid Service Limitations.

(a) Case management services are not reimbursable as Medicaid services when another payor is liable for payment or if case management services are associated with the proper and efficient administration of the Medicaid state plan.

(b) Case management services associated with the following are not payable as TCM [optional targeted case management] services under Medicaid:

(1) Medicaid eligibility determinations and redeterminations;

(2) Medicaid eligibility intake processing;

(3) Medicaid preadmission screening;

(4) prior authorization for Medicaid services;

(5) required Medicaid utilization review;

(6) Texas Health Steps program administration;

(7) Medicaid "lock-in" provided for under the Social Security Act [Act,] §1915(a);

(8) services that are an integral or inseparable part of another Medicaid service;

(9) outreach activities that are designed to locate individuals who are potentially eligible for Medicaid; and

(10) any medical evaluation, examination, or treatment billable as a distinct Medicaid-covered benefit. However, referral arrangements and staff consultation for such services are reimbursable as case management services.

§350.411. Assignment of Service Coordinator.

(a) ECI [Early Childhood Intervention (ECI)] case management services must be provided by service coordinators who meet the educational, training, and work experience requirements, commensurate with their job responsibilities, as specified in Subchapter C of this chapter (relating to Staff Qualifications).

(b) The subrecipient [ECI contractor] is responsible for:

(1) assigning one service coordinator for each eligible child and the child's family according to the following:

(A) an initial service coordinator must be assigned at the time of referral; and

(B) a new service coordinator may be assigned at the time the IFSP is developed or the original service coordinator may be retained; [retained, if appropriate;]

(2) ensuring that the service coordinator assigned by the subrecipient [ECI contractor] has a combination of education, training, and work experience relevant to the child's needs; and

(3) appointing a new service coordinator if requested by the parent.

§350.415. Documentation.

(a) The child's record must include:

(1) whether the parent has declined recommended services;

(2) the need for, and occurrences of, coordination with other service coordinators or case managers; and

(3) whether case management goals have been achieved.

(b) Documentation of each case management contact must include:

(1) name of the child;

(2) name of the ECI program; [Early Childhood Intervention contractor;]

(3) name and credential of the assigned service coordinator;

(4) date, start time, and duration of the contact;

(5) physical location of the service coordinator at the time of contact (e.g., office, child's home, hospital, daycare);

(6) method of service (face-to-face or telephone);

(7) with whom the contact was made (e.g., parent, routine caregiver, physician);

(8) a description of the case management activity performed as described in §350.405 of this subchapter (relating to Case Management Services);

(9) course of action to respond to identified needs;

(10) any relevant information provided by the family, or other individual or entity; and

(11) service coordinator's signature.

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

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SUBCHAPTER E. SPECIALIZED REHABILITATIVE SERVICES

26 TAC §350.501, §350.507

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.501. Specialized Rehabilitative Services.

(a) SRS, as defined by §350.103 of this chapter (relating to Definitions), includes [~~Specialized rehabilitative services are rehabilitative services that promote age-appropriate development by correcting deficits and teaching compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions. Specialized rehabilitative services include~~] physical therapy, speech language pathology services, occupational therapy, and SST as defined in §350.103 of this chapter. [~~specialized skills training.~~]

(1) Physical therapy.

(A) Physical therapy services are defined in 34 CFR §303.13(b)(9).

(B) Physical therapy services must meet the requirements of subsection (b) of this section.

(C) Physical therapy services must be provided by a licensed physical therapist who meets the requirements of 42 CFR §440.110(a) and all other applicable state and federal laws or a licensed physical therapy assistant [~~(LPTA)~~] when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

(2) Speech language pathology services.

(A) Speech language pathology services are defined in 34 CFR 303.13(b)(15).

(B) Speech language pathology [~~therapy~~] services must meet the requirements of subsection (b) of this section.

(C) Speech language pathology [~~therapy~~] services must be provided by:

(i) a licensed speech language pathologist (SLP) who meets the requirements of 42 CFR §440.110(c) and all other applicable state and federal laws;

(ii) a licensed assistant in SLP when the assistant is acting under the direction of a licensed SLP in accordance with 16 TAC §111.52 (relating to Assistant in Speech-Language Pathology License--Practice and Duties of Assistants) [~~42 CFR §440.110~~] and all other applicable state and federal laws; or

(iii) a licensed intern when the intern is acting under the direction of an SLP who is licensed [~~a qualified SLP~~] in accordance with 42 CFR §440.110 and all other applicable state and federal laws.

(3) Occupational therapy.

(A) Occupational therapy services are defined in 34 CFR §303.13(b)(8).

(B) Occupational therapy services must meet the requirements of subsection (b) of this section.

(C) Occupational therapy services must be provided by a licensed occupational therapist who meets the requirements of 42 CFR §440.110(b) and all other applicable state and federal laws or a certified occupational therapy assistant [~~(COTA)~~] when the assistant is acting under the direction of a licensed occupational therapist in accordance with 40 TAC §373.2 (relating to Supervision of a Temporary Licensee) [~~42 CFR §440.110~~] and all other applicable state and federal laws.

(4) Specialized Skills Training. [~~skills training.~~] As defined in §350.103 of this chapter, SST:

(A) [~~Specialized skills training seeks to reduce the child's functional limitations across developmental domains including, strengthening the child's cognitive skills, positive behaviors, and social interactions. (B) Specialized skills training~~] includes skills training and anticipatory guidance for family members or other routine caregivers to ensure effective treatment and to enhance the child's development; [~~development.~~]

(B) [~~(C) Specialized skills training~~] services must meet the requirements of subsection (b) of this section; and [~~section.~~]

(C) [~~(D) Specialized skills training~~] must be provided by an EIS on active status as defined in §350.313 of this chapter (relating to Early Intervention Specialist). [~~Specialist.~~]

(b) SRS [~~Specialized rehabilitative services~~] must:

(1) be designed to create learning environments and activities that promote the child's acquisition of skills in one or more of the following developmental areas: physical/motor, communication, adaptive, cognitive, and social/emotional;

(2) be provided in the child's natural environment, as defined in 34 CFR §303.26, unless the criteria listed in [~~at~~] 34 CFR §303.126 are met and documented in the case record; and [~~record and may be provided via telehealth with the prior written consent of the parent, and if the parent does not consent to telehealth services, will be provided in person;~~]

(3) meet the requirements of §350.1104 of this chapter (relating to Early Childhood Intervention Services Delivery).[~~Delivery); and~~]

[~~(4) be provided on an individual or group basis.~~]

[~~(c) In addition to the criteria in subsection (b) of this section, group services must meet the requirements as described in §350.1107 of this chapter (relating to Group Services for Children).~~]

(c) [~~(d)~~] Service authorization [~~Authorization~~].

(1) SRS [~~Specialized rehabilitative services~~] must be recommended by an interdisciplinary team that includes an LPHA. [~~a licensed practitioner of the healing arts~~]

(2) SRS must be [~~and be~~] documented in the child's IFSP [~~an Individualized Family Service Plan (IFSP)~~] in accordance with Subchapter J of this chapter (relating to Individualized Family Service Plan). [~~Plan (IFSP)).~~]

(3) [~~(2)~~] Services must be monitored by the interdisciplinary team as described in §350.1104 of this chapter.

[~~(e) Documentation. Documentation of each specialized rehabilitative services contact must meet the requirements in §350.1111 of this chapter (relating to Service Delivery Documentation Requirements).~~]

§350.507. Due Process.

(a) Medicaid-eligible individuals. Any Medicaid-eligible individual whose request for eligibility for SRS [~~specialized rehabilitative services~~] is denied by Medicaid, or is not acted upon with reasonable promptness, or whose specialized rehabilitative services have [~~has~~] been terminated, suspended, or reduced, is entitled to a fair hearing in accordance with 1 TAC Chapter 357, Subchapter A (relating to Uniform Fair Hearing Rules).

(b) All individuals. If an ECI program [~~Early Childhood Intervention contractor~~] denies, involuntarily reduces, or terminates SRS [~~specialized rehabilitative services~~] for an individual, the individual has the right [~~all rights~~] to file complaints, request mediation, or request a hearing in accordance with Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures) and in accordance with 40 TAC Chapter 101, Subchapter E, Division 3 (relating to Division for Early Childhood Intervention Services).

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

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SUBCHAPTER F. PUBLIC OUTREACH

26 TAC §350.601

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.601. Purpose.

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♦ ♦ ♦

26 TAC §§350.605, 350.607, 350.609, 350.611, 350.613, 350.615, 350.617

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.605. Definitions.

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

[~~(1) Central Directory--As described in 34 CFR §303.117.~~]

(1) [~~(2)~~] Public awareness [~~Awareness~~]--As described in 34 CFR §303.116 and §303.301.

(2) [~~(3)~~] Public outreach [~~Outreach~~]--The combined efforts of child find, public awareness, and interagency coordination.

§350.607. Public Outreach.

(a) The subrecipient [~~contractor~~] must plan and implement child find, public awareness, and interagency coordination goals and strategies that comply with [~~the Individuals with~~] IDEA Part C.

(b) When HHSC provides language to use in communicating with primary referral sources, parents of infants and toddlers, or the general public, the subrecipient [~~contractor~~] must use the provided language.

§350.609. Child Find.

(a) The subrecipient must document that it communicated any major HHSC ECI policy change concerning the information described in subsection (d) of this section to primary referral sources.

(b) [~~(a)~~] The purpose of child find efforts is to establish working relationships and effective communications [~~communicate effectively~~] with primary referral sources [~~in order~~] to support and promote the referral of [~~their referring~~] children potentially eligible for ECI services.

(c) [~~(b)~~] The subrecipient [~~contractor~~] must have written procedures that establish systems to:

(1) inform primary referral sources of the requirement to refer children suspected of having a developmental delay or a medical diagnosis with a high probability of resulting in a developmental delay in a timely manner as established in 34 CFR §303.303;

(2) accept referrals effectively; and

(3) monitor referral dates and sources.

(d) [~~(c)~~] The subrecipient [~~contractor~~] must document that primary referral sources listed in 34 CFR §303.303(c) have been provided current information on:

(1) ECI eligibility criteria and evaluation process; [~~criteria;~~]

(2) the ECI array of services;

(3) how to explain ECI services to the family, including the coaching approach and [~~service delivery to families, including~~] the family's role;

(4) how to make a referral to ECI;

(5) the importance of informing families when a referral is made; and

(6) the family cost share system of payments for ECI [~~early childhood intervention~~] services.

[~~(d) The contractor must document that any major HHSC ECI policy change concerning the types of information described in subsection (c) of this section is communicated to primary referral sources.~~]

§350.611. Public Awareness.

(a) The subrecipient must conduct public awareness activities to [~~purpose of public awareness efforts is to~~] increase recognition of ECI programs in the community so that families with children who are potentially eligible for ECI [~~early childhood intervention~~] services will access those services.

(b) The subrecipient [~~contractor~~] must document that families and the general public are provided current HHSC ECI materials on:

(1) ECI service delivery, including the family's role and the coaching model;

(2) eligibility criteria and the evaluation process;

(3) the ECI array of services;

(4) how to make a referral to ECI; and

(5) the family cost share system of payments for ECI [~~early childhood intervention~~] services.

(c) The ECI program [~~contractor's program~~] staff who conduct public awareness activities must be able to explain to families and the public the information listed in subsection (b) of this section.

(d) The subrecipient [~~contractor~~] must assist HHSC ECI as requested in public awareness activities, including informing families and their community of appropriate resources. [~~the HHSC ECI Central Directory.~~]

(e) The subrecipient [~~contractor~~] must establish and maintain ongoing relationships with public and private agencies that serve children and families in their community to:

(1) increase quality referrals for ECI services; and

(2) coordinate with community partners to increase access to resources and services for ECI children and families.

§350.613. Publications.

(a) The subrecipient [~~contractor~~] must maintain a current inventory of ECI publications and public outreach materials provided by HHSC ECI.

(b) Public outreach materials created by the subrecipient [~~contractor~~] must comply with graphics standards required by HHSC ECI. [~~the ECI Graphics Manual.~~]

§350.615. Interagency Coordination.

(a) The purpose of interagency coordination is to enhance the subrecipient's [~~contractor's~~] child find and public awareness efforts and to coordinate with community partners to increase access to resources and services for ECI children and families.

(b) The subrecipient [~~contractor~~] must comply with all child find and public outreach requirements in all state-level HHSC ECI MOUs with TEA, Head Start and Early Head Start, DFPS, and [~~memoranda of understanding (MOUs) with the Texas Education Agency (TEA), Head Start and Early Head Start, Texas Department of Family and Protective Services (DFPS), and~~] any other state agency with which HHSC ECI enters into a MOU.

(c) The subrecipient [~~contractor~~] must coordinate with LEA representatives to facilitate an effective transition from ECI to ECSE [~~public school special education~~] services and the LEA provision of services for children who are deaf or hard of hearing or blind or visually impaired. [~~auditory and visual impairment services.~~] Coordination activities focus on developing a joint understanding of:

(1) eligibility requirements for public school services, including for Part B services;

(2) the state-level MOUs with TEA; and

(3) if applicable, MOUs with the LEAs.

(d) The subrecipient [~~contractor~~] must coordinate with representatives from Head Start and Early Head Start to ensure that families eligible for Head Start and Early Head Start have access to those services, as available. Coordination activities focus on developing a joint understanding of:

(1) eligibility requirements for Head Start and Early Head Start placement;

(2) the state-level MOU with Head Start and Early Head Start;

(3) referral procedures; and

(4) if applicable, the local MOU with Head Start and Early Head Start.

(e) The subrecipient [~~contractor~~] must ensure [~~document~~] coordination of ECI services with local agencies, as required by 34 CFR §303.302 and other programs identified by HHSC ECI.

(f) The subrecipient [~~contractor~~] must maintain a current list of community resources for families that includes for each resource:

(1) services provided;

(2) contact information;

(3) referral procedures; and

(4) cost to families.

(g) The subrecipient [~~contractor~~] must document the reasonable efforts to mitigate any systemic issues with achieving the requirements of this section.

§350.617. Public Outreach Contact, Planning, and Evaluation.

(a) The subrecipient [~~contractor~~] must inform HHSC ECI of whom [~~the Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI) of the person~~] to contact within their office regarding public outreach efforts.

(b) The subrecipient [~~contractor~~] must establish goals, strategies, and activities to meet the requirements of this subchapter. The public outreach [~~This~~] strategic planning process must include the review and incorporation of any major HHSC ECI policy change concerning the types of information described in §350.609(d) [~~§350.609(b)~~] of this subchapter (relating to Child Find).

(c) The strategic planning process must be coordinated with other subrecipients [~~contractors~~] that share counties and primary referral sources.

(d) The public outreach strategic planning process must include an annual evaluation of the success of the subrecipient's [~~contractor's~~] public outreach efforts with a focus on the:

(1) number of children referred to the ECI program;

(2) percentage of children referred that are determined eligible for the program;

(3) percentage of children determined eligible that enroll in the program;

(4) referral source and eligibility type; and [~~data in paragraphs (1), (2), and (3) of this subsection broken down by age, race, and ethnicity at referral; referral source; and eligibility type; and~~]

(5) plans to address issues found in the evaluation of public outreach efforts.

(e) Data in subsections (d)(1), (d)(2), and (d)(3) of this section must be broken down by race, ethnicity, and age at referral.

(f) [~~(e)~~] The subrecipient [~~contractor~~] must be prepared to describe this strategic planning process and its outcomes to HHSC ECI upon request.

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

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SUBCHAPTER G. REFERRAL, PRE-ENROLLMENT, AND DEVELOPMENTAL SCREENING

26 TAC §350.701

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.701. Purpose.

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26 TAC §§350.704, 350.706 - 350.709

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.704. Referral Requirements.

(a) The subrecipient [~~contractor~~] must:

(1) accept referrals for children younger [~~less~~] than 36 months of age;

(2) document in the child's record the referral date, source, and reason for referral; and

(3) contact the family in a timely manner after receiving the referral.

(b) The subrecipient [contractor] must follow all requirements described in this chapter when a referral is received 45 days or more before the child's third birthday.

(c) When [In accordance with 34 CFR §303.209(b)(iii) and §108.1207(h) of this title (relating to Transition Planning), when] a referral is received less than 45 days before the child's third birthday, the subrecipient [contractor] is not required to conduct pre-enrollment procedures, an evaluation, an assessment, or an initial IFSP meeting. With [In accordance with 34 CFR §303.209, with] written parental consent, if the toddler is potentially eligible for ECSE [special education] services:

(1) the subrecipient [contractor] must notify the LEA; and

(2) HHSC coordinates the notification to the SEA. [State Education Agency.]

§350.706. Referrals Received While the Child is in the Hospital.

(a) In order to facilitate discharge planning and provide continuity of care, a subrecipient [contractor] may accept referrals for children who are residing in a hospital at the time of referral.

(b) If a referral is received for a child who has an adjusted age of zero months or younger [less] or who has a qualifying medical diagnosis, the subrecipient [contractor] may choose to determine eligibility and complete the initial IFSP [Individualized Family Service Plan (IFSP)] prior to the child's discharge from the hospital. The interdisciplinary team that determines eligibility and the IFSP team must include at least one ECI professional and a licensed or registered hospital professional who is familiar with the needs of the child and knowledgeable in the area or areas of concern.

(1) The [interdisciplinary team who determines eligibility may include a] licensed or registered hospital professional [professional, who] will serve as the LPHA [Licensed Practitioner of the Healing Arts (LPHA)] while the child is in the hospital. The LPHA on the IFSP team may participate by means other than face-to-face, [face to face,] if acceptable to the team and if the initial IFSP is conducted while the child is in the hospital.

(2) [The interdisciplinary team must include at least one Early Childhood Intervention professional and a licensed or registered hospital professional who is familiar with the needs of the child and knowledgeable in the area or areas of concern.] The participating licensed or registered hospital professional is not required to complete the orientation training required in §350.309(c) [§350.309(b)] of this chapter (relating to Minimum Requirements for All Direct Service Staff). Allowable licensed or registered hospital professionals include:

(A) licensed physician;

(B) registered nurse;

(C) licensed physical therapist;

(D) licensed occupational therapist;

(E) licensed speech language pathologist;

(F) licensed dietitian;

(G) licensed audiologist;

(H) licensed physician assistant;

(I) licensed intern in speech language pathology; or

(J) advanced practice registered nurse.

§350.707. Child Referred with an Out-of-State Individualized Family Service Plan [IFSP].

(a) When a child moves to Texas with a completed IFSP from another state, eligibility for Texas ECI [early childhood intervention] services must be determined in accordance with Subchapter H of this chapter (relating to Eligibility, Evaluation, and Assessment).

(b) The interdisciplinary team considers existing evaluation data and medical diagnoses, as documented on the out-of-state IFSP, as appropriate.

(c) ECI [Early childhood intervention] services in Texas must be planned in accordance with Subchapter J of this chapter (relating to Individualized Family Service Plan [(IFSP)]) and delivered in accordance with Subchapter K of this chapter (relating to Service Delivery).

§350.708. Pre-Enrollment Activities.

(a) Pre-enrollment begins at the point of referral, includes the following activities, and ends when the parent signs the IFSP [Individualized Family Service Plan (IFSP)] or a final disposition is reached.

(1) The subrecipient [contractor] must assign an initial service coordinator for the family and document the name of the service coordinator in the child's record.

(2) The subrecipient [contractor] must provide the family the HHSC ECI [Texas Health and Human Services Commission Early Childhood Intervention] Parent Handbook and document in the child's record that the following were explained to the parent:

(A) the family's rights regarding eligibility determination and enrollment;

(B) the early childhood intervention process for determining eligibility and enrollment; and

(C) the types of ECI [early childhood intervention] services that may be delivered to the child and the manner in which they may be provided.

(3) The subrecipient [contractor] must provide pre-IFSP service coordination as defined in 34 CFR §303.13(b)(11) and §303.34.

(4) The subrecipient [contractor] must collect information on the child throughout the pre-enrollment process.

(5) The subrecipient [contractor] must assist the child and family in gaining access to the evaluation and assessment process, including:

(A) scheduling the interdisciplinary initial evaluation and assessment; and

(B) preparing the family for the evaluation and assessment process.

(6) The subrecipient [contractor] must comply with all requirements in Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures).

(b) The subrecipient [contractor] must explain to the family, before eligibility determination, the requirement to provide ECI [early childhood intervention] services in the natural environment.

(c) The subrecipient [contractor] must determine the need for and appoint a surrogate parent in accordance with 34 CFR §303.422 and §350.213 of this chapter (relating to Surrogate Parents).

§350.709. Optional Developmental Screenings.

(a) Optional developmental screenings are [Developmental screening is] done to determine the need for further evaluation. When a developmental screening is completed, the subrecipient [A contractor] must:

(1) use an HHSC ECI-approved screening tool; [tools that are approved by HHSC ECI;] and

(2) train providers to administer the selected screening tool [administering the tool] according to the requirements of [parameters required by] the selected tool.

(b) A parent has the right to request at any time:

(1) a comprehensive evaluation after a developmental screening; [screening] or

(2) a comprehensive evaluation instead of a developmental screening. [screening at any time.]

(c) If the results of a child's developmental screening do not indicate a concern, the subrecipient [a contractor] must:

(1) provide written documentation to the parent that further evaluation is not recommended;

(2) offer the parent a comprehensive evaluation; and

(3) conduct a comprehensive evaluation if requested by the parent.

(d) In accordance with the MOU between HHSC ECI and DFPS, the subrecipient must coordinate with DFPS [A contractor must coordinate with the Texas Department of Family and Protective Services (DFPS)] to accept a referral for a child under 36 months of age who is: [is involved in a substantiated case of child abuse or neglect, affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or suspected of having a disability or developmental delay.]

(1) involved in a substantiated case of child abuse or neglect;

(2) suspected to have a disability or developmental delay; or

(3) identified as affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a Fetal Alcohol Spectrum Disorder (FASD).

(e) Requirements for optional developmental screenings or comprehensive evaluations for a child who meets the criteria in subsection (d) of this section are as follows.

(1) If the subrecipient receives a completed developmental screening from a health care provider for a child who is in DFPS conservatorship that indicates the child has a developmental delay, the subrecipient must offer a comprehensive evaluation to determine eligibility for ECI services. [A child in DFPS conservatorship. A contractor must offer a comprehensive evaluation to determine eligibility for early childhood intervention services when the contractor receives a completed developmental screening from a health care provider indicating the child has a developmental delay.]

(2) If the subrecipient receives a referral for a child who meets one of the criteria in subsection (d) of this section, the subrecipient must offer either a developmental screening or proceed directly to comprehensive evaluation.

[(2) A child not in DFPS conservatorship who is involved in a substantiated case of abuse or neglect. A contractor must offer either a developmental screening or proceed directly to a comprehensive evaluation.]

(3) If the subrecipient receives a referral for a child who does not meet one of the criteria in subsection (d) of this section, the subrecipient follows their local procedures for accepting a referral, conducting a developmental screening, and completing an evaluation.

[(3) A child affected by illegal substance abuse or withdrawal symptoms from prenatal drug exposure. A contractor must offer either a developmental screening or proceed directly to comprehensive evaluation.]

[(4) A child suspected of having a disability or developmental delay. A contractor follows their local procedures for accepting a referral, conducting a developmental screening, and completing an evaluation unless the child meets one of the criteria in paragraphs (1) - (3) of this subsection.]

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

Filed with the Office of the Secretary of State on August 30, 2024.

TRD-202404093
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 424-6580

SUBCHAPTER H. ELIGIBILITY, EVALUATION, AND ASSESSMENT

26 TAC §350.801

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.801. Purpose.

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

Filed with the Office of the Secretary of State on August 30, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
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26 TAC §§350.805, 350.807, 350.809, 350.811, 350.813, 350.815, 350.817, 350.821, 350.823, 350.825, 350.829, 350.833, 350.835, 350.837

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.805. Definitions.

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

(1) Adjusted age [Age]--The chronological age of a child minus the number of weeks or months of prematurity.

(2) Chronological age--The actual number of months and years a person has lived calculated from the date of birth to the present date.

§350.807. Eligibility.

(a) The subrecipient must ensure requirements in 34 CFR §303.321(a)(1) are met.

(b) [(a)] The subrecipient [contractor] must determine that a child meets Texas eligibility requirements [in order] to provide ECI [early childhood intervention] services to the child and family.

(c) [(b)] Subrecipients must [Contractors shall] apply the same eligibility criteria for all children residing in Texas.

[(c) The contractor must establish a system of management oversight to ensure consistent eligibility determination.]

(d) If a child is determined eligible in one area of Texas, the child remains eligible if the family moves to another part of the state until the child's annual evaluation is due.

(e) [(d)] The subrecipient [contractor] must comply with all requirements in Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures) when determining eligibility.

(f) The subrecipient must provide prior written notice in accordance with §350.204 of this chapter (relating to Prior Written Notice) to the parent if a child is determined to be ineligible for ECI services.

§350.809. Initial Eligibility Criteria.

(a) A child must be younger than [under] 36 months of age and meet initial eligibility criteria to receive ECI [early childhood intervention] services. Initial eligibility is established by:

(1) documentation of a medically diagnosed condition that has a high probability of resulting in developmental delay;

(2) meeting the TEA definition of deaf or hard of hearing or criteria for a visual impairment provided in [an auditory or visual impairment as defined by the Texas Education Agency rule at] 19 TAC §89.1040 (relating to Eligibility Criteria); or

(3) a developmental delay, which[delay. Each developmental area] must be evaluated as described [defined] in 34 CFR §303.321 and the [§303.321. Developmental] delay is determined based on:

(A) an evaluation using a standardized tool designated by HHSC ECI that indicates a delay of at least 25 percent in one or more of the following developmental areas:

(i) communication;

(ii) cognitive;

(iii) gross motor;

(iv) fine motor;

(v) social emotional; or

(vi) adaptive; [or]

(B) an evaluation using a standardized tool designated by HHSC ECI that indicates a delay of at least 33 percent if the child's only delay is in expressive communication; [language;] or

(C) a qualitative determination of delay, as defined in §350.821 of this subchapter (relating to Qualitative Determination of Developmental Delay). [indicated by responses or patterns that are disordered or qualitatively different from what is expected for the child's age, and significantly interfere with the child's ability to function in the environment. When the interdisciplinary team determines there is evidence that the results of the standardized tool do not accurately reflect the child's development, eligibility must be established using a supplemental protocol designated by HHSC ECI.]

(b) A child must meet the same eligibility standards in subsection (a)(3)(A) or (a)(3)(B) [subparagraph (A) or (B)] of this section [this paragraph] on the designated tool to qualify for a qualitative determination of delay unless the child has an adjusted age or chronological age of under three [3] months.

§350.811. Qualifying Medical Diagnosis. [Eligibility Determination Based on Medically Diagnosed Condition That Has a High Probability of Resulting in Developmental Delay]

(a) The interdisciplinary team must review medical documentation to determine eligibility for a child who has a qualifying medical diagnosis. The subrecipient must maintain documentation reviewed for this purpose in the child's record. [To determine eligibility for a child who has a qualifying medical diagnosis the interdisciplinary team must review medical documentation to determine initial eligibility.]

(1) Qualifying medical diagnoses are approved by the HHSC Director of ECI based on prevailing medical opinion that the diagnoses have a high probability of resulting in developmental delay.

(2) HHSC ECI maintains a searchable database of qualifying medical diagnoses that is made available to the public. HHSC ECI will notify subrecipients and the public when changes to the database are made.

[(b) The Texas Health and Human Services Commission (HHSC) Director of Early Childhood Intervention approves the list of qualifying medical conditions based on prevailing medical opinion that the diagnoses have a high probability of resulting in developmental delay. Copies of the list of medically qualifying diagnoses can be obtained from HHSC.]

(b) [(c)] If a review of the child's records indicates that the child has a qualifying medical diagnosis, [condition,] the interdisciplinary team must determine and document a need for ECI [early childhood intervention] services as required in §350.837 of this chapter (relating to Needs Assessment).

§350.813. Deaf or Hard of Hearing. [~~Determination of Hearing and Auditory Status~~]

(a) The interdisciplinary team may not determine a child ineligible if the child is suspected or confirmed to be deaf or hard of hearing until all evaluations, examinations, and assessments required in this section have been completed and reviewed by the interdisciplinary team, including the appropriate LEA staff.

(b) [~~(a)~~] As part of the evaluation to determine eligibility, the interdisciplinary team must determine any need for further hearing assessment by analyzing risk factors and evaluation results. [~~This determination is completed by reviewing the current hearing and auditory status for every child through an analysis of evaluation protocol results. A screening tool may be used for a child who is eligible based on a medical diagnosis or vision impairment.~~]

(c) A hearing screening tool may be used when an evaluation tool is not administered for a child who is eligible based on a medical diagnosis or a child who meets the criteria of having a visual impairment as defined by 19 TAC §89.1040 (relating to Eligibility Criteria).

(d) [~~(b)~~] The subrecipient [~~contractor~~] must refer the [a] child to a licensed audiologist if the child has been identified as having a need for further hearing assessment and the child has not had a hearing assessment within the six months prior to identifying the need. [~~of the hearing needs identification.~~]

(1) If necessary to access a licensed audiologist, the subrecipient [~~contractor~~] may refer the child to the child's [~~their~~] primary health care provider.

(2) The referral must be made:

(A) [~~(1)~~] within five working days; and

(B) [~~(2)~~] with parental consent.

(e) [~~(c)~~] If the subrecipient [~~contractor~~] receives an audiological assessment that indicates the child is deaf or hard of hearing, the subrecipient [~~has an auditory impairment, the contractor~~] must respond as follows.

(1) With written parental consent consistent with §350.207 of this chapter (relating to Parental Consent), refer the child for an otological examination.

(A) The referral must be made to:

(i) an otologist;

(ii) an otolaryngologist; or

(iii) an otorhinolaryngologist.

(B) If one of the professionals listed in subsection (e)(1) of this section is not available, any licensed medical physician may complete the otological examination. The child's record must include documentation that an otologist, an otolaryngologist, or an otorhinolaryngologist was not available to complete the examination.

[~~(1) The contractor must, within five business days, make a referral to the LEA to participate in the eligibility determination process as part of the interdisciplinary team, and with written parental consent, complete the communication evaluation. The contractor must refer to the LEA any child who uses amplification.~~]

(2) Within five business days after the audiological assessment is received, make a referral to the LEA to participate in eligibility determination as part of the interdisciplinary team. Per 20 USC §1232g(b), parental consent is not required for this referral, but the parent must be notified that the referral is being made.

[~~(2) With prior written parental consent, the contractor must refer the child to an otologist, an otolaryngologist, or an otorhinolaryngologist for an otological examination. An otological examination may be completed by any licensed medical physician when an otologist is not available. The child's record must include documentation that an otologist, an otolaryngologist, or an otorhinolaryngologist was not available to complete the examination.~~]

(f) The subrecipient must refer any child who uses amplification to the LEA.

(g) The Certified Teacher of the Deaf and Hard of Hearing from the LEA participates in the eligibility determination process as part of the interdisciplinary team and, with written parental consent, completes the communication evaluation.

§350.815. Blindness or Visual Impairment. [~~Determination of Vision Status~~]

(a) The interdisciplinary team may not determine a child ineligible if the child is suspected or confirmed to be blind or visually impaired until all evaluations, examinations, and assessments required in this section have been completed and reviewed by the interdisciplinary team, including the appropriate LEA staff.

(b) [~~(a)~~] As part of the evaluation to determine eligibility, the interdisciplinary team must determine any need for further vision assessment by analyzing risk factors and evaluation results. [~~This determination is completed by reviewing the current vision status for every child through an analysis of evaluation protocol results. A screening tool may be used for a child who is eligible based on a medical diagnosis or hearing impairment.~~]

(c) A vision screening tool may be used when an evaluation tool is not administered for a child who is eligible based on a qualifying medical diagnosis or because the child meets the definition of deaf or hard of hearing in 19 TAC §89.1040 (relating to Eligibility Criteria).

(d) [~~(b)~~] The subrecipient [~~contractor~~] must refer the [a] child to an ophthalmologist or optometrist if the child has been identified as having a need for further vision assessment and the child has not had a vision assessment within the nine months prior to identifying the need. [~~of the vision needs identification.~~]

(1) If necessary to access an ophthalmologist or optometrist, the subrecipient [~~contractor~~] may refer the child to the child's [~~their~~] primary health care provider. The referral must be made:

(A) [~~(1)~~] within five working days; and

(B) [~~(2)~~] with parental consent.

(e) [~~(c)~~] If the subrecipient [~~contractor~~] receives a medical eye examination report that indicates the child is blind or visually impaired, the subrecipient must, within five business days[~~vision impairment, the contractor must within five business days~~] of receiving the report:

(1) with written parental consent consistent with §350.207 of this chapter (relating to Parental Consent), refer the child to the local office of the Health and Human Services Blind Children's Vocational Discovery and Development Program; and [~~refer the child to the LEA; and~~]

(2) refer the child to the LEA using a form containing elements required by TEA completed by an ophthalmologist or an optometrist, or a medical physician when an ophthalmologist or optometrist is not available. Per 20 USC §1232g(b), parental consent is not required for this referral, but the parent must be notified that the referral is being made. [~~with prior written consent, refer the child to the local office of the HHS Blind Children's Vocational Discovery and Development Program (BCVDDP).~~]

[(d) The referral to the LEA must be accompanied by a form containing elements required by the Texas Education Agency completed by an ophthalmologist or an optometrist, or a medical physician when an ophthalmologist or optometrist is not available.]

§350.817. Developmental Delay. [Eligibility Determination Based on Developmental Delay]

(a) The subrecipient [contractor] must:

(1) comply with all requirements in 34 CFR §303.321(b);

(2) maintain all test protocols and other documentation used to determine eligibility and continuing eligibility in the child's record; and

[(3) provide prior written notice to the parent when the child is determined to be ineligible for early childhood intervention services; and]

(3) [(4)] ensure that all evaluations are conducted by qualified personnel.

(b) The subrecipient must ensure evaluations to determine initial and continuing eligibility based on developmental delay, as defined in §350.809 of this subchapter (relating to Initial Eligibility Criteria), are conducted by at least two professionals from different disciplines with participation by the parent. [parent and at least two professionals from different disciplines must conduct the evaluation to determine initial and continuing eligibility based on developmental delay as defined by §350.809(3) of this chapter (relating to Initial Eligibility Criteria).]

(1) An LPHA [A Licensed Practitioner of the Healing Arts] must be one of the two professionals.

(2) Service coordination is not considered a discipline for evaluation.

(3) The evaluation procedures must include:

(A) [(1)] administration of a [the] standardized tool designated by HHSC ECI; [the Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI);]

(B) [(2)] taking the child's history, including interviewing the parent;

(C) [(3)] identifying the child's level of functioning in each of the developmental areas in 34 CFR §303.21(a)(1);

(D) [(4)] gathering information from other sources such as family members, other caregivers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs;

(E) [(5)] reviewing medical, educational, and other records;

(F) [(6)] in addition to requirements in 34 CFR §303.321(b), determining the most appropriate setting, circumstances, time of day, and participants for the evaluation [in order] to capture the most accurate picture of the child's ability to function in his or her natural environment; and

(G) [(7)] interpreting scores and determining delay through the application of informed clinical opinion to test results.

(4) When a child's chronological or adjusted age is zero months or younger, use of the standardized tool or another protocol is not required. While the interdisciplinary team does not need to administer the standardized tool or protocol, the interdisciplinary team must complete a qualitative determination of developmental delay as described in §350.821 of this subchapter (relating to Qualitative Determination of Developmental Delay).

(c) The subrecipient [contractor] must consider other evaluations and assessments performed by outside entities when requested by the family.

(1) The subrecipient [contractor] must determine whether outside evaluations and assessments:

(A) are consistent with HHSC ECI policies;

(B) reflect the child's current status; and

(C) have implications for IFSP [Individualized Family Service Plan] development.

(2) The subrecipient [If the family does not allow full access to those records or to those entities or does not consent to or does not cooperate in evaluations or assessments to verify their findings, the contractor] may discount or disregard [the other] evaluations and assessments performed by outside entities if the family:[.]

(A) does not allow full access to those records or entities;

(B) does not consent to evaluations or assessments; or

(C) does not cooperate in evaluations or assessments to verify their findings.

§350.821. Qualitative Determination of Developmental Delay.

Qualitative determination of developmental delay [Determination of Developmental Delay] is applied as described in this section. [section:]

(1) Qualitative determination of developmental delay may only be used at initial eligibility determination.

(2) [(1)] When a child's adjusted age or chronological age is zero months or younger, [0 months,] administration of the standardized tool or another protocol is not required.

(3) The interdisciplinary team, which must include an LPHA who is knowledgeable in the area of concern, must document: [describe]

(A) clinical findings; [findings] and

(B) how those findings significantly interfere with the child's functional abilities.

(4) [(2)] When the evaluation results for a child, whose adjusted age or chronological age is greater than zero months, [results, which are measured using the standardized tool designated by HHSC ECI,] do not accurately reflect the child's development or ability to function in the natural environment, the interdisciplinary team must: [team, documents this information in the child's record and proceeds to a qualitative determination of developmental delay.]

(A) document this information in the child's record; and

(B) proceed to a qualitative determination of developmental delay, which must be made by a team that includes an LPHA knowledgeable in the area of concern.

(i) [(A)] For a child with an adjusted or chronological age [of] greater than zero [0] months but less than three [3] months, the interdisciplinary team [team, which must include an LPHA knowledgeable in the area of concern,] qualitatively determines developmental delay by describing clinical findings and how those findings significantly interfere with the child's functional abilities.

(ii) [(B)] For a child with an adjusted or chronological age of at least three [3] months, the interdisciplinary team [team, which must include an LPHA knowledgeable in the area of concern,] must use the supplemental protocol designated by HHSC ECI to qualitatively determine developmental delay. The developmental domains

and sub-domains that can be used for qualitative determination of delay are established by HHSC ECI.

§350.823. Continuing Eligibility Criteria.

(a) The subrecipient [~~contractor~~] must determine the child's eligibility for continued ECI [~~early childhood intervention~~] services at least annually if the child is younger than 21 months of age at the previous eligibility determination. A child who is determined eligible at 21 months of age or older remains eligible for ECI [~~Early Childhood Intervention (ECI)~~] until the child's third birthday or until the child has reached developmental proficiency, whichever happens first.

(b) The subrecipient [~~contractor~~] must comply with all requirements in 34 CFR §303.321(a)(3). [~~§303.321(a)(3), including ensuring that informed clinical opinion may be used as an independent basis to establish a child's continued eligibility.~~]

(1) Continuing eligibility is based on one of the following:

(A) a qualifying medical diagnosis confirmed by a review of the child's medical records with:

(i) interdisciplinary team documentation of the continued need for ECI [~~early childhood intervention~~] services; and

(ii) documentation in the child's record of any change in medical diagnosis;

(B) meeting the TEA definition of deaf or hard of hearing or criteria for a visual impairment documented [~~a visual impairment or deafness or hard of hearing as defined by the Texas Education Agency~~] in 19 TAC §89.1040 (relating to Eligibility Criteria) with:

(i) interdisciplinary team documentation of the continued need for ECI services including the appropriate certified teacher or teachers from the LEA as specified in §350.813 and §350.815 of this subchapter (relating to Deaf or Hard of Hearing and Blindness or Visual Impairment, respectively); [~~early childhood intervention services;~~] and

(ii) documentation in the child's record of any change in hearing or vision status; or

(C) a developmental delay determined by the administration of the standardized tool designated by HHSC [~~the Texas Health and Human Services Commission (HHSC)~~] ECI, with the child demonstrating a documented delay of at least 15 percent in one or more areas of development, including the use of adjusted age as specified in §350.819 of this subchapter (relating to Age Adjustment for Children Born Prematurely), as applicable.

(2) If a child's initial eligibility is based on a qualitative determination of developmental delay, the subrecipient must re-determine eligibility using the criteria in subsection (b)(1) of this section no more than six months after initial eligibility is determined. [~~Continuing eligibility for a child whose initial eligibility was based on a qualitative determination of developmental delay must be determined after six months.~~]

[~~(A) Eligibility is re-determined through an evaluation using the standardized tool designated by HHSC ECI.~~]

[~~(B) The child must demonstrate a documented delay of at least 15 percent in one or more areas of development. If applicable, use adjusted age as specified in §350.819 of this subchapter.~~]

(c) If the parent fails to consent or fails to cooperate in re-determination of eligibility, the child becomes ineligible. The subrecipient [~~contractor~~] must provide [~~send~~] prior written notice of ineligibility and consequent discontinuation of all ECI services to the family at least 14 days before the subrecipient [~~contractor~~] discharges the child from the program, unless the parent:

(1) immediately consents to and cooperates in all necessary evaluations and assessments; and

(2) consents to all or part of a new IFSP. [~~Individualized Family Service Plan.~~]

(d) The family has the right to oppose the actions described in subsection (c) of this section using their procedural safeguards including the rights to use local and state complaint processes, request mediation, or request an administrative hearing in accordance with 40 TAC §101.1107 (relating to Administrative Hearings Concerning Individual Child Rights).

§350.825. Eligibility Statement.

(a) The interdisciplinary team must document eligibility decisions regarding a child on an eligibility statement containing the elements required by HHSC ECI.

(b) The eligibility statement must document the eligibility criteria that applies to the child. Only one of the following eligibility types may be listed on the eligibility statement:

(1) a [~~medically~~] qualifying medical diagnosis; [~~diagnosis, a qualifying auditory or visual impairment, or~~]

(2) meeting the criteria for deaf or hard of hearing or a visual impairment as defined by the TEA; or

(3) completion of the elements required by HHSC ECI for a determination of developmental delay.

(c) The eligibility statement must be:

(1) completed for every child evaluated;

(2) maintained in the child's record; and

(3) updated when eligibility is re-determined.

[~~(d) Only one eligibility type may be listed on the eligibility statement:~~]

[~~(1) medical diagnosis;~~]

[~~(2) vision or hearing impairment as defined by the Texas Education Agency; or~~]

[~~(3) developmental delay.~~]

(d) [~~(e)~~] The eligibility statement is valid:

(1) for 12 [~~twelve~~] months if the child is younger than 21 months of age when eligibility is determined;

(2) until the child's third birthday for a child whose eligibility was determined at 21 months of age or older; or

(3) for six months from the initial eligibility determination if eligibility was based on a qualitative determination of developmental delay.

(e) [~~(f)~~] If new information about additional qualifying criteria is discovered, the new information is documented in the child's record. The eligibility statement does not need to be changed or updated until eligibility is re-determined.

§350.829. Review of Nutrition Status.

(a) The interdisciplinary team must complete a review of the child's nutrition status by any of the following methods no later than 28 days after the initial IFSP is developed: [~~development through any of the following:~~]

(1) a review of the child's medical records;

(2) a review of the child's nutrition evaluation;

(3) a review of a doctor's physical examination for the child;

(4) a review of a nurses' evaluation for the child;

(5) a thorough discussion of family routines; or

(6) a review of nutrition risk factors. [completion of HHSC ECI nutrition screening.]

(b) The service coordinator must refer the child to a registered dietician if nutrition [nutritional] needs are identified.

§350.833. Autism Screening.

(a) Autism screening is not required if the child has been screened for autism spectrum disorder by another entity or has been identified as having autism spectrum disorder.

(b) The subrecipient [contractor] does not diagnose autism spectrum disorder.

(c) If an enrolled child is 18 months or older, the interdisciplinary team must determine if the child:

(1) has a family history of autism spectrum disorder;

(2) has lost previously acquired communication [speech] or social skills; or

(3) exhibits a language or cognitive delay or unusual communication patterns combined with a social, emotional, [emotional] or behavioral concern, including repetitive or stereotypical behaviors.

(d) If the interdisciplinary team identifies any of the issues in subsection (c) of this section, a member of the team must explain to the family the importance of early screening for autism spectrum disorder. [must:]

(e) The subrecipient must obtain written parental consent to refer the child to their licensed health care provider to complete the Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) and the follow-up interview, if appropriate.

(f) If the child is not screened by the child's licensed health care provider or the subrecipient is unable to receive the screening from the child's licensed health care provider in a timely manner, the subrecipient must obtain written parental consent to:

(1) complete the M-CHAT-R; and

[(1) explain to the family the importance of early screening for autism;]

(2) complete the M-CHAT-R follow-up interview for a child who does not pass the M-CHAT-R screening.

[(2) request and obtain written consent for the screening;]

[(3) complete the Modified Checklist for Autism in Toddlers Revised (M-CHAT-R) if the child is not screened by the child's licensed health care provider or is unable to receive the screening from the child's licensed health care provider in a timely manner; and]

[(4) complete the M-CHAT-R follow-up interview for a child who does not pass the M-CHAT-R screening.]

(g) [(e)] The subrecipient [contractor] must make appropriate referrals if needs are identified. Appropriate referrals may [This could] include:

(1) a referral to appropriate clinicians for a child who does not pass both the M-CHAT-R and the follow-up interview; and

(2) the provision of case management to assist the parent with having an autism spectrum disorder screening done by the child's licensed health care provider if they do not consent to a screening by the subrecipient. [contractor.]

(h) [(f)] The use of the M-CHAT-R screening does not take the place of the appropriate evaluation of the child required under this subchapter.

§350.835. Subrecipient [Contractor] Oversight.

Subrecipients [Contractors] must have internal written procedures that establish a system of clinical oversight for eligibility determination. Clinical oversight, which is conducted by a person with knowledge of evaluation and assessment of young children, includes ensuring that:

(1) HHSC ECI eligibility criteria is applied consistently to all children who are evaluated;

(2) testing is administered and scored accurately according to the requirements of the selected tool designated by HHSC ECI;

(3) evaluations to determine eligibility are comprehensive;

(4) test scores are interpreted and determination of delay includes the application of informed clinical opinion; and

(5) eligibility decisions are fully documented in:

(A) the eligibility statement; and

(B) progress note or evaluation report.

§350.837. Needs Assessment.

(a) The IFSP team, which includes the service coordinator, must conduct a comprehensive needs assessment initially and annually as part of the IFSP process. The comprehensive needs assessment must include: [identify and document:]

(1) an assessment of the child; and [the needs of the child in each developmental area as listed in 34 CFR 303.21(a)(1), including those identified through the evaluation and observation;]

(2) a family-directed assessment. [the family's concerns regarding their child's development and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child;]

[(3) the functional abilities and unique strengths of the child; and]

[(4) the family's description of their resources, concerns, and priorities related to enhancing the child's development.]

(b) The assessment of the child must include:

(1) a review of the results of the child's evaluation;

(2) personal observations of the child; [and]

(3) the functional abilities and unique strengths of the child; and

(4) [(3)] the identification of the child's needs in each of the developmental areas listed in 34 CFR §303.21(a)(1).

(c) The subrecipient [contractor] must offer to conduct a family-directed assessment and comply with requirements in 34 CFR §303.321(c). [§303.321(c) (relating to Procedures for assessment of the child and family) to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.] The family-directed assessment must:

(1) be voluntary on the part of each family member participating in the assessment; [and]

(2) be based on information obtained through the assessment as well as [tool and also] through an interview with those family members participating in the assessment; and [assessment.]

(3) identify the family's resources, priorities, and concerns, as well as the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

(d) The IFSP team [Providers] must assess and document the child's progress and needs of the family on an ongoing basis.

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

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Karen Ray
Chief Counsel
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For further information, please call: (512) 424-6580

SUBCHAPTER J. INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

26 TAC §350.1001

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1001. Purpose.

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

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26 TAC §§350.1003, 350.1004, 350.1007, 350.1009, 350.1015, 350.1017, 350.1019

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1003. Definitions.

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

(1) Frequency--The number of days or sessions that a service will be provided within a specified period of time.

(2) Functional ability [Ability]--A child's ability to carry out meaningful behaviors in the context of everyday living, through skills that integrate development across domains.

(3) IFSP goals [Goals]--Statements of the measurable results that the family wants to see for their child or themselves.

(4) Intensity--The length of time a service is provided during a session expressed as a specific amount of time instead of a range.

(5) Method--If the service is delivered in a group or on an individual basis.

(6) Periodic review [Review]--As defined in 34 CFR §303.342(b), a review by the IFSP team, based on the assessment of the child, that results in approval of or modifications to the IFSP.

§350.1004. Individualized Family Service Plan [(IFSP)] Development.

(a) The IFSP team must develop a written initial IFSP no more than [within] 45 days after [from] the date the subrecipient [Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI)] receives a referral on a child unless the child or parent is unavailable due to exceptional family circumstances documented in the child's record. The IFSP must be: [be]

(1) completed during a face-to-face meeting with a [the] family in accordance with 20 USC §1436 and 34 CFR §§303.340 - 303.346; and [303.346.]

(2) [(b) The IFSP must be] developed based on evaluation and assessment of a child as described in 34 CFR §303.321 and Subchapter H of this chapter (relating to Eligibility, Evaluation, and Assessment).

(b) An IFSP must address the developmental needs of the child and the case management needs of the family as identified in the comprehensive needs assessment, unless the family declines to address a specified need.

(c) A subrecipient [contractor] must provide a parent with a copy of the IFSP [IFSP, as required by 34 CFR §303.405 and §303.409] and maintain the original IFSP in the child's record.

(d) A subrecipient [contractor] must deliver ECI [early childhood intervention] services according to the IFSP.

(e) An IFSP team must conduct a periodic review of the IFSP at least every six months in accordance with 34 CFR §303.342.

(f) If a child was [An IFSP meeting must be conducted at least annually, if the child was] younger than 21 months of age on the date of the previous initial or annual IFSP meeting, an IFSP meeting must be conducted at least annually to evaluate and revise, as appropriate, the IFSP for a child and the child's family in accordance with 34 CFR

§303.342. The meeting may be conducted by a method other than face-to-face if:

(1) approved by the parent;

(2) the subrecipient [~~contractor~~] has a plan approved by HHSC for conducting annual IFSP meetings by a method other than face-to-face when appropriate for the child and family; and

(3) the subrecipient [~~contractor~~] documents how the LPHA's [~~Licensed Practitioner of the Healing Arts'~~] observations and conclusions of the re-evaluation of the child were communicated and incorporated into the IFSP.

(g) If a [~~the~~] child was 21 months of age or older on the date of the previous initial or annual IFSP, the IFSP team must conduct a periodic review that meets the requirements in §350.1017 of this subchapter (relating to Periodic Reviews). [~~Review).~~]

(h) Documentation in the child's record must reflect compliance with related state and federal requirements.

(i) The subrecipient [~~contractor~~] must comply with all requirements in Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures) during the IFSP process.

§350.1007. Interim Individualized Family Service Plan [~~(IFSP)~~].

(a) An interim IFSP may be developed for an eligible child and family who need supports and services to begin immediately. ECI [~~Early Childhood Intervention (ECI)~~] services may begin before completing an evaluation and assessment if: [~~if the following conditions are met:~~]

(1) parental consent is obtained;

(2) the interim IFSP includes the name of the assigned service coordinator;

(3) the interim IFSP includes the services that have been determined to be needed immediately; and

(4) the evaluation, assessment, and initial IFSP are completed within the 45-day timeframe in accordance with 34 CFR §303.310.

(b) An annual interim IFSP may be developed for an eligible child and family who need supports and services to continue when exceptional family circumstances prevent the team from completing all required components of the annual meeting to evaluate the IFSP in accordance with §350.1019 of this subchapter (relating to Annual Meeting to Evaluate the Individualized Family Service Plan). [~~IFSP).~~] ECI services may continue if: [~~if the following conditions are met:~~]

(1) parental consent is obtained;

(2) the interim IFSP is in accordance with 34 CFR §303.342;

(3) the interim IFSP includes the name of the assigned service coordinator;

(4) the interim IFSP includes the services that have been determined to be needed; and

(5) the evaluation, assessment, and all required components of the annual meeting to evaluate the IFSP must be completed within 45 days of the date the annual review of the IFSP was due.

§350.1009. Participants in Initial and Annual Individualized Family Service Plan [~~(IFSP)~~] Meetings.

(a) The initial IFSP meeting and each annual meeting to evaluate the IFSP must be conducted by the IFSP team as defined in §350.103 of this chapter (relating to Definitions) and 34 CFR §303.343(a).

[~~(b) The initial IFSP meeting and the annual meeting to evaluate the IFSP must be conducted by an interdisciplinary team that includes, at a minimum, the parent and at least two professionals from different disciplines or professions.~~]

[~~(1) At least one professional must be an Early Childhood Intervention (ECI) service coordinator.~~]

[~~(2) At least one professional must be a Licensed Practitioner of the Healing Arts (LPHA).~~]

[~~(3) At least one ECI professional must have been involved in conducting the evaluation. This may be the service coordinator, the LPHA, or a third professional.~~]

[~~(4) If the LPHA attending the IFSP meeting did not conduct the evaluation, the contractor must ensure that the most recent observations and conclusions of the LPHA who conducted the evaluation were communicated to the LPHA attending the initial IFSP meeting and incorporated into the IFSP.~~]

[~~(5) Other team members may participate by other means acceptable to the team.~~]

(b) [~~(c)~~] With parental consent, the subrecipient [~~contractor~~] must also invite to the initial IFSP meeting and annual meetings to evaluate the IFSP:

(1) Early Head Start or [~~and~~] Migrant Head Start staff members, if the family is jointly served by either of these programs; and

(2) representatives from other agencies serving or providing case management to the child or family, including Medicaid managed care programs.

(c) [~~(d)~~] If a child:

(1) is documented to be deaf or hard of hearing as described in §350.809(2) [~~§350.813(a)~~] of this chapter (relating to Initial Eligibility Criteria [~~Determination of Hearing and Auditory Status~~]), the IFSP team for an initial IFSP meeting and annual IFSP evaluation meetings must include a certified teacher of the deaf and hard of hearing; or

(2) has a documented visual impairment as described in §350.809(2) [~~§350.815(a)~~] of this chapter (relating to Initial Eligibility Criteria [~~Determination of Vision Status~~]), the IFSP team for an initial IFSP meeting and annual IFSP evaluation meetings must include a certified teacher of the visually impaired.

(d) [~~(e)~~] Unless there is documentation that the LEA [~~Local Education Agency~~] has waived notice, the subrecipient [~~contractor~~] must:

(1) provide the certified teacher required in subsection (c) [~~(d)~~] of this section at least a 10-day written notice before the initial IFSP meeting, any annual meetings to evaluate the IFSP, or any review and evaluation that affects the child's deaf and hard of hearing or vision services; and

(2) keep documentation of the notice in the child's [~~ECI~~] record.

(e) [~~(f)~~] The IFSP team cannot plan deaf and hard of hearing or vision services or make any changes that affect those services if the certified teacher required in subsection (c) [~~(d)~~] of this section is not in attendance.

(f) The certified teacher required in subsection (c) of this section is not required to attend an IFSP review when changes do not affect

the child's deaf and hard of hearing or vision services, but the subrecipient must obtain the teacher's input.

(g) The IFSP team must route the IFSP to the certified teacher required in subsection (c) [(d)] of this section for review and signature when changes to the IFSP do not affect the child's deaf and hard of hearing or vision services.

(h) The certified teacher of the deaf and hard of hearing and the certified teacher of the visually impaired required in subsection (c)[(d)] of this section may submit a request within five days of the IFSP meeting to have another IFSP meeting if the teacher disagrees with any portion of the IFSP.

[(i) The certified teacher required in subsection (d) of this section is not required to attend an IFSP review when changes do not affect the child's deaf and hard of hearing or vision services, but the contractor must obtain the teacher's input.]

§350.1015. Content of the Individualized Family Service Plan [IFSP].

(a) The IFSP team must develop a written IFSP containing all requirements in 20 USC §1436(d) and 34 CFR §303.344 [(relating to Content of an IFSP)]. The IFSP must include the IFSP services pages [standardized IFSP Services Pages] and all of the required elements designated by HHSC ECI, including:

(1) a description of the child's present levels of development, including:

(A) information about the child's participation in the family's typical routines and activities;

(B) the child's strengths;

(C) the child's developmental needs;

(D) the family's concerns and priorities; and

(E) the child's functional abilities identified with codes for establishing the child outcome ratings, described in §350.1307 [§108.1307] of this chapter (relating to [(regarding] Child Outcomes); [Outcomes).]

(2) a description of the case management needs of the family;

(3) measurable goals that address:

(A) the child's and family's needs that [which] were identified during pre-enrollment, evaluation, and assessment;

(B) the child's functional developmental skills by describing targeted participation in everyday family and community routines and activities; and

(C) when the IFSP goal [target] is achieved and the action or skill is generalized;

(4) services to:

(A) address the goals in the IFSP;

(B) enhance the child's functional abilities, behaviors, and participation in daily routines; and

(C) strengthen the capacity of the family to meet the child's unique needs;

(5) the discipline of each provider for every service planned; and

(6) the name of the service coordinator.

(b) IFSP services must be monitored by the IFSP team to assess child progress [by the interdisciplinary team] as described in §350.1017 [§108.1017] of this subchapter [chapter] (relating to Periodic Reviews).

(c) If the IFSP team determines co-visits are necessary to meet the developmental needs of the child, the IFSP team must:

(1) list each service on the IFSP; and

(2) document in the IFSP a justification of how the child and family will receive greater benefit from the services being provided at the same time.

(d) If providing services with the participation of the routine caregiver in the absence of the parent is necessary, the IFSP team must follow the requirements in §350.1016 [§108.1016] of this subchapter [chapter] (relating to Planning for Services to be Delivered with the Routine Caregiver).

(e) If the IFSP team determines group services are necessary to meet the developmental needs of the child [individual infant or toddler]:

(1) the group services must be planned in an IFSP that also contains individual IFSP services; and

(2) the planned group services must be documented in the child's IFSP.

(f) If the IFSP team determines that an IFSP goal cannot be achieved satisfactorily in a natural environment, the IFSP must contain a justification as to why an early childhood intervention service will be provided in a setting other than a natural environment, as determined appropriate by the parent and the rest of the IFSP team.

(g) The contents of the IFSP must be fully explained to the parent.

(h) The subrecipient [contractor] must obtain the parent's signature on the IFSP services pages [page]. The parent's signature on the IFSP services pages serve [page serves] as written parental consent to provide the ECI services in the IFSP [services].

(1) The written parental consent is valid for up to one year or until the IFSP team changes the type, intensity, or frequency of services.

(2) The subrecipient [contractor] must not provide ECI services in the IFSP [services] without current written parental consent.

(i) The subrecipient [contractor] must obtain[, on the IFSP services page,] the dated signatures of every member of the IFSP team on the IFSP services pages. The IFSP must be signed by the LPHA on the team to acknowledge the planned services are reasonable and necessary.

(j) The subrecipient [contractor] must provide the parent a copy of the signed IFSP.

(k) Any time the subrecipient [contractor] assigns a new service coordinator, the following must be documented and attached to the IFSP:

(1) the name of the new service coordinator;

(2) the date of the change; and

(3) the date the family was notified of the change and the method of notification.

§350.1017. Periodic Reviews.

(a) Each periodic review must be conducted by individuals who meet the requirements in 34 CFR §303.343(b) [(relating to IFSP

Team meetings and periodic reviews)] and be completed in compliance with 34 CFR §303.342(b) [(relating to Procedures for IFSP development, review, and evaluation)]. The periodic review may be carried out by a meeting or by another means that is acceptable to the parents and other participants.

(b) The [Additionally, the] child's record must contain documentation that includes all required elements designated by HHSC ECI. [of all IFSP team members' participation in the periodic review.]

(1) Participation in the periodic review may be accomplished by a team member attending the meeting face-to-face or by telephone or by providing input and information in advance of the meeting.

(2) If a team member participates by means other than a face-to-face meeting, the team member must give the service coordinator his or her most recent observations and conclusions about the child, and the team member must document how and when the information was shared. [child. The team member must document in the child's record how this information was communicated to the service coordinator.]

(3) If the team member is an LPHA who is not providing ongoing services to the child, he or she must have assessed the child face-to-face within the previous 45 days.

(c) A periodic review is required at least every six months.

(d) Additional periodic reviews of the IFSP are conducted more frequently than six-month intervals if requested by the parent or other IFSP team members.

(e) The periodic review of the IFSP consists of the following actions, which must be documented in the child's record and be provided to the parent:

(1) a review of the child's progress toward meeting each goal on the IFSP and the child's functional abilities related to the goal;

(2) a review of the current developmental needs of the child and the needs of the family related to their ability to meet the developmental concerns and priorities;

(3) a review of the case management needs of the child and the family;

(4) the development of new goals or the modification of existing goals, as appropriate, that must be dated and attached to the IFSP; and

(5) the reasons for any modification to the plan or the rationale for not changing the plan.

(f) If the IFSP team adds transition steps and transition services as part of the periodic review, the team must follow the requirements in §350.1207(d) [§108.1207(d)] of this chapter (relating to Transition Planning).

(g) If the team determines that changes to the type, intensity, or frequency of services are required:

(1) the team completes the [a HHSC required] IFSP services pages [Services Page] and provides a copy to the parent;

(2) the team must document the rationale for:

(A) a change in intensity or frequency of a service;

(B) the addition of a new service; or

(C) the discontinuation of a service; and

(3) the subrecipient [contractor] must continue to provide planned ECI [early childhood intervention] services not affected by the change while the IFSP team develops the IFSP revision and gathers required signatures.

(h) If services remain the same, the documentation must describe the rationale for making no changes and for recommending continued services.

(i) If new goals are developed, the documentation must be provided to the parent.

(j) A change of service coordinator does not require a periodic review.

§350.1019. Annual Meeting to Evaluate the Individualized Family Service Plan [IFSP].

(a) The annual meeting to evaluate the IFSP is conducted after determination of continuing eligibility as described in §350.823 of this chapter (relating to Continuing Eligibility Criteria). [following determination of continuing eligibility.]

(b) In addition to all requirements in 34 CFR §303.342, [§303.342 (relating to Procedures for IFSP development, review, and evaluation),] the documentation of an annual meeting to evaluate [Annual Meeting to Evaluate] the IFSP must [meet the requirements for Complete Review and] include a [documented] team discussion of:

(1) a current description of the child including:

(A) [reviews of the] current evaluations and other information available from ongoing assessment of the child and family needs;

(B) health, vision, hearing, and nutritional status; and

(C) present levels [level] of development related to the three annual child outcome ratings found in §350.1307[§108.1307] of this chapter (relating to Child Outcomes); [Outcomes) including:]

[(i) the functional abilities and strengths of the child;]

[(ii) the developmental needs of the child; and]

[(iii) the family priorities regarding the child's development.]

(2) progress toward achieving the IFSP goals; and

(3) any needed modification of the goals and ECI[early childhood intervention] services.

(c) [(b)] Services provided under an IFSP that has not been evaluated and is not based on a current evaluation and current assessment of needs do [are] not meet the requirements for [fully approved] ECI services.

(1) If the subrecipient [contractor] is at fault, HHSC may disallow and recoup expenditures.

[(2) If the parent has not consented to or has not cooperated with the re-determination of eligibility, the contractor must follow the procedures in §108.807 of this title (relating to Eligibility).]

(2) [(3)] If the parent fails to consent or fails to cooperate in necessary re-evaluations or re-assessments, the subrecipient must respond as indicated in §350.823(c) of this chapter. [no developmental delay or needs may be legitimately determined. The contractor must send prior written notice that the child has no documented current delay or no documented current needs at least 14 days before the contractor discontinues services on the IFSP, unless the parent:]

[~~(A) immediately consents to and cooperates with all necessary evaluations and assessments; and~~]

[~~(B) consents to all or part of a new IFSP.~~]

(d) [~~(c)~~] The parent retains procedural safeguards including the rights to use local and state complaint processes, request mediation, or request an administrative hearing pursuant to 40 TAC §101.1107 [~~of this title~~] (relating to Administrative Hearings Concerning Individual Child Rights).

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

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SUBCHAPTER K. SERVICE DELIVERY

26 TAC §350.1101

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1101. Purpose.

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

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26 TAC §§350.1104, 350.1108, 350.1111

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendment affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1104. Early Childhood Intervention Services Delivery.

(a) ECI services [~~Early childhood intervention services~~] needed by the child must be initiated in a timely manner and delivered as planned in the IFSP. [~~Individualized Family Service Plan (IFSP).~~]

(b) Only qualified staff members, as described in Subchapter C of this chapter (relating to Staff Qualifications), are authorized to provide ECI [~~early childhood intervention~~] services.

(c) [~~(b)~~] The subrecipient [~~contractor~~] must ensure that ECI [~~early childhood intervention~~] services are appropriate, as determined by the IFSP team, and based on scientifically based research. [~~research, to the extent practicable.~~]

(d) In addition to the requirements in 34 CFR §303.13, ECI [~~early childhood intervention~~] services, with the exception cited in subsection (g)[~~(e)~~] of this section, must be provided:

(1) according to a plan and with a frequency that is individualized to the parent and child to effectively address the goals established in the IFSP;

(2) only to children who are located in the state of Texas at the time a service is delivered; [~~of service delivery;~~]

(3) in the presence of the parent or other routine caregiver, with an emphasis on enhancing the family's capacity to meet the developmental needs of the child; and

(4) in the child's natural environment, as defined in 34 CFR §303.26, unless the criteria listed in 34 CFR §303.126 are met and documented in the case record. [~~and may be provided via telehealth~~]

(e) With [~~with~~] the written consent of the parent, ECI services may be provided via telehealth. [~~parent.~~] If the parent declines to consent to telehealth for some or all services, those services must be provided in person.

[~~(c) Family education and training, as defined in §350.1105(5) of this subchapter (relating to Capacity to Provide Early Childhood Intervention Services):~~]

[~~(1) must be provided:~~]

[~~(A) according to a plan and with a frequency that is individualized to the parent and child to effectively address the goals established in the IFSP; and~~]

[~~(B) with a parent or other routine caregiver, with an emphasis on enhancing the family's capacity to meet the developmental needs of the child; and~~]

[~~(2) may be provided:~~]

[~~(A) when a child who resides in Texas is not located in the state at the time of service; and~~]

[~~(B) in a setting other than a child's natural environment.~~]

(f) [~~(d)~~] ECI [~~Early Intervention~~] services must:

(1) address the development of the whole child within the framework of the family;

(2) enhance the parent's competence to maximize the child's participation and functional abilities within daily routines and activities; and

(3) be provided in the context of natural learning activities in order to assist caregivers to implement strategies that will increase child learning opportunities and participation in daily life.

(g) Family education and training, as defined in §350.1105(5) of this subchapter (relating to Capacity to Provide Early Childhood Intervention Services):

(1) must be provided:

(A) according to a plan and with a frequency that is individualized to the parent and child to effectively address the goals established in the IFSP; and

(B) with a parent or other routine caregiver, with an emphasis on enhancing the family's capacity to meet the developmental needs of the child; and

(2) may be provided:

(A) when a child who resides in Texas is not located in the state at the time of service; and

(B) in a setting other than a child's natural environment.

(h) [(e)] The subrecipient [contractor] must provide a service coordinator and an interdisciplinary team for the child and family throughout the child's enrollment.

(i) [(f)] The subrecipient [contractor] must make reasonable efforts to provide flexible hours in programming [in order] to allow the parent or routine caregiver to participate.

(j) [(g)] The subrecipient [contractor] must comply with all requirements in Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures) when planning and delivering ECI [early childhood intervention] services.

(k) [(h)] Services must be monitored by the IFSP team to assess child progress as described in §350.1017 of this chapter (relating to Periodic Reviews). [interdisciplinary team at least once every six months to determine:]

[(1) what progress is being made toward achieving goals;]

[(2) if services are reducing the child's functional limitations, promoting age appropriate growth and development, and are responsive to the family's identified goals for the child; and]

[(3) whether modifications to the plan are needed.]

[(i) Monitoring occurs as part of the IFSP review process and must be documented in the case record.]

§350.1108. State-Funded [State Funded] Respite Services.

(a) The state's [Texas] General Appropriations Act authorizes reimbursement to the enrolled child's family for respite services that are not directly related to IFSP goals.

(b) Respite services are defined as the care of an enrolled child by a relative or substitute caregiver on a short-term or intermittent basis to provide the child's parent with a break from caring for his or her child. Respite services do not include the routine care of a child for the purposes of allowing a parent to attend work or school.

(c) The subrecipient [contractor] must develop and implement a process for administering the state-funded [state funded] reimbursement of respite services.

(1) The subrecipient [contractor] may collaborate with other ECI subrecipients [contractors] within their respective consortium to administer the funds.

(2) The subrecipient [contractor] must identify existing respite resources in the community, including potential respite service providers and additional funding sources, before authorizing state-funded [state funded] respite reimbursement.

(3) The subrecipient [contractor] may provide reimbursement for respite services up to the hourly limit set by HHSC ECI, based on the individual needs of the [20 hours of respite per child per month, based on the individual needs of the] family. The subrecipient [contractor] may exceed the hourly [20 hours] respite limit only if:

(A) the family has more than one child enrolled in the ECI program; and

(B) the IFSP team determines that the children cannot be cared for by a single respite provider.

(4) If the parent and the service coordinator do not agree on the complexity of care, based on the needs of the child, and the ECI reimbursement rate, the subrecipient's ECI program director decides the complexity of care and reimbursement rate.

(5) The subrecipient [contractor] must have a process for prioritizing requests for state-funded [state funded] respite reimbursement, and the [reimbursement. The] process must include consideration of:

(A) how respite will benefit the family relationship; and

(B) past use of respite services.

(6) If state respite funds are not available at the time of a request, the subrecipient [contractor] places the eligible family on a waiting list for respite funds.

(7) State respite funds cannot be used to pay:

(A) insurance co-payments, insurance deductibles, or insurance premiums;

(B) a parent to provide respite services to his or her own child;

(C) individuals who live in the same household as the child;

(D) individuals under 18 years of age; or

(E) costs for the care of siblings of the eligible child.

(d) The subrecipient [contractor] must maintain auditable records of state-funded respite reimbursement.

(e) The subrecipient [contractor] must report the number of children whose families received state-funded [state funded] reimbursement of respite services for each month of the contract period as directed by HHSC.

(f) The service coordinator must:

(1) assist the parent in identifying available family and community resources;

(2) assist the parent in determining the type (for example, individual setting, group setting, care in the child's home, or care out of the child's home) and frequency of respite needed;

(3) assist the parent in applying for available state funds for reimbursement of respite services, if needed;

(4) determine the complexity of care, based on the needs of the child;

(5) inform the parent of the following:

(A) state funds under this provision are limited;

(B) the state's annual hourly limits per child;

(C) the hourly co-pay based on family size and income;

(D) the state's level of reimbursement based upon the complexity of care, frequency, and hourly co-pay;

(E) the subrecipient's [contractor's] criteria for prioritizing requests for state funds for reimbursement of respite services and placement on the waiting list; and

(F) the process for requesting a review and decision by the program director if the parent and the service coordinator do not agree on the frequency and complexity of care, based on the needs of the child, and the ECI reimbursement rate.

(g) The service coordinator must explain to the parent what responsibilities the parent has [their responsibility] regarding state-funded [state funded] reimbursement for respite services. The parent is responsible for:

(1) selecting and supervising a respite provider;

(2) scheduling the respite care with the provider;

(3) paying the provider after the respite care is provided;

(4) submitting the completed respite voucher to the subrecipient [contractor] within one month of the voucher's expiration date;

(5) assuming any liability for the selection and use of specific respite providers; and

(6) complying with any potential tax or Internal Revenue Service [IRS] requirements related to the use of state-funded [state funded] respite reimbursement.

(h) The following events must occur in order:

(1) the subrecipient [contractor] determines the number of hours and the level of care for each month, the number of months approved, the beginning and ending dates of the agreement, and the hourly co-pay required;

(2) the subrecipient [contractor] completes all required information on the respite funding agreement;

(3) the parent, the service coordinator or other assigned staff member, and the program director (or designee)[,] sign the completed respite funding agreement;

(4) the subrecipient [contractor] gives the parent a respite voucher for each calendar month in which respite services are approved;

(5) the parent schedules respite with the respite provider;

(6) the respite provider signs the respite voucher after providing the respite care;

(7) the parent completes, signs, and returns the voucher to the subrecipient [contractor] within one month of the voucher's expiration date; and

(8) the subrecipient [contractor] reimburses the parent no more than [within] 30 days after the [of] receipt of an accurately completed voucher.

§350.1111. Service Delivery Documentation Requirements.

Documentation of each service contact must include:

(1) the name of the child;

(2) the name of the subrecipient; [ECI contractor and]

(3) the name and the discipline of the ECI professional; [service provider;]

(4) [(3)] the date, start time, length of time, and place of service;

(5) [(4)] method (individual or group);

(6) [(5)] a description of the techniques by which the provider engaged the family or routine caregiver in activities to meet the developmental needs of the child, which [child. This] includes:

(A) coaching and strategies provided [instructions] to the family or caregiver;

(B) discussing how activities apply to child and family routines; and

(C) modeling intervention techniques within everyday learning opportunities, including a description of the opportunity for the caregiver's return demonstration;

(7) [(6)] the IFSP goal or goals that were [was] the focus of the intervention;

(8) [(7)] the child's progress related to the IFSP goals addressed during the service; [goals in the IFSP;]

(9) [(8)] relevant new information about the child provided by the family or other routine caregiver; [and]

(10) [(9)] the ECI professional's [service provider's] signature; and [signature.]

(11) the ECI professional's credential.

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

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SUBCHAPTER L. TRANSITION

26 TAC §350.1201

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1201. Purpose.

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

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26 TAC §§350.1203, 350.1207, 350.1209, 350.1211, 350.1213, 350.1215, 350.1217, 350.1219, 350.1221

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1203. Definitions.

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

(1) Community transition meeting [~~Transition Meeting~~]--A meeting held to discuss how the subrecipient[~~contractor~~] will assist the family with transitioning from ECI [~~early childhood intervention~~] services to community services, activities, places, or programs that the family would like the child to participate in after exiting ECI [~~early childhood intervention~~] services.

(2) LEA notification [~~Notification~~]--A notification sent [~~Notification~~] to the LEA of a child who is potentially eligible for ECSE [~~LEA~~] services. [~~The parent may opt out of the LEA Notification.~~]

(3) LEA notification opt out [~~Notification Opt Out~~]--The parent's choice not to allow the subrecipient [~~contractor~~] to send the child's limited personally identifiable information to the LEA to meet [~~LEA Notification~~] requirements in §350.1211 of this subchapter (relating to Local Education Agency Notification of Potential Eligibility for Early Childhood Special Education Services).

(4) LEA transition conference [~~Transition Conference~~]--A meeting to discuss ECSE services [~~LEA special education services~~] and eligibility determination for [~~special education services for~~] children who are potentially eligible for ECSE [~~special education~~] services.

(5) Limited personally identifiable information [~~Personally Identifiable Information~~]--The child's and parent's names, addresses, and phone numbers; child's date of birth; service coordinator's name; and language spoken by the child and family.

(6) Transition planning [~~Planning~~]--The process of identifying and documenting appropriate steps and transition services to support the child and family to smoothly and effectively transition from ECI [~~early childhood intervention~~] services to ECSE [~~LEA special education~~] services or other community services, activities, places, or programs that the family would like the child to participate in after exiting ECI [~~early childhood intervention~~] services.

§350.1207. Transition Planning.

(a) Transition planning is a process for [~~that involves~~] developing and updating appropriate transition steps and transition services:

(1) jointly with families; and

(2) based on recommendations from the IFSP [~~Individualized Family Service Plan (IFSP)~~] team.

(b) All transition activities must be documented in the child's record.

(c) The IFSP must contain an appropriate general transition statement.

(d) The subrecipient [~~contractor~~] must conduct an IFSP [~~a~~] meeting, which includes the parent, in accordance with 34 CFR §303.342(d) and (e) and §303.343(a), to plan and document transition [~~appropriate~~] steps and transition services [~~in the IFSP~~].

(1) Except as provided in subsections (f) and [-] (g) of this section, the meeting to plan and document transition [~~appropriate~~] steps and transition services [~~in the IFSP~~] must be conducted: [~~conducted~~]

(A) no less [~~not fewer~~] than 90 days before the child's third birthday; and [~~days, and at the discretion of all parties,~~]

(B) not more than nine months before the child's third birthday.

(2) If the child is referred and determined to be eligible for ECI services more than 45 but less than 90 days before the child's third birthday, [~~appropriate~~] transition steps and transition [~~transitions~~] services must be included in the child's initial IFSP.

(3) [~~(2)~~] If transition planning occurs at a periodic review instead of an initial or annual IFSP meeting, the meeting must meet the requirements in 34 CFR §303.342(d) and (e) and §303.343(a).

(4) [~~(3)~~] The appropriate transition steps and transition services that the IFSP team plans at the meeting must be documented in the IFSP and must include:

(A) timelines and responsible party for each transition activity;

(B) discussions with and training of parents, as appropriate, regarding future placements and other matters related to the child's transition;

(C) procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting;

(D) the family's choice for the child to transition into a community or educational program or for the child to remain in the home;

(E) identification of transition [~~appropriate~~] steps and transition services, as determined [~~deemed necessary~~] by the IFSP team, to support the family's exit from ECI services to ECSE or other community services, [~~early childhood intervention services to Local Education Agency (LEA) special education services or other appropriate~~] activities, places, or programs the family would like the

child to participate in after exiting ECI [~~early childhood intervention~~] services;

(F) confirmation that the transition notification, which requires child find information to be sent [~~transmitted~~] to the LEA [~~or other relevant agency,~~] has occurred;

(G) program options, if the child is potentially eligible for ECSE [~~special education~~] services, for the period from the child's third birthday through the remainder of the school year; and

(H) for children who are likely to be eligible for long-term [~~specialized~~] services and supports, information on Texas Medicaid waiver programs for people with disabilities or special health care needs, including information on how to add children to the waiver interest lists.

(e) The child's planned transition steps and transition services must be updated and documented in the IFSP anytime the:

(1) IFSP team identifies new transition [~~appropriate~~] steps and transition [~~transitional~~] services; and

(2) parent's goals for the child evolve and change.

(f) At any time during the child's enrollment in ECI [~~early childhood intervention~~] services, the IFSP team must, upon parental request, meet to plan steps to support the child and family to transition:

(1) from one subrecipient [~~contractor~~] to another subrecipient [~~contractor~~];

(2) from one family setting to another family setting; or

(3) when the family is moving out of state.

(g) If the child is referred fewer than 45 days before the child's third birthday, the IFSP team is not required to plan transition steps and transition services. If the child is potentially eligible for ECSE [~~preschool special education~~] services, the subrecipient [~~contractor~~] must, with written parental consent, refer the child directly to the LEA as soon as possible.

(h) The subrecipient [~~contractor~~] must comply with all requirements in Subchapter B of this chapter (relating to Procedural Safeguards and Due Process Procedures).

§350.1209. State Education Agency [SEA] Notification.

HHSC coordinates the SEA [~~State Education Agency's (SEA)~~] notification of children potentially eligible for ECSE, [~~special education services,~~] in compliance with 34 CFR §303.209(b).

(1) HHSC will send notification of children potentially eligible for ECSE [~~special education~~] services to the SEA at least 90 days before each child's third birthday, or as soon as possible for children who are determined eligible for ECI services more than 45 but less than 90 days before the child's third birthday.

(2) If a referral is received for a child fewer than 45 days before the child's third birthday and the child may be potentially eligible for ECSE [~~preschool special education~~] services, HHSC will, with written parental consent, refer the child directly to the SEA.

§350.1211. Local Education Agency [~~(LEA)~~] Notification of Potential Eligibility for Early Childhood Special Education Services.

(a) The IFSP team determines if a child who is two years old or older receiving ECI services is potentially eligible for ECSE. [~~The contractor's Individualized Family Service Plan (IFSP) team determines if a two year old receiving early childhood intervention services is potentially eligible for preschool special education services.~~]

(b) If the IFSP team determines the child is potentially eligible for ECSE, the subrecipient must provide notification to the LEA as soon as possible, unless the parent opts out of the disclosure as described in §350.1213 of this subchapter (relating to The Family's Right to Opt Out of the Local Education Agency Notification).

(1) Written parental consent is not required for the subrecipient [~~contractor~~] to send the LEA Notification [~~of Potentially Eligible for Special Education Services, but the parent may opt out of LEA Notification as described in §350.1213 of this subchapter (relating to LEA Notification Opt Out)~~].

(2) Written parental consent is required before sending information other than the child's limited personally identifiable information to the LEA.

(c) For a child whose parent has not opted out of the disclosure as described in §350.1213 of this subchapter: [~~subchapter,~~]

(1) the subrecipient [~~contractor~~] must notify the LEA at least 90 days before the child's third birthday that the child is potentially eligible for ECSE services; and [~~preschool special education services.~~]

(2) the subrecipient [~~The contractor~~] must send the LEA for the area in which the child resides the LEA Notification, [~~Notification of Potentially Eligible for Special Education Services,~~] which contains the child's limited personally identifiable information as defined in §350.1203(5) of this subchapter (relating to Definitions).

(d) If the subrecipient [~~contractor~~] determines a child is eligible for ECI [~~early childhood intervention~~] services less [~~fewer~~] than 90 days and more than 45 days before the child's third birthday, the subrecipient [~~contractor~~] must determine as soon as possible whether the child is potentially eligible for ECSE [~~preschool special education~~] services. [~~If the contractor determines the child is potentially eligible for preschool special education services, the contractor must provide notification to the LEA as soon as possible, unless the parent opts out of the disclosure as described in §350.1213 of this subchapter.~~]

(e) If the subrecipient [~~contractor~~] receives a referral for a child fewer than 45 days before the child's third birthday and the child may be potentially eligible for ECSE: [~~preschool special education services,~~]

(1) the subrecipient [~~contractor~~] must, with written parental consent, refer the child directly to the LEA; and [~~LEA.~~]

(2) the subrecipient [~~The contractor~~] is not required to conduct pre-enrollment procedures, an evaluation, an assessment, or an initial IFSP meeting.

(f) To assist the LEA in determining eligibility, the subrecipient [~~contractor~~], with written parental consent, must send the LEA the most recent:

(1) evaluations;

(2) assessments; and

(3) IFSPs.

§350.1213. The Family's Right to Opt Out of the Local Education Agency Notification [~~LEA Notification Opt Out~~].

(a) The parent may choose not to allow the subrecipient to: [~~contractor to~~]

(1) send the child's limited personally identifiable information to the LEA; and [~~LEA. The contractor must:~~]

(2) notify the LEA of their child's potential eligibility for ECSE services.

(b) The subrecipient must:

(1) inform the parent of the LEA Notification [~~of Potentially Eligible for Special Education Services~~] requirements before the parent signs the initial IFSP and annually as part of the annual meeting to review the IFSP; and

(2) explain the option to opt out of the LEA Notification [~~LEA Notification Opt Out~~] to the parent and the consequences of this option. [~~choice.~~]

(c) [~~(b) The parent may choose to opt out of the LEA Notification of Potentially Eligible for Special Education Services.~~] The parent must inform the subrecipient [~~contractor~~] of their decision to opt out of the LEA Notification [~~LEA Notification Opt Out choice~~] in writing before the scheduled notification date.

(d) [~~(c)~~] The subrecipient [~~contractor~~] must provide the parent written communication regarding LEA Notification that includes the following information:

(1) what information will be disclosed to the LEA;

(2) the scheduled LEA Notification date;

(3) a clear statement that the parent must inform the subrecipient [~~contractor~~] of their decision to opt out of the LEA Notification [~~LEA Notification Opt Out choice~~] in writing before the scheduled notification date; and

(4) an explanation that the child's limited personally identifiable information will be sent for LEA Notification, unless the parent informs the subrecipient of their decision to opt out of the LEA Notification [~~contractor in writing of their LEA Notification Opt Out choice~~] before the scheduled notification date.

(e) [~~(d)~~] The subrecipient [~~contractor~~] must provide the parent the written communication regarding LEA Notification as required in subsection (d) [~~(c)~~] of this section at least 10 days before limited personally identifiable information is scheduled to be released for the LEA Notification [~~of Potentially Eligible for Special Education Services~~].

(f) [~~(e)~~] If the parent opts out of the LEA Notification [~~of Potentially Eligible for Special Education Services~~] at any time before the scheduled notification date, the subrecipient [~~contractor~~] must:

(1) not send the child's limited personally identifiable information to the LEA;

(2) inform the parent that even if he or she opts out of LEA Notification, he or she can later request that the child's limited personally identifiable information be sent to the LEA; and

(3) document in the child's record:

(A) the date the written communication regarding LEA Notification was provided to the parent; and

(B) the parent's written request to opt out of LEA Notification [~~of Potentially Eligible for Special Education Services~~].

(g) [~~(f)~~] If the subrecipient [~~contractor~~] determines a child is eligible for ECI more than 45 days but less than 90 days before the child's third birthday and the IFSP team determines the child is potentially eligible for special education services, the subrecipient [~~contractor~~] must:

(1) immediately inform the parent of the LEA Notification requirements;

(2) explain the option to opt out of the LEA Notification to the parent and the consequences of this option [~~LEA Notification Opt Out to the parent and the consequences of this choice~~]; and

(3) comply with all other requirements in this section related to the family's right to opt out of the LEA Notification [~~Opt Out~~].

§350.1215. Reporting Late Local Education Agency [~~LEA~~] Notifications.

(a) When the subrecipient [~~contractor~~] provides the LEA Notification to the LEA [~~of Potentially Eligible for Special Education Services to districts or charter schools~~] less than 90 days before the child's third birthday, the subrecipient [~~contractor's ECI program~~] must include in the notification the reason for the delay.

(b) The subrecipient [~~contractor~~] must send the LEA for the area in which the child resides a late LEA Notification for any child aged 33-36 months who [~~whom~~] the IFSP team determines is potentially eligible for ECSE [~~special education~~] services, unless the parent has informed the subrecipient [~~contractor~~] in writing of their decision to opt out of the LEA Notification. [~~opt-out of LEA notification.~~]

§350.1217. Local Education Agency [~~LEA~~] Transition Conference.

[~~(a) The IFSP team determines whether a child is potentially eligible for special education services. The IFSP team's decision regarding a child's potential eligibility for special education services is documented in the child's record.~~]

(a) [~~(b)~~] If the parent gives approval to convene the LEA transition conference, [~~Transition Conference,~~] the subrecipient [~~contractor~~] must:

(1) meet the requirements in 34 CFR §303.342(d) and (e) and §303.343(a), which require: [~~requires:~~]

(A) the face-to-face attendance of the parent and the service coordinator; and

(B) at least one other ECI professional who is a member of the IFSP team who may participate through other means as permitted in 34 CFR §303.343(a)(2);

(2) send an invitation at least 14 days in advance to the appropriate representatives for the LEA that [~~which~~] serves the area where the child resides;

(3) conduct the LEA transition conference [~~Transition Conference~~] at least 90 days before the child's third birthday. The transition conference [~~At the discretion of all parties, the conference~~] may occur up to nine months before the child's third birthday; and

(4) document the date of the conference in the child's record.

(b) [~~(c)~~] The subrecipient [~~contractor~~] must conduct the LEA transition conference, [~~Transition Conference,~~] even if the representatives for the LEA that [~~which~~] serves the area where the child resides do not attend, and provide the parent information about ECSE [~~preschool special education~~] and related services, including a description of the:

(1) eligibility definitions;

(2) timelines;

(3) process for consenting to an evaluation and eligibility determination; and

(4) extended year services.

(c) [~~(d)~~] The subrecipient [~~contractor~~] is not required to conduct the LEA transition conference [~~Transition Conference~~] for children referred to the subrecipient's [~~contractor's~~] ECI program less than 90 days before the child's third birthday.

(d) [~~(e)~~] The 14-day timeline for inviting the LEA representative may be changed by written local agreement between the LEA and the subrecipient [~~contractor~~].

(1) If the subrecipient [contractor] becomes aware of a consistent pattern of the LEA representative not attending transition conferences, the subrecipient [contractor] must make efforts to meet with the LEA to reach a cooperative agreement to maximize LEA participation.

(2) The subrecipient may [One option is to] encourage the LEA representative to participate in the meeting by phone if unable to attend the meeting face-to-face. [in person.]

(e) [(f)] If the parent gives approval to have an LEA transition conference, [Transition Conference,] but does not give written consent to release records to the LEA, then the subrecipient [contractor] may [only] release only limited personally identifiable information to the LEA. With written parental consent, the subrecipient may release other personally identifiable information [may be released] to the LEA.

§350.1219. Transition to Local Education Agency [LEA] Services.

(a) The subrecipient [contractor] may continue to provide ECI [early childhood intervention] services to the child until the child's third birthday even if the Admission, Review, and Dismissal [(ARD)] meeting has occurred and the Individualized Education Plan [(IEP)] has been signed.

(b) The subrecipient [contractor] may discontinue ECI [early childhood intervention] services if the child begins receiving the same services from the LEA when:

(1) prior written notice is given to the parent regarding the discontinuation of ECI [early childhood intervention] services; and

(2) the IFSP is revised at an IFSP meeting.

(c) All transition activities in this section must be clearly documented in the child's record.

§350.1221. Transition Into Community Supports and Services [the Community].

(a) The subrecipient [contractor] must assist the family with transition activities to appropriate community settings before the child exits ECI [child's third birthday] if the:

(1) subrecipient determines the child is not potentially eligible for ECSE services;

(2) [(1)] parent chooses for the child to transition to supports and services in the community other than or in addition to the LEA; [community services;]

(3) [(2)] parent opts out of the LEA Notification; [Notification of Potentially Eligible for Special Education Services;]

(4) [(3)] parent refuses LEA services; or

(5) [(4)] child is determined to be ineligible for ECSE [special education] services.

(b) In compliance with 34 CFR §303.209(c)(2), the subrecipient [contractor] must make a reasonable effort to convene a Community Transition Meeting that meets the requirements in 34 CFR §303.342(d) and (e) and §303.343(a), which requires the attendance of the service coordinator and at least one other ECI professional who is a member of the IFSP team who may participate through other means as permitted in 34 CFR §303.343(a)(2), and also invite:

(1) representatives of the identified community settings;

(2) the Blind Children's Vocational Discovery and Development Program specialist if the child has a vision impairment or the HHSC Office for Deaf and Hard of Hearing Services regional specialist if the child is deaf or hard of hearing; [has a hearing impairment;] and

(3) other program or agency representatives as appropriate.

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

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SUBCHAPTER M. CHILD AND FAMILY OUTCOMES

26 TAC §350.1301

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1301. Purpose.

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26 TAC §350.1307, §350.1309

STATUTORY AUTHORITY

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The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1307. Child Outcomes.

(a) The subrecipient [~~contractor~~] must collect and report information on child outcomes as directed by HHSC ECI and use that information to improve results for children and families.

(b) Child outcomes address three areas of child functioning necessary for each child to be an active and successful participant at home and in the community. These three outcomes are that children will:

(1) have positive social relationships;

(2) acquire and use knowledge and skills; and

(3) take appropriate action to meet their own needs.

(c) An interdisciplinary team of at least two members must agree on the child outcome ratings for each enrolled child at entry, annual evaluation, and exit.

(1) Entry ratings must be completed:

(A) for every newly enrolled child who is 30 months of age or younger on the date of enrollment;

(B) within two weeks of the initial IFSP or the first [~~Texas IFSP;~~] IFSP completed in Texas; and

(C) on each of the three child outcomes for each child.

(2) Annual ratings must include the progress item for each outcome and be completed:

(A) within two weeks of each annual evaluation and IFSP;

(B) independently of the entry ratings; and

(C) on each of the three child outcomes for each child.

(3) Exit ratings must include the progress item for each outcome and be completed:

(A) for each child exiting the HHSC ECI [~~the Texas ECI~~] system who had an entry rating and was enrolled in services for at least six months; and

(B) within two weeks of the exit [~~dismissal~~] date.

(d) Documentation must:

(1) provide information that reflects the rating decisions of the interdisciplinary team;

(2) record ratings on either the child outcomes summary form or in another section of the child's record as identified by the subrecipient [~~contractor~~];

(3) include information related to the child's functional abilities across settings, situations, and people; and

(4) identify sources of information such as evaluation, observation, or parent report.

§350.1309. Family Outcomes.

Family outcomes and indicators of family capacity are measured using a family survey. The subrecipient [~~contractor~~] is required to deliver the family survey as directed by HHSC ECI to measure family outcomes and indicators.

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SUBCHAPTER N. FAMILY COST SHARE SYSTEM

26 TAC §350.1401

STATUTORY AUTHORITY

The repeal is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The repeal affects Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1401. Purpose.

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26 TAC §§350.1405, 350.1411, 350.1413, 350.1431, 350.1433

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, as well as Texas Government Code §2001.039, which requires a state agency to review and consider for readoption each of its rules every 4 years, and Texas Government Code §531.02119, which provides that the Executive Commissioner of HHSC shall adopt rules prohibiting discrimination based on immunization status.

The amendments affect Texas Government Code Section 531.0055 and Texas Human Resources Code Chapter 73.

§350.1405. Definitions.

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

(1) Ability to pay [~~Pay~~]--The determination that the family is financially able to pay out-of-pocket[~~,~~] for their child's ECI [~~early childhood intervention~~] services.

(2) Adjusted income [~~Income~~]--The dollar amount equal to the family's annual gross income minus their allowable deductions. The subrecipient [~~contractor~~] uses adjusted income to determine the family's ability to pay and to calculate the family's maximum charge.

(3) Allowable deductions [~~Deductions~~]--Certain unreimbursed family expenses that are subtracted from the family's gross income to calculate their adjusted income.

(4) CHIP--The Children's Health Insurance Program [~~(CHIP)~~] administered by HHSC.

(5) Dependent--Any person who meets the definition of 26 USC §152 [~~Dependent Defined~~].

(6) Family Cost Share System--The system of collecting reimbursement for ECI [~~early childhood intervention~~] services from public insurance, private insurance, and out-of-pocket payments from families.

(7) Family size--The total number of people in the family, including the child's parents who live in the home, the child, and other dependents of the parent. Other dependents do not have to live in the home, but they must be financially dependent upon the parent.

(8) Federal poverty guidelines [~~Poverty Guidelines~~]--The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 USC §9902(2).

(9) Gross income [~~Income~~]--All income received by the family considered income by the Internal Revenue Service before federal allowable deductions are applied.

(10) Inability to pay [~~Pay~~]--The determination that the family is financially unable to make out-of-pocket payments because the family has an adjusted income at or below 100 percent [~~100%~~] of the federal poverty level.

(11) Maximum charge [~~Charge~~]--The maximum out-of-pocket amount the subrecipient [~~contractor~~] can charge the family for services delivered in one calendar month.

(12) Out-of-pocket [~~Out-of-Pocket~~]--Payment [~~received~~] from the family [~~to pay~~] for their child's ECI [~~early childhood intervention~~] services. This includes insurance co-pays, co-insurance, and deductibles as well as payment for services not covered by the family's insurance.

(13) Sliding fee scale [~~Fee Scale~~]--The HHSC-developed scale of maximum charges that is based on the federal poverty guidelines.

(14) Third-party payor [~~Third-Party Payor~~]--A company, organization, insurer, or government agency that makes payments for the ECI [~~early childhood intervention~~] services received by a child and family. Third-party payors include commercial insurance companies, health maintenance organizations, preferred provider organizations, [~~HMOs, PPOs,~~] and public insurance such as Medicaid, CHIP, and TRICARE.

(15) TRICARE--The U.S. Department of Defense health care entitlement for active duty, Guard and Reserve, retired members of the military, and their eligible family members and survivors.

§350.1411. Early Childhood Intervention Services Provided with No Out-of-Pocket Payment from the Parent.

(a) The ECI [~~early childhood intervention~~] services provided with no out-of-pocket payment [~~from the parent~~] are:

(1) child find;

(2) evaluation and assessment;

(3) development of the IFSP;

(4) services for children who are deaf or hard of hearing or who have visual impairments; [~~to children with auditory or visual impairments that are required by an individualized education program (IEP) pursuant to Texas Education Code, §29.003(b)(1);~~]

(5) case management;

(6) translation and interpreter services; and

(7) administrative and coordination activities related to the implementation of procedural safeguards and other components of the statewide system of ECI [~~early childhood intervention~~] services.

(b) ECI [~~Early childhood intervention~~] services provided at no out-of-pocket charge to the parent must:

(1) not be denied or delayed if the family fails to provide information related to third-party coverage, gross income, or family size;

(2) begin or continue regardless of whether or not the parent has a signed family cost share agreement;

(3) not be denied or delayed if the family refuses to consent to bill or to release personally identifiable information to a third-party payor;

(4) begin or continue during any period of reconsideration; and

(5) continue during any suspension period.

(c) If the family has an inability to pay, all ECI [~~IDEA Part C~~] services are provided with no out-of-pocket charge to the family.

§350.1413. Individualized Family Service Plan [~~(IFSP)~~] Services Subject to Out-of-Pocket Payment [~~from the Family~~].

(a) IFSP services subject to out-of-pocket payment [~~from the family~~] are:

(1) assistive technology;

(2) behavioral intervention;

(3) occupational therapy services;

(4) physical therapy services;

(5) speech-language pathology services;

(6) nutrition services;

(7) counseling services;

(8) nursing services;

(9) psychological services;

(10) health services;

(11) social work services;

(12) transportation;

(13) SST [~~specialized skills training~~];

(14) family education and training; and

(15) any IFSP services to children with visual impairments or who are deaf or hard of hearing that are not required by an individualized education program [~~(IEP)~~] pursuant to Texas Education Code §29.003(b)(1).

(b) The family pays out-of-pocket up to their maximum charge. The family's maximum charge is determined based on their

placement on the HHSC ECI sliding fee scale, [Texas Health and Human Services Commission (HHSC) Early Childhood Intervention (ECI) Sliding Fee Scale,] as described in §350.1431 of this subchapter (relating to Texas Health and Human Services Commission Early Childhood Intervention [HHSC ECI] Sliding Fee Scale).

§350.1431. Texas Health and Human Services Commission [(HHSC)] Early Childhood Intervention [(ECI)] Sliding Fee Scale.

(a) The subrecipient [contractor] must provide the family with a copy of the HHSC ECI sliding fee scale. Based on family size and income, placement on the HHSC ECI sliding fee scale determines the family's maximum charge for services received in one calendar month.

(1) [(b)] The HHSC ECI sliding fee scale assigns a set dollar amount as the maximum charge for adjusted income ranges less than or equal to 1000 percent of the federal poverty level.

(2) HHSC calculates the maximum charge for each income range by applying a fixed percentage (ranging from 0.25 to 5 percent) to the mid-point income within each range based on the U.S. Department of Health and Human Services' [Services] most recently published federal poverty levels. [Federal Poverty Levels.]

(b) [(c)] The [For children and families who enroll in ECI services on or after September 1, 2015, the] family's maximum charge shall be pursuant to Figure: 26 TAC §350.1431(b) [§350.1431(c)] identified in this subsection. If the parent refuses to attest in writing that information about their third-party coverage, family size, and gross income is true and accurate, then the family monthly maximum payment equals the full cost of services.
Figure: 26 TAC §350.1431(b)
[Figure: 26 TAC §350.1431(c)]

§350.1433. Billing Families for Individualized Family Service Plan [IFSP] Services.

(a) The subrecipient [contractor] must bill the family up to the family's maximum charge.

(1) The total collection of payments, including third-party payment and the family's out-of-pocket payment, cannot exceed the actual cost of services.

(2) The family's total out-of-pocket for the month cannot exceed the family's maximum charge.

(b) A balance remaining unpaid by the parent 30 days after the bill date is delinquent unless the delay in payment is due to a delay in:

(1) third-party reimbursement; or

(2) notice of denial of a claim from a private or public third-party payor.

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

Filed with the Office of the Secretary of State on August 30, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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For further information, please call: (512) 424-6580

CHAPTER 745. LICENSING

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes amendments to §§745.11, 745.8906, 745.8911, 745.8913, 745.8914, 745.8925, 745.8933, 745.8965, 745.8967, 745.8976, and 745.9028 - 745.9030; the repeal of §§745.8901, 745.8903, 745.8905, 745.8907 - 745.8909, 745.8923, and 745.9025 - 745.9027; and new §§745.8905, 745.8907 and 745.9023 - 745.9027.

BACKGROUND AND PURPOSE

The purpose of the proposal is to update and clarify some of the rules pertaining to the licensure of administrators of general residential operations (GROs) and child-placing agencies (CPAs) to make the rules consistent with current policies, practices, and other HHSC rules; consolidate rules; update citations and titles; and improve the readability and understanding of the rules.

Some of the proposed changes update the administrator's licensing rules related to a military member, spouse, or veteran to be consistent with the recent changes made by HHSC to §351.3 and §351.6 in Texas Administrative Code, Title 1, Part 15 that comply with Senate Bill (S.B.) 422, 88th Legislature, Regular Session, 2023, including (1) updating the expedited application process for a military member, spouse, or veteran who applies for an administrator's license or to act as an administrator without a license, by clarifying that Child Care Regulation (CCR) will process the application within 30 days after CCR receives the application; (2) adding that a military member who is licensed in good standing by another state with substantially equivalent requirements to Texas may apply to act as an administrator without obtaining an administrator's license under certain circumstances, which is already allowed for a military spouse; (3) clarifying that a military spouse approved to act as an administrator without a license may continue to do so for three years from the date of the approval even if there is a divorce or similar event that changes the marital status of the military spouse; and (4) clarifying that an approval of a military member or spouse to act as an administrator without a license may not be renewed.

Other proposed changes not related to the statutory changes include (1) clarifying when a child-care administrator must have a Child-Care Administrator's License (CCAL) or a Child-Placing Agency Administrator's License (CPAAL), including clarifying and consolidating the exceptions and the deletion of an exception for a CPAAL; (2) clarifying that CCR will waive examination, experience, and education requirements for an applicant with a license in good standing by another state that has licensing requirements substantially equivalent to Texas, including an applicant who is a miliary member, spouse, or veteran, if the applicant meets the background check requirements and is otherwise eligible to apply for an administrator's license; (3) updating the application requirements, including those for a military member, spouse, or veteran, to be consistent with current application and policy requirements; (4) clarifying other methods a military member, spouse, or veteran may use to demonstrate competency in the examination, experience, or education requirements for an administrator's license; (5) waiving the replacement fee for a military member, spouse, or veteran to obtain a copy of a lost or destroyed administrator's license or approval letter to act as an administrator without an administrator's license; and (6) clarifying that the Child Care Enforcement Department may revoke a military member's or spouse's ability to act as an administrator without a license if the military member or spouse fails to comply with relevant statutes, rules, and minimum standards or if the military member or spouse is no longer licensed in good standing by another state.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §745.11 clarifies that the term "Child Care Regulation" also represents the Child Care Regulation department of HHSC.

The proposed repeal of §745.8901 deletes the rule as no longer necessary because the content of subsection (a) is incorporated into proposed new §745.8905 and subsection (b) is incorporated into proposed new §745.8907.

The proposed repeal of §745.8903 deletes the rule as no longer necessary because the content of subsection (a) is incorporated into proposed new §745.8905 and subsection (b) is incorporated into proposed new §745.8907.

The proposed repeal of §745.8905 deletes the rule as no longer necessary because the content is incorporated into proposed new §745.8905.

Proposed new §745.8905 incorporates the terms "child-care administrator," "child-placing agency administrator," and "licensed administrator" that were previously defined in the proposed repeal of §§745.8901(a), 745.8903(a), and 745.8905. Two new terms are also added to this new rule: "another state" and "licensed in good standing by another state."

The proposed amendment to §745.8906 (1) replaces "Licensing" and "we" with "Child Care Regulation (CCR)"; and (2) updates two citations.

The proposed repeal of §745.8907 deletes the rule as no longer necessary because the content has been updated and incorporated into proposed new §745.8907.

Proposed new §745.8907 incorporates and updates the content from the proposed repeal of §§745.8901(b), 745.8903(b), 745.8907, 745.8908, and 745.8909 relating to when a license is required to serve as an administrator, including clarifying the exceptions for when a full CCAL is not required to serve as a child care administrator. The rule also adds an exception that does not require a child care administrator to have a full CCAL if the person has a provisional CCAL according to proposed amended §745.8913(c).

The proposed repeal of §745.8908 deletes the rule as no longer necessary because the content has been updated and incorporated into proposed new §745.8907.

The proposed repeal of §745.8909 deletes the rule as no longer necessary because the content has been incorporated into proposed new §745.8907.

The proposed amendment to §745.8911 (1) improves the language of the rule for better readability and understanding; (2) updates a title; and (3) clarifies at §745.8911(b)(1) that the statutory exception (Texas Human Resources Code §43.003(b)) to serve as an administrator without a CCAL for a GRO that only provides emergency care services is only available if the GRO is in a county with a population of less than 40,000.

The proposed amendment to §745.8913 clarifies that CCR will waive examination, experience, and education requirements for an applicant with a license in good standing by another state if (1) CCR determines the licensing requirements in the other state are substantially equivalent to Texas, or (2) there is a reciprocity agreement between Texas and the other state. In addition, to obtain an administrator's license under subsection (a), the applicant must meet background check requirements and be otherwise eligible to apply for an administrator's license. The proposed rule also clarifies the language for better readability and understanding.

The proposed amendment to §745.8914 (1) replaces "Licensing" and "we" with "Child Care Regulation (CCR)"; and (2) provides an example to further clarify "scope of work authorized to be performed under the license issued by the other state."

The proposed repeal of §745.8923 deletes the rule as no longer necessary because (1) the portion of the rule stating CCR may issue a provisional CCAL has been incorporated into proposed amended §745.8925; and (2) there is no basis in law for the exception to the one year of management or supervisory experience requirement for a CPAAL, which currently allows the Associate Commissioner for Child Care Regulation or designee to grant an exception when the applicant provides a compelling justification that the applicant's experience qualifies the applicant to act as the licensed administrator for a CPA.

The proposed amendment to §745.8925 (1) clarifies that CCR may issue a provisional CCAL if certain requirements are met; and (2) clarifies the language of the rule for better readability and understanding.

The proposed amendment to §745.8933 (1) substantially updates the application requirements for different application scenarios to be consistent with current policy, including the applicable forms; and (2) clarifies the language of the rule for better readability and understanding.

The proposed amendment to §745.8965 (1) clarifies the language of the rule for better readability and understanding; and (2) updates titles.

The proposed amendment to §745.8967 (1) improves the language of the rule for better readability and understanding; (2) updates titles; and (3) clarifies that upon request the Associate Commissioner or designee will review whether CCR exceeded application timeframes.

The proposed amendment to §745.8976 (1) updates two citations; and (2) improves the language of the rule for better readability and understanding.

Proposed new §745.9023 incorporates the proposed repeal of §745.9025 relating to the definitions of the terms "military member," "military spouse," and "military veteran" with minor changes for clarity.

Proposed new §745.9024 rewrites a portion of the proposed repeal of §745.9026 by (1) replacing the term "special consideration" with "alternative licensing" for consistency with the Texas Occupations Code §55.004 and between CCR and HHSC rules; and (2) clarifying that CCR will waive examination, experience, and education requirements for a military member, spouse, or veteran who applies for an administrator's license and either has a license in good standing by another state that has licensing requirements substantially equivalent to Texas, or previously held an administrator's license in Texas within the last five years. To obtain a license under this rule, the applicant meets background check requirements and be otherwise eligible to apply for an administrator's license.

The proposed repeal of §745.9025 deletes the rule as no longer necessary because with minor changes for clarity the rule has been incorporated into proposed new §745.9023.

Proposed new §745.9025 rewrites a portion of the proposed repeal of §745.9026 by clarifying the other methods that are available to a military member, spouse, or veteran to demonstrate

competency in the examination, experience, or education requirements for an administrator's license.

The proposed repeal of §745.9026 deletes the rule as no longer necessary because the content has been further clarified and incorporated and divided into proposed new §§745.9024, 745.9025, and 745.9026.

Proposed new §745.9026 (1) incorporates the portion of the repeal of §745.9026 that waives the application and examination fees for a military member, spouse, or veteran who meets the requirements to obtain an administrator's license; and (2) adds that CCR will waive the replacement fee for a military member, spouse, or veteran to obtain a copy of a lost or destroyed administrator's license.

The proposed repeal of §745.9027 deletes the rule as no longer necessary because the content has been updated and incorporated into proposed new §745.9027.

Proposed new §745.9027 incorporates the proposed repeal of §745.9027 by adding a chart to include substantially updated application requirements for a military member, spouse, or veteran that are consistent with current policy, including the applicable forms.

The proposed amendment to §745.9028 updates the expedited application process for a military member, spouse, or veteran who has a license in another state and applies for an administrator's license or to act as an administrator without a license, by clarifying that CCR will (1) determine whether the application is complete withing 21 days of receiving the application; and (2) within 30 day of receiving a complete application (A) issue the applicant an administrator's license or approve the ability to act as administrator without having a license; or (B) forward a recommendation to the Child Care Enforcement Department to deny the applicant an administrator's license or the ability to act as an administrator without a license. The rule also lists the reasons the Child Care Enforcement Department may deny an administrator's license or the ability to act as an administrator.

The proposed amendment to §745.9029 clarifies the language of the rule for better readability and understanding.

The proposed amendment to §745.9030 (1) adds that a military member that is licensed in good standing by another state with substantially equivalent requirements to Texas may apply to act as an administrator without obtaining an administrator's license under certain circumstances, which is already allowed for a military spouse; (2) improves the language of the rule for better readability and understanding; (3) deletes a definition for "license in good standing by another state" as not necessary because the definition has been incorporated into new proposed §745.8905; (4) creates a new chart to clarify that a military spouse approved to act as an administrator without a license may continue to do so for three years from the date of the approval even if there is a divorce or similar event that changes the marital status of the military spouse; (5) clarifies that a military member or spouse may request, at no cost, a replacement letter that approves the member or spouse to act as an administrator without obtaining an administrator's license; (6) clarifies that the Child Care Enforcement Department may revoke the person's ability to act as an administrator without a license if the person fails to comply with relevant statutes, rules, and minimum standards or if the military member or spouse is no longer licensed in good standing by another state; and (7) clarifies that an approval of a military member or spouse to act as an administrator without a license may not be renewed.

FISCAL NOTE

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

GOVERNMENT GROWTH IMPACT STATEMENT

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

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

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

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

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

(5) the proposed rules will create new regulations;

(6) the proposed rules will expand existing regulations;

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

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

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

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

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules (1) are necessary to protect the health, safety, and welfare of the residents of Texas; (2) do not impose a cost on regulated persons; and (3) are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Rachel Ashworth-Mazerolle, Associate Commissioner for Child Care Regulation, has determined that for each year of the first five years the rules are in effect, the public benefit will be (1) CCR will be complying with statutory requirements; (2) simplified rules related to the process for obtaining an administrator's license; and (3) the possibility of having more administrators for GROs and CPAs.

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

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to the owner's property that would otherwise ex-

ist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Questions about the content of this proposal may be directed by email to Gerry.Williams@hhs.texas.gov.

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

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register.* Comments must be (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 24R060" in the subject line.

SUBCHAPTER A. PRECEDENCE AND DEFINITIONS

DIVISION 1. DEFINITIONS FOR THE LANGUAGE USED IN THIS CHAPTER

26 TAC §745.11

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendment affects Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.11. What words must a person [I] know to understand this chapter?

The following words have the following meanings when used in this chapter:

(1) I, my, you, and your--An applicant or permit holder, unless otherwise stated or the context clearly indicates otherwise.

(2) We, us, our, [and] Licensing, and Child Care Regulation--The Child Care Regulation department of the Texas Health and Human Services Commission.

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

Filed with the Office of the Secretary of State on August 29, 2024.

TRD-202404054

Karen Ray

Chief Counsel

Health and Human Services Commission

Earliest possible date of adoption: October 13, 2024

For further information, please call: (512) 438-3269

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SUBCHAPTER N. ADMINISTRATOR'S LICENSING

DIVISION 1. OVERVIEW OF ADMINISTRATOR'S LICENSING

26 TAC §§745.8901, 745.8903, 745.8905, 745.8907 - 745.8909, 745.8923

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The repeals affect Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.8901. What is a child-care administrator?

§745.8903. What is a child-placing agency administrator?

§745.8905. What is a licensed administrator?

§745.8907. When must I have a Child-Care Administrator's License? (CCAL)?

§745.8908. Where may a person serve as a child-care administrator with a provisional Child-Care Administrator's License (CCAL)?

§745.8909. When must I have a full Child-Placing Agency Administrator's License (CPAAL)?

§745.8923. What if I do not meet the one year of management or supervisory experience required for a Child-Care Administrator's License (CCAL) or a full Child-Placing Agency Administrator's License (CPAAL)?

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

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Karen Ray

Chief Counsel

Health and Human Services Commission

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For further information, please call: (512) 438-3269

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26 TAC §§745.8905 - 745.8907, 745.8911, 745.8913, 745.8914, 745.8925

STATUTORY AUTHORITY

The amendments and new rules are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendments and new rules affect Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.8905. What terms must a person know to understand this subchapter?

These terms have the following meanings:

(1) Another state--Includes:

(A) Any state in the United States other than the State of Texas;

(B) Any territory of the United States; or

(C) The District of Columbia.

(2) Child-care administrator--A person who:

(A) Supervises and exercises direct control over a general residential operation, including a residential treatment center, as described in Figure: 26 TAC §745.37(2) of this chapter (relating to What specific types of operations does Licensing regulate?); and

(B) Is responsible for the operation's program and personnel, regardless of whether the person has an ownership interest in the operation or shares duties with anyone.

(3) Child-placing agency administrator--A person who:

(A) Supervises and exercises direct control over a child-placing agency, as described in Figure: 26 TAC §745.37(2) of this chapter; and

(B) Is responsible for the agency's program and personnel, regardless of whether the person has an ownership interest in the agency or shares duties with anyone.

(4) Licensed administrator--A licensed child-care administrator or a licensed child-placing agency administrator.

(5) Licensed in good standing by another state--Requires the license issued by another state to be:

(A) Valid, active, and current (has not expired); and

(B) Not subject to a disciplinary action or corrective action.

§745.8906. What type of administrator's license may Child Care Regulation (CCR) [Licensing] issue to an applicant?

CCR [We] may issue an administrator's license to an applicant as described in the following chart.[:]
Figure: 26 TAC §745.8906
[Figure: 26 TAC §745.8906]

§745.8907. When is a person required to have a license to serve as an administrator?

(a) A person must have a full Child-Care Administrator's License (CCAL) to serve as a child-care administrator for a general residential operation, including a residential treatment center, except:

(1) When serving as a child-care administrator for an exempt general residential operation that only provides emergency care services according to §745.8911 of this division (relating to When may a person serve as a child-care administrator of a general residential operation that only provides emergency care services without having a Child-Care Administrator's License (CCAL)?); or

(2) When serving as a child-care administrator under a provisional CCAL according to:

(A) §745.8913(c) of this division (relating to When can licensure in another state qualify an applicant for an administrator's license under this subchapter?); or

(B) §745.8925 of this division (relating to How does an applicant qualify for a provisional Child-Care Administrator's License (CCAL) if the applicant does not meet the minimum management or supervisory experience required for a full CCAL?) at a general residential operation that meets the requirements of §748.532 of this title (relating to When can a child-care administrator with a provisional license serve as the administrator for a general residential operation?).

(b) A person must have a full Child-Placing Agency Administrator's License to serve as a child-placing agency administrator.

§745.8911. When may a person serve as a child-care administrator of a [For] general residential operation [operations] that only provides [provide] emergency care services without having[, in what circumstances do I not need] a Child-Care Administrator's License (CCAL) [(CCAL) to be a child-care administrator]?

(a) A person may serve as a child care administrator without having [You do not need] a CCAL if:

(1) The person would be serving as a child care administrator for a [we exempt the] general residential operation that only provides emergency care services; and

(2) Child Care Regulation exempts the general residential operation from needing a licensed child-care administrator after receiving the information required under subsection (b) of this section.

(b) To qualify for the exemption described in subsection (a) of this section, the governing body or designee of the emergency shelter must send to the Associate [Assistant] Commissioner for Child Care Regulation [Child-Care Licensing] a letter that includes the following:

(1) The name of the county with a population of less than 40,000 where the operation is located;

(2) The date that the operation's governing body adopted a resolution certifying that the operation made a reasonable attempt to hire a licensed child-care administrator but was unable to do so;

(3) A statement that the governing body adopted the resolution by a majority vote;

(4) The name of the unlicensed administrator hired; and

(5) A statement of the administrator's qualifications, including any areas where the person's qualifications do not meet the requirements for a CCAL.

§745.8913. When can [Can my] licensure in another state qualify an applicant [me] for an administrator's license under this subchapter?

(a) Child Care Regulation (CCR) will [We may] waive the examination, experience, and education prerequisites for a full administrator's license under §745.8915 of this division (relating to How do I qualify for a full Child-Care Administrator's License (CCAL)?),

§745.8917 of this division (relating to How do I qualify for a full Child-Placing Agency Administrator's License (CPAAL)?), or both, [any prerequisite for you to get an administrator's license from us] if the applicant [you have a valid administrator's license from another state and]:

(1) Is licensed in good standing by another state; and

(2) Either:

(A) CCR determines the [The] other state's license requirements are substantially equivalent to the requirements for a license according to [under this subchapter, as determined by Licensing under] §745.8914 of this division [subchapter] (relating to How does Child Care Regulation (CCR) [Licensing] determine whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter?); or

(B) [(2)] There is a reciprocity agreement between Texas and the other state.

(b) To be eligible to obtain a license under subsection (a) of this section, the applicant must be eligible to:

(1) Receive and continue to maintain an administrator's license, as specified in §745.775(c) of this chapter (relating to How may a criminal conviction or a child abuse or neglect finding affect my ability to receive or maintain an administrator's license?); and

(2) Apply for an administrator's license under §745.9037(c) of this subchapter (relating to Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application?).

(c) [(b)] CCR [We] may issue a provisional license to an applicant licensed by another state if the applicant meets [you once you apply for a child-care administrator's license from us and meet] the requirements in Human Resources Code §43.0081(a)(1) [§43.0081].

§745.8914. How does Child Care Regulation (CCR) [Licensing] determine whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter?

CCR [We] will review and evaluate the following criteria when determining whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter and Chapter 43 of the Texas Human Resources Code:

(1) Whether the other state requires an applicant to pass an examination that demonstrates competence in the field of child care administration or placing children in residential settings, as appropriate, [in order] to obtain the license;

(2) Whether the other state requires an applicant to meet the full-time experience qualifications, as described in this division, [in order] to obtain the license;

(3) Whether the other state requires an applicant to meet the education qualifications, as described in this division, [in order] to obtain the license; and

(4) The other state's license requirements, including the scope of work authorized to be performed under the license issued by the other state. For example, the license in the other state must require an administrator to meet responsibilities equivalent to those that an administrator of an applicable residential child-care operation in Texas must meet.

§745.8925. How does an applicant [do I] qualify for a provisional Child-Care Administrator's License (CCAL) if the applicant does [I do] not meet the minimum management or supervisory experience required for a full CCAL?

If an applicant does [you do] not meet the minimum management or supervisory experience in §745.8919(a) of this division (relating to What qualifies as one year of experience in management or supervision of personnel and programs required for a full Child-Care Administrator's License (CCAL) or full Child-Placing Agency Administrator's License (CPAAL)?), the applicant [you] will qualify for, and Child Care Regulation (CCR) may issue, a provisional CCAL if:

(1) The applicant meets [You meet] the requirements in §745.8915(a)(1), (2), and (4) [§745.8915(1), (2), and (4)] of this division (relating to How do I qualify for a full Child-Care Administrator's License (CCAL)?);

(2) The applicant has [You have] six months of full-time experience in management or supervision of personnel as specified in §745.8927 of this division (relating to What qualifies as six months of experience in management or supervision of personnel required for a provisional Child-Care Administrator's License (CCAL)?); and

(3) CCR has [We have] not denied the applicant [you] a full CCAL for an issue identified in §745.9037(a) of this subchapter (relating to Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application?) while the applicant [you] had a provisional CCAL.

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

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DIVISION 2. SUBMITTING [YOUR] APPLICATION MATERIALS

26 TAC §745.8933

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendment affects Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.8933. What must a complete application to become a licensed administrator include?

(a) A complete application to become a licensed administrator must include:

(1) A completed Application for a Child Care Administrator License or a Child-Placing Agency Administrator License (Form 3015) [application form];

(2) An official, stamped [A] transcript or certification on letterhead [of verification] from the appropriate educational institutions to substantiate [your] educational qualifications;

(3) Three completed references, using Administrator Licensing - Reference for an Applicant (Form 3016), including:

(A) Two professional references who can attest to work experience and competence as a child-care administrator or child-placing agency administrator, as applicable; and [that verify your professional skills, character, and if applicable, two years of full-time work experience;]

(B) [(4)] An employer or supervisor reference that documents [your] one year of management or supervisory experience as described in §745.8919 of this subchapter (relating to What qualifies as one year of experience in management or supervision of personnel and programs required to qualify for a full Child-Care Administrator's License (CCAL) or a full Child-Placing Agency Administrator's License (CPAAL)?);

[(5) An application fee of $100;]

(4) [(6)] A notarized Affidavit for Applicants for Employment with a Licensed Operation or Registered Child-Care Home (Form 2985) [affidavit] documenting criminal history background information [on a form provided by Licensing]; [and]

(5) [(7)] A completed Request for Background Checks for an Administrator's License (Form 3017) [background check request form] and background check fee; and [.]

(6) An application fee of $100.

(b) An applicant [If you are applying] for a full CCAL that does [and do] not meet the one year of management or supervisory experience required in §745.8915(a)(3) [§745.8915(3)] of this subchapter (relating to How do I qualify for a full Child-Care Administrator's License (CCAL)?) [, you] may qualify for a provisional CCAL. To apply for a provisional CCAL, the applicant's [your application must include an] employer or supervisor reference required in subsection (a)(3)(B) of this section must document [that describes your] six months of management or supervisory experience as required in §745.8927 of this subchapter (relating to What qualifies as six months of experience in management or supervision of personnel required for a provisional Child Care Administrator's License (CCAL)?).

(c) An applicant [A complete application submitted by any applicant who applies] for an administrator's license under §745.8913(a) of this subchapter (relating to When can [Can my] licensure in another state qualify an applicant [me] for an administrator's license under this subchapter?) is only required to submit [must also include, as applicable]:

(1) An Application for a Child-Care Administrator's License or a Child-Placing Agency Administrator's License (Form 3015) and complete Sections I, VIII, and X;

(2) A notarized Affidavit for Applicants for Employment with a Licensed Operation or Registered Child-Care Home (Form 2985) documenting criminal history background information;

(3) A completed Request for Background Checks for an Administrator's License (Form 3017) and background check fee;

(4) [(1)] Proof of the applicant's administrator's license or any other professional or occupational license that the applicant holds by another state [Documentation related to each administrator's license currently held outside of Texas]; and

(5) [(2)] A copy of the regulations pertaining to the [current out-of-state administrator's] license issued by another state or a web address where the regulations can be found.

(d) A military member, military spouse, or military veteran applying for an administrator's license through alternative licensing or by demonstrating other methods of competency must comply with the application requirements at §745.9027 of this subchapter (relating to What must a complete application include for a military member, military spouse, or military veteran to become a licensed administrator or to act as an administrator without a license?). [A military spouse with a license in another state seeking to act as an administrator must complete the application as required by §745.9030 of this subchapter (relating to When may a military spouse with a license in another state act as an administrator without a license under this subchapter?).]

(e) A military member or military spouse applying to act as an administrator without a license must comply with the application requirements at §745.9030 of this subchapter (relating to When may a military member or military spouse act as an administrator without a license under this subchapter?).

(f) [(e)] An [Your] application is incomplete if it fails [you fail] to include [complete] any requirement of this section, as applicable, including inadequate documentation of [your] qualifications.

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DIVISION 3. LICENSING'S REVIEW OF AN [YOUR] APPLICATION

26 TAC §745.8965, §745.8967

STATUTORY AUTHORITY

The amendments are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendments affect Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.8965. What if Child Care Regulation (CCR) [Licensing] does not process my application within the appropriate timeframes?

If an applicant believes [you believe] that CCR [we] did not process the [your] application within the appropriate timeframes, the applicant [you] may request that the Associate [Assistant] Commissioner for Child Care Regulation [Child-Care Licensing] review the situation. The applicant [You] must submit the [your] written request for [the] review within 30 days after the CCR timeframe [our time limit] expires. The applicant [You] must send the [your] request to: Associate [Assistant] Commissioner for Child Care Regulation [Child-Care Licensing], Texas Health and Human Services Commission, [Mail Code] E-550, [Texas Department of Family and Protective Services,] P.O. Box 149030, Austin, Texas 78714-9030. The [Your] request must include a specific complaint and any supporting documentation.

§745.8967. What happens after the Associate [Assistant] Commissioner for Child Care Regulation (CCR) receives a [Child-Care Licensing receives my] request for a review of the application timeframes?

(a) After receiving a [your] request for a review of the application timeframes, the associate commissioner or designee [Assistant Commissioner] will:

(1) Determine [decide] if CCR [we] processed the [your] application within the appropriate timeframes, and if not, whether there was [. If the Assistant Commissioner decides that we did not, he/she will decide if we had] good cause to exceed the timeframes; and

(2) Notify the applicant [. We will reimburse your application fee to you if the Assistant Commissioner determines that we exceeded the time limits without good cause. The Assistant Commissioner will notify you] of the [his/her] decision within 30 days of [after] receiving the [your] request.

(b) CCR will reimburse the application fee if the associate commissioner or designee determines that CCR exceeded the timeframes without good cause.

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DIVISION 4. MAINTAINING AN [YOUR] ADMINISTRATOR'S LICENSE

26 TAC §745.8976

STATUTORY AUTHORITY

The amendment is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendment affects Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.8976. How long is a provisional Child-Care Administrator's License (CCAL) valid?

A provisional CCAL is valid for the timeframe listed in the following chart.[:]
Figure: 26 TAC §745.8976
[Figure: 26 TAC §745.8976]

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

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DIVISION 6. MILITARY MEMBERS, MILITARY SPOUSES, AND MILITARY VETERANS

26 TAC §§745.9025 - 745.9027

STATUTORY AUTHORITY

The repeals are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The repeals affect Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.9025. What terms must I know to understand this division?

§745.9026. What special considerations can Licensing give to a military member, military spouse, or military veteran that applies for an administrator's license?

§745.9027. What must a military member, military spouse, or military veteran submit to Licensing to receive special consideration during the application process?

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26 TAC §§745.9023 - 745.9030

STATUTORY AUTHORITY

The amendments and new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Human Resources Code (HRC) §43.005, which states the Executive Commissioner for HHSC may adopt rules to administer Chapter 43; and Texas Occupations Code §§55.004, 55.0041, and 55.005, which requires HHSC to adopt rules for the issuance of an administrator's license to a military member, spouse, or veteran.

The amendments and new sections affect Texas Government Code §531.0055, HRC §43.005, and Texas Occupations Code §§55.004, 55.0041, and 55.005.

§745.9023. What terms must a person know to understand this division?

These terms have the following meanings when used in this division:

(1) Military member--A person who is currently serving full-time in:

(A) Any branch of the United States Armed Forces, which include the United States Army, Navy, Air Force, Space Force, Coast Guard, and Marine Corps;

(B) A reserve unit of one of the branches of the United States Armed Forces, including the National Guard; or

(C) The state military service of any state, such as the Texas National Guard or the Texas State Guard.

(2) Military spouse--A person married to a military member.

(3) Military veteran--A person who has served as a military member and was discharged or released from service.

§745.9024. What alternative licensing is available for a military member, military spouse, or military veteran?

(a) Alternative licensing is available to a military member, military spouse, or military veteran who applies for an administrator's license and:

(1) Is licensed in good standing by another state that has licensing requirements substantially equivalent to the requirements for a license under this chapter as determined by Child Care Regulation (CCR) under §745.8914 of this subchapter (relating to How does Child Care Regulation (CCR) determine whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter?); or

(2) Held an administrator's license in Texas within the last five years.

(b) If the military member, military spouse, or military veteran meets an alternative licensing requirement in subsection (a) of this section, CCR will waive the examination, experience, and education prerequisites for an administrator's license in §745.8915 of this subchapter (relating to How do I qualify for a full Child-Care Administrator's License (CCAL)?), §745.8917 of this subchapter (relating to How do I qualify for a full Child-Placing Agency Administrator's License (CPAAL)?), or both.

(c) To be eligible to obtain a license under this section, the military member, military spouse, or military veteran must not be:

(1) Prohibited from receiving or continuing to maintain an administrator's license, as specified in §745.775(c) of this chapter (relating to How may a criminal conviction or a child abuse or neglect finding affect my ability to receive or maintain an administrator's license?); or

(2) Ineligible to apply for an administrator's license under §745.9037(c) of this subchapter (relating to Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application?).

(d) If CCR issues an administrator's license under this section, the license will be a full license.

§745.9025. What other methods are available for a military member, military spouse, or military veteran to demonstrate competency in any of the requirements for an administrator's license?

For a military member, military spouse, or military veteran who is applying for an administrator's license, but does not have an administrator's license issued by another state and has not held an administrator's license in Texas within the last five years, the Associate Commissioner for Child Care Regulation, or a designee may accept other forms of compliance with examination, experience, and education qualifications, including:

(1) Accepting proof of a passing score on a national exam or other examination that demonstrates, as appropriate, competence in the field of:

(A) Child-care administration; or

(B) Child-placing administration.

(2) Crediting the military member, military spouse, or military veteran for verified military service, training, education, or clinical or professional experience that meets the experience or education requirements; and

(3) Substituting any demonstrated competency that a military member, military spouse, or military veteran has to meet the experience and education qualifications.

§745.9026. Will Child Care Regulation (CCR) waive any fees for a military member, military spouse, or military veteran?

CCR will waive the following fees for a military member, military spouse, or military veteran who meets the requirements to obtain an administrator's license under this subchapter:

(1) The application and examination fees; and

(2) A replacement fee as required by §745.8989 of this subchapter (relating to How do I get a replacement copy of my current administrator's license if the original is lost or destroyed?).

§745.9027. What must a complete application include for a military member, military spouse, or military veteran to become a licensed administrator or to act as an administrator without a license?

(a) If a military member, military spouse, or military veteran applies to become a licensed administrator or to act as an administrator

without a license, the application must meet the requirements in this chart.

Figure: 26 TAC §745.9027(a)

(b) An application is incomplete if it fails to include any requirement of this section, as applicable.

§745.9028. When and how will Child Care Regulation (CCR) [~~Will Licensing~~] expedite the [~~review of an~~] application process for [~~of~~] a military member, military spouse, or military veteran?

(a) Subsections (b) - (d) of this section apply to an application from:

(1) A military member, military spouse, or military veteran for an administrator's license under §745.9024 of this division (relating to What alternative licensing is available for a military member, military spouse, or military veteran?); or

(2) A military member or military spouse to act as an administrator without a license under §745.9030 of this division (relating to When may a military member or military spouse act as an administrator without a license under this subchapter?).

(b) Within 21 days after receiving an application, CCR will determine whether the application is complete as described in §745.9027 of this division (relating to What must a complete application include for a military member, military spouse, or military veteran to become a licensed administrator or to act as an administrator without a license?). If CCR determines that the application is incomplete, CCR will notify the applicant of the following, as applicable:

(1) Why any application materials the applicant submitted do not show compliance with relevant statutes and rules; and

(2) Any additional materials that the applicant must submit to show compliance.

(c) Within 30 days after receiving a complete application, CCR will:

(1) Issue the applicant an administrator's license or approve the ability to act as an administrator without having an administrator's license; or

(2) Forward to the Child Care Enforcement Department a recommendation to deny the applicant an administrator's license or the ability to act as an administrator without a license.

(d) The Child Care Enforcement Department may deny:

(1) An administrator's license under §745.9024 of this division because:

(A) The license by another state:

(i) Is not in good standing; or

(ii) Does not meet the requirements of §745.8914 of this subchapter (relating to How does Child Care Regulation (CCR) determine whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter?);

(B) The applicant is prohibited from receiving or continuing to maintain an administrator's license, as specified in §745.775(c) of this chapter (relating to How may a criminal conviction or a child abuse or neglect finding affect my ability to receive or maintain an administrator's license?); or

(C) The applicant is ineligible to apply for an administrator's license under §745.9037(c) of this subchapter (relating to Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application?); or

(2) The applicant the ability to act as an administrator without a license because the applicant does not meet one of the requirements of §745.9030 of this division, including the applicant's license by another state:

(A) Is not in good standing; or

(B) Does not meet the requirements of §745.8914 of this subchapter;

(e) For a military member, military spouse, or military veteran who is applying for an administrator's license under this subchapter and does not have a license from another state, CCR will expedite the applicable application processes described in the following rules unless there is good cause to delay the process as described in §745.8969 of this chapter (relating to When does Licensing have good cause for not processing my application within the established time period?):

(1) §745.8951 of this subchapter (relating to What happens after Licensing receives my application materials and fees?); and

(2) §745.8961 of this subchapter (relating to What happens after I take a licensing examination?).

[~~We will expedite the application process when the applicant for an administrator's license under this section is a military member, military spouse, or military veteran.~~]

§745.9029. What special considerations may apply to the renewal of a military member's administrator's license?

(a) The following special considerations are applicable to the renewal of a military member's administrator's license:

(1) An [~~Your~~] administrator's license will no longer be valid after two years, but the license will be considered dormant until the military member requests Child Care Regulation (CCR) [~~you request Licensing~~] to renew it or for two additional years, whichever comes first;

(2) No continuing education will be required prior to renewal; and

(3) CCR [~~Licensing~~] will waive late renewal fees required in (a)(2) and (3) in Figure: 40 TAC §745.9003(a) [~~under §745.9003(a)(2) and (3)~~] of this subchapter (relating to How much is the renewal fee?) if the military member establishes [~~you establish~~] that the [~~your~~] failure to renew the license in a timely manner was due to the military member's [~~your~~] service [~~as a military member~~].

(b) To be eligible for any special consideration under this section, the military member [~~you~~] must not be prohibited from receiving or continuing to maintain an administrator's license, as specified in §745.775(c) of this chapter (relating to How may a criminal conviction or a child abuse or neglect finding affect my ability to receive or maintain an administrator's license?).

§745.9030. When may a military member or military spouse [~~with a license in another state~~] act as an administrator without a license under this subchapter?

(a) A military member or [~~If you are a~~] military spouse[~~, you~~] may act as an administrator for a general residential operation, child-placing agency, or both, without obtaining an administrator's license under this subchapter and Chapter 43 of the Texas Human Resources Code, for up to three years if Child Care Regulation (CCR) determines [~~we determine~~] that the military member or military spouse [~~you~~]:

(1) Is [~~Are currently~~] licensed in good standing by another state that has licensing requirements that are substantially equivalent to the requirements for an administrator's license under this subchapter; and

(2) Meets [Meet] the other requirements in this section.

(b) To [In order for us to] evaluate whether the military member or military spouse is [you are currently] licensed in good standing by [in] another state with requirements that are substantially equivalent to the requirements for an administrator's license under this subchapter, the military member or military spouse [you] must submit:

(1) An Application for a Child-Care Administrator's License or a Child-Placing Agency Administrator's License (Form 3015) and complete Sections I, VIII, [(and attach a copy of your valid military identification card to establish your status as a military spouse),] and X;

(2) A copy of a valid military identification card to establish the status of the military member or military spouse;

(3) [(2)] A letter indicating [your] intent to act as an administrator for a general residential operation, child-placing agency, or both in Texas [this state];

(4) [(3)] A [Documentation of your residency in this state, including a] copy of the permanent change of station order to Texas for the military member [to whom you are married];

(5) [(4)] Proof of the [of your] administrator's license or any other professional or occupational license held by another [that you currently hold in the other] state; and

(6) [(5)] A copy of the regulations pertaining to the [current] license issued by another [in the other] state or a web address where the regulations can be found.

(c) Once CCR receives [we receive] the application and the additional documentation, CCR [we] will:

(1) Verify that the application is complete, and the documentation is accurate;

(2) Determine whether the requirements for the license issued by another [in the other] state are substantially equivalent to the requirements for an administrator's license according to §745.8914 of this subchapter (relating to How does Child Care Regulation (CCR) [Licensing] determine whether another state's licensing requirements are substantially equivalent to the requirements for an administrator's license under this subchapter?); and

(3) Verify that the license by another state is [you are licensed in the other state and are] in good standing. [, including that:]

[(A) Your license in the other state is valid, active, and current (is not pending renewal and has not expired); and]

[(B) There is no current disciplinary action or corrective action pending or attached to the license].

(d) CCR will complete [After completing] the actions in subsection (c) of this section and [, we will] notify the military member or military spouse according to §745.9028(b) - (d) of this division (relating to When and how will Child Care Regulation (CCR) expedite the application process for a military member, military spouse, or military veteran?). [you whether we approve or deny you to act as an administrator for a general residential operation, child-placing agency, or both without having an administrator's license under this subchapter.]

(e) If CCR approves the applicant's ability [we approve you] to act as an administrator for a general residential operation, child-placing agency, or both, the person acting as the administrator without a license[:]

[(1)] [You] must comply with all other applicable statutes, rules, and minimum standards [laws and regulations], including those relating to:

(1) [(A)] Administrator's Licensing in this subchapter and Chapter 43 of the Texas Human Resources Code;

(2) [(B)] Subchapter F of this chapter (relating to Background Checks) when employed by a general residential operation or a child-placing agency; and

(3) [(C)] Minimum standards for general residential operations and child-placing agencies. [; and]

(f) [(2)] The [Our] approval [for you] to act as an administrator expires as provided in the following chart. [on the earlier of:]
Figure: 26 TAC §745.9030(f)

(g) A military member or military spouse may request in writing a replacement copy of the letter approving the military member or military spouse to act as an administrator without a license. No fee is required, but the written request must include:

(1) A statement detailing the loss or destruction of the original approval letter; or

(2) The damaged letter.

[(A) The date your spouse is no longer stationed at a military installation in this state; or]

[(B) The third anniversary of the date when we notified you that you may act as an administrator for a general residential operation, child-placing agency, or both.]

(h) [(f)] The Child Care Enforcement Department [We] may revoke the [our] approval [for you] to act as an administrator without a license: [for]

(1) For failure to comply with subsection (e) of this section;

(2) For any reason noted in §745.9037 of this subchapter (relating to Under what circumstances may Licensing take remedial action against my administrator's license or administrator's license application?); or[.]

(3) If the military member or military spouse is no longer licensed in good standing by another state.

(i) CCR may not renew the approval to act as an administrator without a license.

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

Filed with the Office of the Secretary of State on August 29, 2024.

TRD-202404064
Karen Ray
Chief Counsel
Health and Human Services Commission
Earliest possible date of adoption: October 13, 2024
For further information, please call: (512) 438-3269

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 30. OCCUPATIONAL LICENSES AND REGISTRATIONS

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) proposes new Texas Administrative Code (TAC) §30.344 and §30.394 and the amendments to 30 TAC §§30.5, 30.7, 30.14, 30.18, 30.20, 30.24, 30.26, 30.28, 30.185, 30.340, 30.342, 30.350, 30.387, 30.390, and 30.392.

Background and Summary of the Factual Basis for the Proposed Rules

Legislative Implementation

House Bill (HB) 1845 amended Texas Water Code (TWC) Chapter 37, Occupational Licensing and Registration, to add TWC §37.0045 which requires the commission to establish, by rule, a provisional occupational license for Class D Wastewater operators and public water system operators for persons without a high school diploma or equivalent.

HB 2453 amended Texas Occupations Code (TOC) by adding new Chapter 60, to allow licensing agencies to issue a digital license or certificate of registration in lieu of a physical paper license. The bill does not require rulemaking. However, the executive director (ED) will be amending 30 TAC §30.5 to explicitly state that the ED may issue a digital license in lieu of physical paper license.

Senate Bill (SB) 422 amended TOC Chapter 55, to allow military service members to engage in a business or occupation for which a license is required, without a Texas license, provided the military service member holds a current license in good standing from another jurisdiction. The ED has a reciprocity process for military service members and already complies with the intent of the bill to ease the burden on military families relocated to Texas. Therefore, no rulemaking is required in this regard. However, the bill also requires that the ED process applications and issue the license for qualified military service members, veterans, or spouses, within 30 days of the receipt of application.

Staff Recommended Changes

This rulemaking proposes to amend 30 TAC Chapter 30 to incorporate the operator resiliency training requirements. On June 8, 2021, the 87th Texas Legislature passed SB 3 to address preparing for, preventing, and responding to weather emergencies and power outages. In the aftermath of Winter Storm Uri, TCEQ was tasked to conduct an "after-action review" to evaluate the factors that impacted public water systems during the Winter Storm. The project team engaged stakeholders from the private and public sectors to discuss a variety of topics to enhance critical infrastructure resilience. One of the recommendations that came out of the after-action review was to require public water system operators to take resiliency training. The amendments to the rules will assist licensed operators, public water systems, and affected utilities prepare for, respond to, and recover from severe weather-related events. TCEQ has the authority to expand the requirements for minimum operator training under existing language in TWC, §37.002 and 30 TAC Chapter 30 Subchapter K. TCEQ's rule currently requires specific courses to be taken to qualify for specific license levels. This rulemaking would codify in rule the new requirements for public water system operators to comply with the resiliency training requirements for new and renewal of public water system operator licenses.

This rulemaking proposes to amend 30 TAC Chapter 30 to require all applicants for new and renewal licenses to subscribe to the Federal Bureau of Investigation's (FBI) fingerprinting to allow the commission to more timely meet the statutory requirement to automatically revoke a license or registration upon an individual's imprisonment following a criminal conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision, as stated in TOC §53.021(b). Currently, the ED does not have a way to timely know when a licensee is imprisoned due to a felony conviction until they apply for a renewal application, which could potentially be three years after the conviction. Through the FBI fingerprint subscription, the ED will receive notification through the Criminal Justice Rap Back Program of Texas when a person who has fingerprints on file with the FBI is arrested or has criminal activity associated with those fingerprints. Additionally, this would allow the ED to verify out-of-state offenses to ensure applicant's self-attestations are complete and accurate to protect public safety.

This rulemaking also proposes to reduce the number of continuing education (CE) credits required to renew the Leaking Petroleum Storage Tank Project Manager license from 32 hours to 20 hours. Currently, individuals are required to complete 32 hours of continuing education every three years to be eligible to renew their license. The regulated community has expressed difficulty in meeting this requirement based on the available TCEQ-approved training (note the commission does not develop or offer training for this license). The ED does not believe there would be any impact to the environment by reducing the training requirement.

The rulemaking also proposes minor updates to provide consistency with other licensing requirements and rules. These include updating occupational training terminology to be consistent with current training policies and technologies.

Section by Section Discussion

The commission proposes to amend 30 TAC §30.5 to reflect the addition of TOC Chapter 60, Digital Licenses. The proposed amendment would add §30.5(g) to allow the ED to issue a digital license in lieu of a physical paper license.

The commission proposes to amend 30 TAC §30.7 to update definitions to be consistent with current training technology, delivery methods, and approval procedures. Definitions in this section have been renumbered to account for the added definitions.

The commission proposes to amend 30 TAC §30.7(3) to remove the term "classroom" from the definition of 'approved classroom training providers'. This definition now incorporates all types of training, rather than just classroom training.

The commission proposes to amend existing 30 TAC §30.7(4) to remove the definition of "approved conference and webinar training providers" as this term is no longer relevant. The term "approved training provider" encompasses training providers for all types of training.

The commission proposes to amend existing 30 TAC §30.7(5) to remove the definition of "approved distance training providers" as this term is no longer relevant. The term "approved training provider" encompasses training providers for all types of training. Subsequent definitions have been renumbered.

The commission proposes to amend existing 30 TAC §30.7(6) (proposed §30.7(4)) to update the definition of "approved training" to add the term "registration" since training is used for obtaining or renewing both licenses and registrations.

The commission proposes to amend existing 30 TAC §30.7(7) (proposed §30.7(5)) to update the terms used for training delivery methods. The three types of approved training delivery methods include in-person (occurs at the same place and time for the instructor and student), live-online (occurs at the same time for the instructor and student, but not at the same place), and self-paced training (occurs with a separation of both place and time between the instructor and student). The following terms were removed from this definition (conferences, seminars, workshops, training at association meetings) as they are considered types of training, rather than types of delivery methods.

The commission proposes to amend existing 30 TAC §30.7(8) (proposed §30.7(6)) to update the definition of "association" to add the term "registrations" since members could hold either licenses or registrations.

The commission proposes to add new 30 TAC §30.7(7) to include a definition for "association meetings" which refers to any in-person or online sessions conducted by an association that are delivered in-person, live-online, or a combination of both.

The commission proposes to add new 30 TAC §30.7(8) to include a definition for "classroom training". "Classroom training" refers to courses that are held in real-time and can be held in-person, live-online, or a combination of both.

The commission proposes to amend 30 TAC §30.7(9) to clarify that conferences may be delivered in-person, live-online, or a combination of both and must be conducted by a governmental entity, association, or accredited college.

The commission proposes to amend 30 TAC §30.7(10) to add the term "registration" since continuing education is required for renewal of both licenses and registrations.

The commission proposes to add new 30 TAC §30.7(11) to include a definition of "core training" which refers to courses that are required to obtain an occupational license or registration that are approved by the ED.

The commission proposes to amend existing 30 TAC §30.7(11) (proposed §30.7(12)) to update definition of "correspondence training". Correspondence training is a type of self-paced training that can be conducted as paper-based training, electronic-based (such as receiving a CD in the mail), or a combination of these systems.

The commission proposes to delete existing 30 TAC §30.7(12), the definition for "distance training". The term "self-paced training delivery method" (proposed §30.7(26) is proposed to replace the term "distance training" to be consistent with current training terminology.

The commission proposes to amend existing 30 TAC §30.7(13) to add the term "registrations" since a distributor can sell a product to individuals with either occupational licenses or registrations.

The commission proposes to add new 30 TAC §30.7(16) to define "in-person training delivery method" as an interactive instructor-led training delivered in real time at the same physical location as the student.

The commission proposes to add new 30 TAC §30.7(18) to define "live-online training delivery method" as training that occurs at the same time for the instructor and student, but not at the same place. Instructor-led classroom, conferences, or association meetings can be held using this delivery method.

The commission proposes to add 30 TAC §30.7(22) to define "prerecorded training" as training that has been previously recorded or developed through and online platform that is not delivered in person or in real-time. This type of training occurs with a separation of both place and time between the instructor and student.

The commission proposes to amend existing 30 TAC §30.7(20) (proposed §30.7(24)) to clarify that a "qualified instructor" is an individual that is approved to teach a TCEQ-approved core occupational licensing course.

The commission proposes to add new 30 TAC §30.7(24) to define "qualified presenter" as an individual that is approved to teach continuing education training. This individual has the instructional and work-related experience, as well as subject matter expertise to answer students' questions and deliver the training.

The commission proposes to add new 30 TAC §30.7(26) to define "self-paced training delivery method" as training delivered with a separation of time and place between the instructor and learning resources and the learner. The term "self-paced training" replaces the term "distance training".

The commission proposes to amend existing 30 TAC §30.7(23) (proposed §30.7(28)) to add the term "hands-on" to clarify that a subject matter expert needs hands-on work-related experience.

The commission proposes to delete existing 30 TAC §30.7(24) to remove the term "technology-based training". The term is no longer relevant and the terms "live-online training" or "self-paced training" replace this term.

The commission proposes to amend 30 TAC §30.7(26) (proposed §30.7(30)) to clarify that a "training provider" refers to an administrative entity and its designated personnel, not just an individual, responsible for delivering the training. This update is meant to clarify that the training provider is the company that develops the training, not the instructor or presenter.

The commission proposes to delete existing 30 TAC §30.7(27) to remove the term "webinar". The term is no longer relevant and has been incorporated into the term "live-online training".

The commission proposes to amend the title of 30 TAC §30.14 and §30.14(a) to change "registration" to "company registration" to clarify that this section applies only to company registrations and not individual registrations, which are proposed to be included in §30.18.

The commission proposes to amend 30 TAC §30.14(f) to clarify that an applicant for a new registration must not only resolve outstanding deficiencies, but also notify the executive director that the deficiencies have been resolved, within the established timeframe, before the application is considered expired. The timeframe has been adjusted from 60 to 120 days to be consistent with the timeframe allowed for an applicant for a new license to resolve deficiencies. The term "expired" replaces the term "void" to be consistent with the Occupational Licensing Section's terminology.

The commission proposes to add "individual registrations" to the title of 30 TAC §30.18 to clarify that the requirements in the section apply to both licenses and individual registrations. Company registrations are covered in §30.164 The commission proposes to amend §30.18(a) to add "individual registrations" to the requirement for applications for a license to be made on a standard form. This section requires that the application be submit-

ted prior to taking an exam. Since individual registrations have no examination requirement, "if applicable" was added.

The commission proposes to add 30 TAC §30.18(b) to require applicants for an initial license or individual registration to submit a set of fingerprints with their application, for the purpose of obtaining a criminal history record from the Texas Department of Public Safety (TXDPS) and FBI, unless a waiver is approved by the executive director to submit their criminal history information through an alternate method.

The commission proposes to add 30 TAC §30.18(c) to outline the fingerprinting requirement waiver process. An individual who is unable to get fingerprinted, may request a waiver from the executive director in writing. The proposed rule stipulates that an individual with out-of-state arrests or convictions is not eligible to request a waiver. The waiver must be accompanied by appropriate supporting documentation. Waivers are reviewed and approved on a case-by-case basis. If a waiver is approved, the individual must either attest that he/she does not have any criminal history or provide a TXDPS report or court documents to their criminal history. An approved waiver is only valid for three years. Additionally, the individual must notify the executive director if they are imprisoned due to a felony conviction, revocation of parole, or revocation of mandatory supervision during the period that the waiver is valid.

Under TOC §53.021(b), the executive director is required to automatically revoke a license or registration upon an individual's imprisonment following a criminal conviction, felony community supervision revocation, revocation of parole, or revocation of mandatory supervision. Currently, the executive director does not have a way to timely know when a licensee is imprisoned due to a felony conviction until they apply for a renewal application, which could potentially be three years after the conviction. This means that an individual whose license should have been revoked upon imprisonment due to a felony would have continued access to persons and property that the license provides and could potentially re-offend upon release. The fingerprint subscription provides access to the Criminal Justice Rap Back Program of Texas which notifies the executive director when a person who has fingerprints on file with the FBI is arrested or has criminal activity associated with those fingerprints. For this reason, the commission will be requiring that all applicants for new and renewal licenses and individual registrations submit fingerprints with the application, unless a waiver is approved by the executive director to submit their criminal history information through an alternate method.

As referenced in TOC §53.021(a), the commission has the authority to revoke, suspend, or deny a license or individual registration if the applicant was convicted of offenses that are directly related to the license, violent offenses, or sexually violent offense. This review is currently based on information provided by the applicant attesting to their criminal history and a report provided by the TXDPS. However, the TXDPS report only contains the applicant's in-state criminal history. The executive director does not have access to any out-of-state criminal history information unless the applicant attests to the out-of-state offenses, or the applicant chooses to utilize the fingerprint subscription option when applying.

The commission proposes to amend existing 30 TAC §30.18(g) (proposed §30.18(h)) to clarify that an applicant for a new registration must not only resolve deficiencies, but to also notify the executive director that the deficiency has been resolved, within the prescribed timeframe. The term "expired" replaces the term "void" to clarify that an application expires if the deficiencies have not been resolved.

The commission proposes to amend 30 TAC §30.20(d) and (e) to replace the term "void" with the term "expired" to clarify that an application expires if the deficiencies have not been resolved. An application expires after 365 days from the approval date of the application or failing the same examination four times.

The commission proposes to add 30 TAC §30.24(c) to require applicants for a renewal license or individual registration submit a set of fingerprints with their application, for the purpose of obtaining a criminal history record from TXDPS and FBI, unless a waiver is approved by the executive director to submit their criminal history information through an alternate method.

The commission proposes to add 30 TAC §30.24(d) to outline the fingerprinting requirement waiver process. An individual who is unable to get fingerprinted, may request a waiver from the executive director in writing. The proposed rule stipulates that an individual with out-of-state arrests or convictions is not eligible to request a waiver. The waiver must be accompanied by appropriate supporting documentation. Waivers are reviewed and approved on a case-by-case basis. If a waiver is approved, the individual must either attest that he/she does not have any criminal history or provide a TXDPS report or court documents to their criminal history. An approved waiver is only valid for three years. Additionally, the individual must notify the executive director if they are imprisoned due to a felony conviction, revocation of parole, or revocation of mandatory supervision during the period that the waiver is valid. The subsequent subsections have been renumbered.

The commission proposes to amend existing 30 TAC §30.24(r) (proposed §30.24(t)) to clarify that an applicant for a renewal of a license or registration must not only resolve deficiencies, but to also notify the executive director that the deficiency has been resolved, within the timeframe. The term "expired" replaces the term "void" to be consistent with the Occupational Licensing section's terminology.

The commission proposes to amend 30 TAC §30.26(f) to add paragraph (4), as required by HB 4123. The amendment will require the executive director to issue a license to a military service member, military veteran, or military spouse that holds a current license in good standing with another jurisdiction that is substantially equivalent within 30 days. If the application is deficient or the ED has not received verification from the out-of-state jurisdiction that the license held out-of-state is substantially equivalent to the license the individual is applying for from the TCEQ, the executive director will not be able to issue a license within 30 days of receipt of application. In these circumstances, the executive director will issue a license or registration as soon as practicable after the deficiency has been resolved or the verification has been received.

The commission proposes to amend 30 TAC §30.28(b), (b)(3), and (b)(4) to update the terminology for types of training that the executive director may approve. The term "events" in §30.28(b) has replaced the term "delivery methods" to define the types of training events the executive director may approve. The types of delivery methods that the executive director may approve are included in new §30.28(c). The term "prerecorded training" has replaced the term "technology-based training" and the term "distance training" has been removed to be consistent with the proposed amendments to the definitions in §30.7.

The commission proposes to add 30 TAC §30.28(c) to clarify the types of delivery methods for which the executive director may approve training. Training delivery methods include in-person (occurs at the same place and time for the instructor and student), live-online (occurs at the same time for the instructor and student, but not at the same place, and self-paced training (occurs with a separation of both place and time between the instructor and student), as defined in §30.7. Subsequent sections have been renumbered.

The commission proposes to amend existing 30 TAC §30.28(e)(7) (proposed §30.28(f)(7)) to clarify that a training provider must not only resolve deficiencies, but to also notify the executive director that the deficiency has been resolved, within the 60-day timeframe.

The commission proposes to amend existing 30 TAC §30.28(g) (proposed §30.28(h)) to the number of core courses for instructor qualifications as a basis for calculating fees for training applications. Separate instructor qualification fees are not required when submitted with an initial training application for a core course. However, after an initial training application is submitted and approved, a $10 fee per instructor and core course will be assessed.

The commission proposes to amend existing 30 TAC §30.38(h) (proposed §30.38(i)) to require training providers to verify the identity of students. Additionally, the amendments replace the term "technology-based" with "self-paced" to be consistent with current training terminology.

The commission also proposes to update Figure: 30 TAC §30.28(g) (proposed Figure: 30 TAC §30.28(h)) to ensure the fee table for training applications is consistent with the proposed updates to the training terminology. The rows for "technology-based training" and "webinar" have been deleted since these terms are proposed to be deleted from this chapter. The new organization of the table makes it clearer which fee applies to which type of training. A new row for Instructor Qualification has been added.

The commission proposes to amend existing 30 TAC §30.28(p) (proposed §30.28(q)) to remove reference to "webinars" as this term is proposed to be deleted in this chapter and replace the term "distance training" with "self-paced training". Additionally, the term "live-online" has been added as a type of delivery method that cannot be approved to teach required manual skills.

The commission proposes to amend 30 TAC §30.185, Qualification for License Renewal. The proposed amendment would reduce the number of continuing education hours required to renew a Leaking Petroleum Storage Tank Project Manager license. Currently, individuals are required to complete 32 hours of continuing education every three years to be eligible to renew their license. The regulated community has expressed difficulty in finding training that is approved for continuing education (CE) credit for this particular license. The commission does not develop or offer training for this license, it only approves training for CE credit. TCEQ believes that reducing the required CEs from 32 to 20 will address the lack of available TCEQ-approved training without any detrimental effects on the environment or to public health.

The commission proposes to amend 30 TAC §30.340 to implement new TWC §37.0045, Qualifications for Certain Licenses, created by HB 1845. The commission proposes to update Figure: 30 TAC §30.340(a) to add a row for the Provisional Class D License for wastewater operators to the table. The table lists the minimum requirements by wastewater operator license type. The Provisional Class D License has no education or work experience required and has 20 hours of required training.

The commission also proposes to update Figure: 30 TAC §30.340(f) to add the Provisional Class D Wastewater License to the table. The table shows the required courses and elective courses for each type of wastewater operator license. The Provisional Class D Wastewater Operator License requires the Basic Wastewater Operation course and requires no elective courses. The proposed updates also clarify that the Basic Wastewater Operation course is required for Class B and Class A Wastewater Operators. This proposed change will provide consistency between the requirements for the Water and Wastewater operators, as Class B and Class A Water Operators are required to the take the basic training course as shown in Figure: 30 TAC §30.390(f). This does not change the total hourly requirements for either license level shown in Figure §30.390(a).

The commission proposes to delete 30 TAC §30.342(a)(2) to eliminate the option for licensed wastewater operators to renew their license through examination in lieu of continuing education credits. Currently, licensed wastewater operators can either meet the continuing education requirements or pass the applicable exam again to be eligible to renew their license. The option to renew a license by taking the exam again was offered in the past to all license types, however this option was removed for all other licenses except for water and wastewater operators and is very rarely used. For consistency, and to ensure that all water operators take the required resiliency CEs, the option to renew through re-examination needs to be discontinued. To maintain consistency, this option will be discontinued for wastewater operators as well. Approximately 3 individuals, out of approximately 2,500, use this option to renew a wastewater operation license per year.

The commission proposes new 30 TAC §30.344 to implement new TWC §37.0045, Qualifications for Certain Licenses, as required by HB 1845. The commission proposes §30.344(a) to establish that the Wastewater D Provisional license may be issued to an individual that does not possess a high school diploma or equivalent and has also completed the required training, passed the applicable examination, and acts under the direct supervision of a license holder. The commission proposes §30.344(b) to establish that the provisional license is valid for two years and that the application fee is $74. The commission proposes §30.344(c) to establish that provisional licenses are not renewable or reobtainable. The commission proposes §30.344(d) to establish that a provisional license holder whose license expires must submit proof of a high school diploma or equivalent and apply for a Class D operator or higher prior to the expiration date of the provisional license, to be able to continue to work as a licensed wastewater operator. An advantage of applying for the Class D operator prior to the expiration date of the provisional license, is that the individual would not have to retake the Class D Operator exam, as it is the same exam. However, if the provisional license expires before the individual applies for the Class D license, the individual would need to re-test.

The commission proposes to amend 30 TAC §30.350(e) to restructure Figure: 30 TAC §30.350(e) to make it easier to determine which license type is required based on the treatment technology and permitted flow. No changes to the requirements were made.

The commission proposes to add proposed 30 TAC §30.387(8) and (9) to add definitions for "resiliency continuing education training" and "resiliency overview course". The "resiliency continuing education" refers to any training on resiliency topics that TCEQ approves to count toward the resiliency training that is required to renew a water operator license. The "resiliency overview course" refers to the overview of the resiliency topics, as outlined by the ED, that is required for a new or upgraded water operator license starting on April 1, 2024. The requirement was implemented as part of an agency policy and is being codified in rule through this rulemaking. The resiliency overview course can be taken as a stand-alone course or as part of the Basic Waterworks Operations core course, if the course has been updated to include the resiliency overview topics. Subsequent sections have been renumbered.

The commission proposes to amend 30 TAC §30.390 to implement new TWC §37.0045, Qualifications for Certain Licenses, required by HB 1845, and incorporate the resiliency training requirement, as recommended by the Winter Storm Uri After Action Review. The commission proposes to update Figure: 30 TAC §30.390(a) to add the Provisional Class D License for water operators to the table. The table lists the minimum requirements by water operator license type. The Provisional Class D License has no education or work experience required and has 22 hours of required training. Additionally, the training credit hours required for each license type was increased by 2 to account for the resiliency overview core course requirement. Starting on April 1, 2024, individuals who apply for a new water operator license and have not taken an updated core course with the resiliency component are required to take the Resiliency Overview Course for an additional two hours. Once the Resiliency Overview Course has been completed, it does not need to be repeated if the individual applies for another license level.

The commission also proposes to update Figure: 30 TAC §30.390(f) to add the Provisional Class D Water Operator License to the table. The table shows the required courses and elective courses for each type of water operator license. The Provisional Class D Water Operator License requires the Basic Waterworks Operation and the Resiliency Overview courses and requires no elective courses. The updated table also adds the Resiliency Overview course as core course requirement for all water operator license levels. This requirement has already been implemented and applies to applications received on or after April 1, 2024. The standalone Resiliency Overview Course is required if the individual did not take the updated Basic Waterworks Operation that incorporates resiliency overview topics into the course.

The commission proposes to amend 30 TAC §30.390(g) to clarify that an individual who previously held a Class A, B, or C license would not be eligible to apply for a Class D Water Operator license if the individual currently operates facilities listed in §30.390(g)(1)-(5). This is consistent with the requirements for the Wastewater Operator D license.

The commission proposes to amend 30 TAC §30.392 to implement the resiliency requirements for renewing a water operator license, as recommended by the Winter Storm Uri After Action Review. The commission proposes to amend §30.392(a)(1) to specify that two of the required 30 CE credit hours must be approved as resiliency training.

The commission proposes to delete 30 TAC §30.392(a)(2) to eliminate the option for licensed water operators to renew their license through examination. Currently, licensed water operators can either meet the continuing education requirements or pass the applicable exam again to be eligible to renew their license. The option to renew a license by taking the exam again was offered in the past to all license types, however this option was removed for all other licenses except for water and wastewater operators. To ensure that all water operators take the required resiliency CEs, the option to renew through re-examination needs to be discontinued. To maintain consistency, this option will be discontinued for water operators as well. Approximately 5 licensees use this option annually to renew their license.

The commission proposes to add 30 TAC §30.392(e) to establish that applicants whose license expires on or after April 1, 2024, are required to take the Resiliency Overview Course as part of the continuing education requirement to renew a license. An individual must take the Resiliency Overview Course once to meet the resiliency training requirement. After that, the individual may repeat the course for continuing education hours. Although not stated in the rule, TCEQ policy will allow these individuals two renewal cycles to complete the course. For example, if an individual's license expires on May 1, 2024, that individual would have until the next renewal cycle (May 1, 2027) to take the Resiliency Overview Course.

The commission proposes new 30 TAC §30.394 to implement new TWC §37.0045, Qualifications for Certain Licenses, as a result of HB 1845. The commission proposes §30.394(a) to establish that the Water Operator D provisional license may be issued to an individual that does not possess a high school diploma or equivalent and has also completed the required training, passed the applicable examination, and acts under the direct supervision of a license holder. The commission proposes §30.394(b) to establish that the provisional license is valid for two years and that the application fee is $74. The commission proposes §30.394(c) to establish that provisional licenses are not renewable or reobtainable. The commission proposes §30.394(d) to establish that a provisional license holder whose license expires must submit proof of a high school diploma or equivalent and apply for a Class D operator or higher prior to the expiration date of the provisional license, to be able to continue to work as a licensed water operator. An advantage of applying for the Class D operator prior to the expiration date of the provisional license, is that the individual would not have to retake the Class D Operator exam. However, if the provisional license expires before the individual applies for the Class D license, the individual would need to re-test.

Fiscal Note: Costs to State and Local Government

Kyle Girten, Analyst in the Budget and Planning Division, has determined that for the first five-year period the proposed rules are in effect, fiscal impacts are anticipated for TCEQ as a result of implementation of the proposed rule. Proposed changes to 30 TAC §30.18, which would require applicants to submit fingerprints for the purposes of obtaining a criminal history record unless they receive a waiver from TCEQ, would lead to cost savings for the agency. TCEQ pays $1 for a TXDPS report each time individuals apply for new licenses or renewals. TXDPS waives this fee for the DPS reports reviewed within 30 days of the date that fingerprinting subscriptions are obtained by the applicant. Currently, TCEQ runs approximately 25,000 reports per year for new licenses and renewals, so it is estimated that $25,000 will be saved each of the first three years after the proposed rules are in effect. In years four and five, which would be after the first licensing cycle after the fingerprinting requirement is implemented, it is estimated that savings would be approximately $6,000 per year

because savings would only apply to new applicants. Existing licensees will have already been fingerprinted by this time, so TCEQ will be responsible for the $1 fee in years four and five for these new applicants.

Proposed changes to 30 TAC §§30.340, 30.344, and 30.394, which would create new Provisional Class D Licenses for water and wastewater operators that do not have a high school diploma or its equivalent, would result in increased revenue for TCEQ. TCEQ would receive $74 as an application fee for each applicant. It cannot be estimated how many total applicants will apply for this license.

The rulemaking is not anticipated to result in any fiscal implications for other state or local government entities.

Public Benefits and Costs

Mr. Girten determined that for each year of the first five years the proposed rules are in effect, the public benefit will be compliance and consistency with state law, specifically HB 1845, HB 2453, and SB 422 from the 88th Regular Legislative Session (2023). Additionally, proposed changes to 30 TAC §30.390 and §30.394, which would require resiliency training for water operators, would assist licensed operators, public water systems, and affected utilities with preparing for, responding to, and recovering from severe weather-related events. This may assist with reducing the frequency with which water supplies are compromised during and following severe weather-related events. Lastly, the proposed rulemaking to require fingerprinting for applicants would improve public safety. Currently, TCEQ relies on applicants to attest to out-of-state offenses. The fingerprinting requirement would result in TCEQ having direct access to national criminal history information, and this would provide greater assurance that the agency has accurate information and can revoke a license or registration when necessary.

The proposed rulemaking would also benefit individuals without a high school diploma or its equivalent by making it possible for these individuals to obtain a provisional Class D Water and/or Wastewater Operator license. This would offer such individuals a means to enter the water and/or wastewater profession while working to obtain their high school diploma or its equivalent.

The proposed rulemaking would result in costs for individuals applying for a new license or individuals seeking a renewal of an existing license. These individuals would be responsible for a one-time fee, currently set at $40, to get their fingerprints. In most cases, the employer is likely to pay this fee or reimburse the applicant for this cost. Individuals that receive a waiver from fingerprinting requirements from TCEQ would not incur this cost.

Local Employment Impact Statement

The commission reviewed this proposed rulemaking and determined that a Local Employment Impact Statement is not required because the proposed rulemaking does not adversely affect a local economy in a material way for the first five years that the proposed rule is in effect.

Rural Communities Impact Assessment

The commission reviewed this proposed rulemaking and determined that the proposed rulemaking does not adversely affect rural communities in a material way for the first five years that the proposed rules are in effect. The amendments would apply statewide and have the same effect in rural communities as in urban communities.

Small Business and Micro-Business Assessment

No adverse fiscal implications are anticipated for small or micro-businesses due to the implementation or administration of the proposed rule for the first five-year period the proposed rules are in effect.

Small Business Regulatory Flexibility Analysis

The commission reviewed this proposed rulemaking and determined that a Small Business Regulatory Flexibility Analysis is not required because the proposed rule does not adversely affect a small or micro-business in a material way for the first five years the proposed rules are in effect.

Government Growth Impact Statement

The commission prepared a Government Growth Impact Statement assessment for this proposed rulemaking. The proposed rulemaking does not create or eliminate a government program and will not require an increase or decrease in future legislative appropriations to the agency. The proposed rulemaking does not require the creation of new employee positions, eliminate current employee positions, nor require an increase or decrease in fees paid to the agency. The proposed rulemaking amends an existing regulation, and it does not create, expand, repeal, or limit this regulation. The proposed rulemaking does not increase or decrease the number of individuals subject to its applicability. During the first five years, the proposed rule should not impact positively or negatively the state's economy.

Draft Regulatory Impact Analysis Determination

The commission reviewed this rulemaking action in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the proposed rules are not subject to that statute because the proposed rules do not meet the criteria for "major environmental rules" as defined in Texas Government Code, §2001.0225(g)(3). Texas Government Code, §2001.0225 applies only to rules that are specifically intended to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. Texas Government Code, §2001.0225 does not apply because the proposed rules would only modify existing licensing and registration requirements.

The purpose of the proposed rules is to implement HB 1845, HB 2453, and SB 422 (88th Texas Legislature).

The specific intent of the proposed rules is: to ensure consistency between the rules and their applicable statutes as amended by recent legislation; to establish, by rule, a provisional occupational license for Class D Wastewater operators and public water system operators for persons without a high school diploma or equivalent; to issue a digital license or certificate of registration in lieu of a physical paper license; and to allow military service members to engage in a business or occupation for which a license is required, without a Texas license, provided the military service member holds a current license in good standing from another jurisdiction.

Furthermore, even if the proposed rules did meet the definition of a major environmental rule, the proposed rules are not subject to Texas Government Code, §2001.0225, because they do not meet any of the four applicability requirements specified in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225(a) applies to rules proposed by an agency, the result of which is to: 1) exceed a standard set by federal law,

unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law.

In this case, the proposed rules do not meet any of these requirements: there are no federal standards for the occupational licenses and registrations program administered by the commission; the rules do not exceed an express requirement of state law; there is no delegation agreement that would be exceeded by the rules; and the proposed rules would implement HB 1845 and HB 2453 and SB 422 (88th Texas Legislature).

Written comments on the Draft Regulatory Impact Analysis Determination may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Takings Impact Assessment

The commission has prepared a takings impact assessment for these proposed rules pursuant to Texas Government Code, §2007.043. The specific purpose of these proposed rules is: to ensure consistency between the rules and their applicable statutes as amended by recent legislation; to establish, by rule, a provisional occupational license for Class D Wastewater operators and public water system operators for persons without a high school diploma or equivalent; to issue a digital license or certificate of registration in lieu of a physical paper license; and to allow military service members to engage in a business or occupation for which a license is required, without a Texas license, provided the military service member holds a current license in good standing from another jurisdiction.

The proposed regulations do not affect a landowner's rights in private real property because this proposed rulemaking does not burden, restrict, or limit the owner's right to property and reduce its value by 25% or more beyond that which would otherwise exist in the absence of the regulations. The proposed rules do not constitute a taking because they would not burden private real property.

Consistency with the Coastal Management Program

The commission reviewed the proposed rules and found that they are neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §29.11(b)(2) or (4), nor will they affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §29.11(a)(6). Therefore, the proposed rules are not subject to the Texas Coastal Management Program.

Written comments on the consistency of this rulemaking may be submitted to the contact person at the address listed under the Submittal of Comments section of this preamble.

Announcement of Hearing

The commission will hold a hold a hybrid virtual and in-person public hearing on this proposal in Austin on October 10, 2024, at 2:00 p.m. in building F, room 2210 at the commission's central office located at 12100 Park 35 Circle. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, commission staff members will be available to discuss the proposal 30 minutes prior to the hearing at 1:30 p.m.

Individuals who plan to attend the hearing virtually and want to provide oral comments and/or want their attendance on record must register by Tuesday, October 8, 2024. To register for the hearing, please email Rules@tceq.texas.gov and provide the following information: your name, your affiliation, your email address, your phone number, and whether or not you plan to provide oral comments during the hearing. Instructions for participating in the hearing will be sent on Wednesday, October 9, 2024, to those who register for the hearing.

For the public who do not wish to provide oral comments but would like to view the hearing may do so at no cost at:

https://events.teams.microsoft.com/event/9911ca85-b213-403e-bf2f-bb1182a11080@871a83a4-a1ce-4b7a-8156-3bcd93a08fba

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Sandy Wong, Office of Legal Services at (512) 239-1802 or (800) RELAY-TX (TDD). Requests should be made as far in advance as possible.

Submittal of Comments

Written comments may be submitted to Gwen Ricco, MC 205, Office of Legal Services, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to *fax4808@tceq.texas.gov.* Electronic comments may be submitted at: https://tceq.commentinput.com/comment/search. File size restrictions may apply to comments being submitted via the TCEQ Public Comments system. All comments should reference Rule Project Number 2024-004-030-WS. The comment period closes on October 14, 2024. Please choose one of the methods provided to submit your written comments.

Copies of the proposed rulemaking can be obtained from the commission's website at *https://www.tceq.texas.gov/rules/propose_adopt.html*. For further information, please contact Rebecca Morigan, Occupational Licensing & Registration Division, (512) 239-2463.

SUBCHAPTER A. ADMINISTRATION OF OCCUPATIONAL LICENSES AND REGISTRATIONS

30 TAC §§30.5, 30.7, 30.14, 30.18, 30.20, 30.24, 30.26, 30.28

Statutory Authority

These amendments are proposed under the authority granted to the Texas Commission on Environmental Quality (commission) in Texas Water Code (TWC), §5.012, which provides that the commission is the agency responsible for implementing the constitution and laws of the state relating to conservation of natural resources and protection of the environment; and §5.103 and §5.105, which establish the commission's general authority to adopt rules.

These amendments are also proposed under TWC, §37.002, which provide the commission's specific authority to adopt rules governing occupational licenses and registrations; TWC, §§26.0301, 37.003, 37.005, and 37.006; Texas Health and Safety Code, §§341.033, 341.034, 361.027, and 366.071, and Texas Occupations Code (TOC), §1903.251.

The proposed rules implement TWC, §37.045 as added by House Bill (HB) 1845; 30 TOC, §60.002 as added by HB 2453; and 30 TOC, §55.0041 and §55.005(a) as amended by Senate Bill 422.

§30.5. General Provisions.

(a) A person must be licensed or registered by the commission before engaging in an activity, occupation, or profession described by Texas Water Code, §§26.0301, 26.345, 26.452, 26.456, Texas Health and Safety Code, §§341.033, 341.034, 361.027, 366.071, 366.0515, or Texas Occupations Code, §1903.251 and §1904.051. The commission shall issue a license or registration only after an applicant has met the minimum requirements for a license or registration as specified in this chapter.

(b) A person shall not advertise or represent themselves to the public as a holder of a license or registration unless that person possesses a current license or registration. A person shall not advertise or represent to the public that it can perform services for which a license or registration is required unless it holds a current license or registration, or unless it employs individuals who hold current licenses.

(c) The executive director may contract with persons to provide services required by this chapter. The commission may authorize contractors to collect reasonable fees for the services provided.

(d) Licenses and registrations are not transferable.

(e) New licenses shall not be issued to employees of the commission who have regulatory authority over the rules of this chapter. Commission employees may maintain a license if that license was issued prior to employment with the commission.

(f) Prohibited Employment.

(1) Individuals subject to registration under the Texas Code of Criminal Procedure, Chapter 62 because of a reportable conviction or adjudication for which an affirmative finding is entered under Texas Code of Criminal Procedure, Article 42.015(b) or Section 5(e)(2), Article 45.12, and licensed after September 1, 2013, may not, for compensation, provide or offer to provide any type of service in the residence of another person unless the provision of service will be supervised.

(2) For purposes of this subsection.

(A) "Residence" means a structure primarily used as a permanent dwelling and land that is contiguous to that permanent dwelling.

(B) "Supervision" means direct, continuous visual observation of the individual at all times.

(g) The executive director may issue a digital license or registration in lieu of a paper certificate or pocket card.

§30.7. Definitions.

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

(1) Aerobic treatment system owner--Persons that in their individual capacities own a single-family dwelling that is serviced by an on-site sewage disposal system using aerobic treatment.

(2) Approved application--An application submitted to the Occupational Licensing Section that contains all the information the executive director has deemed necessary to be accurately processed and that the executive director has determined to be approved.

(3) Approved [~~classroom~~] training providers--Entities that have been approved by the executive director to provide [~~classroom~~] training after demonstration of hands-on subject matter expertise, knowledge of and experience with educational principles, and effective instructional designs.

[~~(4) Approved conference and webinar training providers--Governmental entities or their designated agents, associations, or colleges as listed by accrediting agencies that are recognized by the United States Department of Education and that have been approved by the executive director to provide conference and webinar training.~~]

[~~(5) Approved distance training providers--Governmental entities or their designated agents, associations, or colleges as listed by accrediting agencies that are recognized by the United States Department of Education and that have~~] ~~been approved by the executive director to provide distance training after demonstrating comparable subject matter expertise, knowledge of and experience with educational principles, and effective instructional designs.~~]

(4) [~~(6)~~] Approved training--Training which provides the knowledge and skills necessary to perform occupational job tasks and is used for obtaining or renewing a license or registration, as determined by the executive director.

(5) [~~(7)~~] Approved training delivery method--Methods approved by the executive director that currently include in-person, live-online, self-paced, and may include other technologies approved by the executive director. [~~instructor-led classroom training, conferences, seminars, workshops, training at association meetings, distance training, or technology-based training.~~]

(6) [~~(8)~~] Association--The term association as used in the context of this chapter is an industry-related non-profit association whose members hold licenses or registrations issued by the commission or whose members are required to employ or contract with individuals who hold licenses or registrations issued by the commission.

(7) Association meetings--Sessions conducted by an Association that may be delivered in-person, live-online, or a combination of both.

(8) Classroom training--Training that is an instructor-led course held in real-time in a classroom environment and may be held in-person, live-online, or a combination of both.

(9) Conference--The term conference as used in the context of this chapter includes TCEQ-approved conferences, seminars, workshops, symposiums, expos, and any other such training venues and may be delivered in-person, live-online, or a combination of both and conducted by a governmental entity or their designated agents, associations, or colleges as listed by accrediting agencies that are recognized by the United States Department of Education.

(10) Continuing education--Job-related training credit approved by the executive director used for renewal of licenses or registrations.

(11) Core training--Courses required to obtain an occupational license or registration that are approved by the executive director.

(12) [~~(11)~~] Correspondence training--The term correspondence training as used in the context of this chapter is self-paced [~~distance~~] training that can either be paper-based and conducted through a postal system, electronic-based [~~and conducted through a website~~], or a blend of these delivery systems.

[~~(12) Distance training-- The acquisition of knowledge that occurs through various technologies with a separation of place and time between the instructor(s) or learning resources and the learner.~~]

(13) Distributor--Any person or nongovernmental organization that sells a product primarily to individuals maintaining occupational licenses or registrations administered by the agency.

(14) High school diploma--An earned high school diploma from a United States high school, an accredited secondary school equivalent to that of United States high school, or a passing score on the general education development (GED) test that indicates a high school graduation level.

(15) Home school diploma--An earned diploma from a student who predominately receives instruction in a general elementary or secondary education program that is provided by the parent, or by a person in parental authority, in or through the child's home.

(16) In-person training delivery method--Training that is interactive instructor-led and delivered in real time at the same physical location.

(17) [~~(16)~~] License--An occupational license issued by the commission to a person authorizing the person to engage in an activity covered by this chapter.

(18) Live-online training delivery method-- Training that is delivered virtually in real time as either instructor-led classroom, conference, or association meeting.

(19) [~~(17)~~] Maintenance provider--A person that, for compensation, provides service or maintenance for one or more on-site sewage disposal systems using aerobic treatment.

(20) [~~(18)~~] Manufacturer--For the purpose of this subchapter any person, company, or nongovernmental organization that produces a product for sale primarily to individuals who maintain occupational licenses that are administered by the agency.

(21) [~~(19)~~] Person--As defined in §3.2 of this title (relating to Definitions).

(22) Prerecorded training--Training that has previously been recorded or developed through a virtual or online platform and is not delivered in person nor in real time.

(23) [~~(20)~~] Qualified instructor--An individual approved to teach a TCEQ-approved core occupational licensing or registration course who has instructional experience, work-related experience, and subject matter expertise that enables the individual to communicate course information in a relevant, informed manner and to answer students' questions.

(24) Qualified presenter--An individual approved to present TCEQ-approved continuing education training who has instructional experience, work-related experience, and subject matter expertise that enables the individual to answer students' questions and to communicate course information in a relevant, informed manner.

(25) [~~(21)~~] Registration--An occupational registration issued by the commission to a person authorizing the person to engage in an activity covered by this chapter.

(26) Self-paced training delivery method--Training that is delivered using various technologies with a separation of place and time between the instructor or learning resources and the learner. Self-paced training may include correspondence training, prerecorded training, and other technologies approved by the executive director.

(27) [~~(22)~~] Service provider--Any person, company, or nongovernmental organization that provides a service for its own profit to individuals who maintain occupational licenses that are administered by the agency.

(28) [~~(23)~~] Subject matter expert--A person having a minimum of three years of hands-on work-related experience and expert knowledge in a particular content area or areas as relates to training.

[~~(24) Technology-based training--The term technology-based training as used in the context of this chapter includes training offered through computer equipment or through a website (also known as on-line training or e-learning).~~]

(29) [~~(25)~~] Training credit--Hours awarded by the executive director for successful completion of approved training.

(30) [~~(26)~~] Training provider--An administrative entity and its designated personnel who are [~~or individual~~] responsible for obtaining approval of training, providing acceptable delivery of approved training, ensuring that qualified instructors or subject matter experts are utilized in the delivery, support, and development of training and monitoring, recording, and reporting attendance accurately and promptly as required by the executive director.

[~~(27) Webinar--Interactive training delivered live via the Internet as a combination of conference training and distance training where the learner is separated by place from the learning source.~~]

§30.14. Applications for Initial Company Registration.

(a) Applications for initial company registrations shall be made on a standard form approved by the executive director. The application must be submitted to the executive director with the appropriate fee.

(b) Supplemental information for each individual program shall be submitted according to the specific requirements for each program.

(c) All statements and qualifications provided by the applicant or on the behalf of the applicant are subject to verification by the executive director.

(d) All statements, qualifications, and attachments provided by the applicant relating to an application shall be true, accurate, complete, and contain no misrepresentation or falsification.

(e) Misrepresentation or falsification of any information may be grounds for denial of an application and for enforcement action.

(f) All applications must be completed in full. All deficiencies must be resolved, and the applicant must notify the executive director that the deficiency has been resolved [~~corrected~~] within 120 [~~60~~] days of notification, or the application shall be considered expired [~~void~~].

(g) The executive director shall determine whether an applicant meets the requirements of this subchapter. If all requirements have been met, the executive director shall issue the registration. The registration shall be valid for the term specified in Subchapters B - L of this chapter (relating to Backflow Prevention Assembly Testers, Customer Service Inspectors, Landscape Irrigators, Installers, Irrigation Technicians and Irrigation Inspectors, Leaking Petroleum Storage Tank Corrective Action Project Managers and Specialists, Municipal Solid Waste Facility Supervisors, On-Site Sewage Facilities Installers, Apprentices, Designated Representatives, Maintenance Providers, Maintenance Technicians, and Site Evaluators. Water Treatment Specialists, Underground Storage Tank On-Site Supervisor Licensing and Contractor Registration, Wastewater Operators and Operations Companies, Public Water System Operators and Operations Companies, Visible Emissions Evaluator Training and Certification, respectively.) The effective date of the registration shall be the date the executive director issues the registration.

§30.18. Applications for an Initial License and Individual Registrations.

(a) Applications for initial licenses and individual registrations shall be made on a standard form provided by the executive director. The application must be submitted to the executive director with the fee according to §30.30 of this title (relating to Terms and Fees for Licenses and Registrations). The application must be submitted to the executive director before the applicant may take the examination, if applicable.

(b) Applicants must submit a set of fingerprints for the purpose of obtaining a criminal history record from the Texas Department of Public Safety (TXDPS) and the Federal Bureau of Investigation, unless a waiver is approved by the executive director to allow an applicant to submit a criminal history via a different method.

(c) An individual unable to get fingerprinted may request a waiver from fingerprinting in writing from the executive director to be reviewed on a case-by-case basis.

(1) An individual who has any out-of-state arrests or convictions is not eligible for a waiver.

(2) Waiver requests shall be accompanied by appropriate documentation to support the waiver request.

(3) If a waiver is approved, the individual must either attest that they do not have a criminal history or provide a Texas DPS report or court documents attesting to their criminal history.

(4) If a waiver is approved, it is valid for three years.

(5) If a waiver is approved, the individual must notify the executive director if they are imprisoned due to a felony conviction, revocation of parole, or revocation of mandatory supervision during the period that the waiver is valid.

(d) [~~(b)~~] Supplemental information for each individual program shall be submitted according to the specific requirements for each program.

(e) [~~(c)~~] An approved application shall be valid for one year from the date of application approval.

(f) [~~(d)~~] All statements and qualifications provided by each applicant or on the behalf of the applicant are subject to verification by the executive director.

(g) [~~(e)~~] All statements, qualifications, and attachments provided by the applicant relating to an application shall be true, accurate, complete, and contain no misrepresentation or falsification.

(h) [~~(f)~~] Misrepresentation or falsification of any information may be grounds for denial of an application and for enforcement action.

(i) [~~(g)~~] All applications must be completed in full. All deficiencies must be resolved, and the applicant must notify the executive director that the deficiency has been resolved, [~~corrected~~] within 120 days of notification, or the application shall be considered expired [~~void~~].

(j) [~~(h)~~] An applicant must furnish evidence of any training credit, proof of education, or work experience when requested. Diplomas from non-accredited high schools will be evaluated by the executive director on a case-by-case basis and will be considered based on the following submitted information:

(1) transcript;

(2) documentation of actual coursework;

(3) time spent on coursework or program; and

(4) any additional documentation the executive director might reasonably request or that would assist the applicant in demonstrating the proof of their education claim.

(k) [~~(i)~~] The executive director shall determine whether an applicant meets the requirements of this subchapter. If all requirements have been met, the executive director shall issue the license. The license shall be valid for the term specified in Subchapters B - L of this chapter (relating to Backflow Prevention Assembly Testers; Customer Service Inspectors; Landscape Irrigators, Irrigation Technicians, and Irrigation Inspectors; Leaking Petroleum Storage Tank Corrective Action Project Managers and Specialists; Municipal Solid Waste Facility Supervisors; On-Site Sewage Facilities Installers, Apprentices, Designated Representatives, Maintenance Providers, Maintenance Technicians, and Site Evaluators; Water Treatment Specialists; Underground Storage Tank On-Site Supervisor Licensing and Contractor Registration; Wastewater Operators and Operations Companies; Public Water System Operators and Operations Companies; and Visible Emissions Evaluator Training and Certification, respectively.) The effective date of the license shall be the date the executive director issues the license.

§30.20. Examinations.

(a) The executive director shall prescribe the content of licensing examinations. Examinations shall be based on laws, rules, job duties, and standards relating to the particular license. The contents of any examination required for licensure under this chapter are confidential and examinees may not share them with anyone.

(b) Examinations shall be graded and the results forwarded to the applicant no later than 45 days after the examination date. The minimum passing score for an examination is 70%.

(c) An individual with an approved application who fails an examination may not repeat an examination until receiving notification of examination results for that particular examination.

(d) The application expires [~~becomes void~~] either after 365 days from date of application or failing the same examination four times, whichever occurs first. If an application expires [~~becomes void~~], a new fee and a new application must be submitted before the applicant may take the same examination again.

(e) Any scores for repeat examinations taken after an application expires [~~becomes void~~] will not be applied to the issuance of the license.

(f) Any qualified applicant with a physical, mental, or developmental disability may request reasonable accommodations to take an examination.

(g) Examinations shall be given at places and times approved by the executive director.

(h) Examinees must comply with all written and verbal instructions of the proctor and shall not:

(1) bring any unauthorized written material, in either printed or electronic formats, into the examination room;

(2) bring any electronic devices, including any device with a camera, into the examination room;

(3) share, copy, or in any way reproduce any part of the examination;

(4) engage in any deceptive or fraudulent act; or

(5) solicit, encourage, direct, assist, or aid another person to violate any provision of this section or compromise the confidentiality of the examination.

(i) The executive director shall provide an analysis of an examination when requested in writing by the applicant. The executive director shall ensure that an examination analysis does not compromise the fair and impartial administration of future examinations.

(j) An individual who wishes to observe a religious holy day on which the individual's religious beliefs prevent the individual from taking an examination scheduled by the agency on that religious holy day shall be allowed to take the examination on an alternate date.

(k) The executive director may deny an individual the opportunity to take a licensing examination on the grounds that the individual has been convicted of an offense, other than an offense punishable as a Class C misdemeanor, that:

(1) directly relates to the duties and responsibilities of the licensed occupation;

(2) is an offense listed in Texas Code of Criminal Procedure, Article 42.12, Section 3g; or

(3) is a sexually violent offense, as defined by Texas Code of Criminal Procedure, Article 62.001.

(l) The executive director may deny an individual the opportunity to take a licensing examination on the grounds that:

(1) the individual was charged with:

(A) any offense described by Texas Code of Criminal Procedure, Article 62.001(5); or

(B) an offense other than an offense described by subparagraph (A) of this paragraph if:

(i) the individual has not completed the period of supervision, or the individual completed the period of supervision less than five years before the date the individual applied for the license; or

(ii) a conviction for the offense would make the individual ineligible for the license by operation of law; and

(2) after consideration of the factors described by Texas Occupations Code, §§53.021(d), 53.022, and 53.023(a), the executive director determines that:

(A) the individual may pose a continued threat to public safety; or

(B) employment of the individual in the licensed occupation would create a situation in which the individual has an opportunity to repeat the prohibited conduct.

(m) After notice and opportunity for a hearing, the commission may deny or revoke any license or registration held by a person who violates any of the provisions of this section. The commission may file a criminal complaint against any individual who removes or attempts to remove any portion of the examination, reproduces without permission any part of the examination, or who engages in any fraudulent act relating to the examination process.

(n) The commission shall follow the notification requirements in §30.36 of this title (relating to Notice) prior to denying an individual the opportunity to take a licensing examination based on the individual's prior conviction of an offense.

§30.24. License and Registration Applications for Renewal.

(a) A license or registration may not be renewed if it has been:

(1) expired for more than 30 days and an application has not been received by the executive director or postmarked within 30 days after the expiration date of the license or registration;

(2) revoked; or

(3) replaced by a higher class of license.

(b) Applications for renewal must be made on a standard form provided by the executive director.

(1) The executive director shall mail a renewal notification at least 60 days before the license or registration expires to the most recent address provided to the executive director. If a person does not receive a renewal notification, the person is not relieved of the responsibility to timely submit a renewal application.

(2) The person is responsible for ensuring that the completed renewal application, the renewal fee, and other required information are submitted to the executive director by the expiration date of the license or registration.

(c) Applicants for a license or individual registration must submit a set of fingerprints for the purpose of obtaining a criminal history record from the Texas Department of Public Safety TXDPS and the Federal Bureau of Investigation unless a waiver is approved by the executive director to allow an applicant to submit a criminal history via a different method.

(d) An individual unable to get fingerprinted may request a waiver from fingerprinting in writing from the executive director to be reviewed on a case-by-case basis.

(1) An individual who has any out-of-state arrests or convictions is not eligible for a waiver.

(2) Waiver requests shall be accompanied by appropriate documentation to support the waiver request.

(3) If a waiver is approved, the individual must either attest that he/she has no criminal history or provide a Texas DPS report or court documents attesting to their criminal history.

(4) If a waiver is approved, it is valid for three years.

(5) If a waiver is approved, the individual must notify the ED within 30 days if they are imprisoned due to a felony conviction, revocation of parole, or revocation of mandatory supervision during the period that the waiver is valid.

(e) [(c)] All statements, qualifications, and attachments provided by the applicant that relate to a renewal application shall be true, accurate, complete, and contain no misrepresentation or falsification.

(f) [(d)] Approved training to renew a license must be successfully completed after the issuance date and before the expiration date of the current license. Any training credits completed in excess of the amount required for the renewal period shall not be carried over to the next renewal period.

(g) [(e)] An individual who holds a license prescribed by Texas Water Code, §26.0301, or Texas Health and Safety Code, §341.033 or §341.034, specifically the holder of a Class A or Class B public water system operator or Class A or B wastewater treatment facility operator license may certify compliance with continuing education requirements prior to or at the time the license is renewed by submitting a continuing education certification form available from the executive director.

(h) [(f)] The executive director may renew a license or registration if the application is received by the executive director or is postmarked within 30 days after the expiration date of the license or registration, and the person meets the requirements for renewal by the expiration date of the license or registration and pays all appropriate fees. This subsection does not extend the validity period of the license or registration nor grant the person authorization to perform duties requiring a license or registration. This subsection only allows an additional 30 days after the expiration of the license or registration for the person to submit the renewal application, any supporting documentation, and appropriate fees.

(i) [~~(g)~~] An individual whose license renewal application is not received by the executive director or is not postmarked within 30 days after the license expiration date may not renew the license and must meet the current education, training, and experience requirements, submit a new application with the appropriate fee, and pass the examination. A person whose registration renewal application is not received by the executive director or is not postmarked within 30 days after the expiration date may not renew the registration and must submit a new application with the appropriate fee and meet all applicable requirements for a new registration.

(j) [~~(h)~~] Persons failing to renew their license or registration in a timely manner due to serving as a military service member may renew their license within two years of returning from active duty by submitting the following:

(1) a completed renewal application;

(2) a copy of the military orders substantiating the military service during the time the license expired; and

(3) the applicable license renewal fee.

(k) [~~(i)~~] For good cause the executive director may extend the two years period for a military service member seeking to renew their license. Good cause may include, but is not limited to, hospitalization or injury to the licensee.

(l) [~~(j)~~] Completion of the required continuing education will be waived for the renewal cycle for military service members outside of this state who were unable to complete the requirements.

(m) [~~(k)~~] These procedures apply only to military service members who are outside this state and not to military contractors.

(n) [~~(l)~~] All licensees must notify the executive director of any change in the previously submitted application information within ten days from the date the change occurs.

(o) [~~(m)~~] All registration holders must notify the executive director of any change in the previously submitted application information within ten days after the month in which the change occurs.

(p) [~~(n)~~] Licenses and registrations that have renewal cycles in transition shall follow the renewal requirements in the applicable subchapter.

(q) [~~(o)~~] The executive director shall determine whether an applicant meets the renewal requirements of this subchapter. If all requirements have been met, the executive director shall renew the license or registration.

(r) [~~(p)~~] The license or registration shall be valid for the term specified.

(s) [~~(q)~~] If the application does not meet the requirements, the executive director shall notify the applicant in writing of the deficiencies.

(t) [~~(r)~~] All deficiencies must be resolved, and the applicant must notify the executive director that the deficiency has been resolved [~~corrected~~] within 30 days of date printed on the notification, or the renewal application shall be considered expired [~~void~~] after the license expiration date.

(u) [~~(s)~~] A person whose license or registration has expired shall not engage in activities that require a license or registration until the license or registration is renewed or a new license or registration has been obtained.

(v) [~~(t)~~] The commission shall follow the notification requirements in §30.36 of this title (relating to Notice) prior to denying an individual the opportunity to renew a license based on the individual's prior conviction of an offense.

§30.26. Recognition of Licenses from Out-of-State; Licenses for Military Service Members, Military Veterans, or Military Spouses.

(a) Except for landscape irrigators the executive director may waive qualifications, training, or examination for individuals with a good compliance history who hold a current license from another state, territory, or country if that state, territory, or country has requirements equivalent to those in this chapter.

(b) A license may be issued after review and approval of the application, receipt of the appropriate fee, and verification of the license from the corresponding state, territory, or country.

(c) The executive director may waive any of the prerequisites for obtaining a landscape irrigator license, if the applicant is licensed as an irrigator in another jurisdiction that has a reciprocity agreement with the State of Texas.

(d) The executive director may require the applicant to provide information about other occupational licenses and registrations held by the person, including:

(1) the state in which the other license or registration was issued;

(2) the current status of the other license or registration; and

(3) whether the other license or registration was ever denied, suspended, revoked, surrendered, or withdrawn.

(e) To maintain a license that was issued on the basis of reciprocity, applicants must comply with the renewal requirements of this subchapter. Reciprocity will not be granted for the issuance of lower level licenses of the same type as the one that was initially issued on the basis of reciprocity.

(f) Military Service Members, Military Veterans, or Military Spouses.

(1) The executive director shall issue a license to an applicant who is a military service member, military veteran, or military spouse and:

(A) holds a current license issued by another jurisdiction that has licensing requirements that are substantially equivalent to the requirements for the license; or

(B) within the five years preceding the application date held the license in this state.

(2) A license issued under this subsection shall be valid for the term specified in §30.18(i) of this title (relating to Applications for an Initial License).

(3) The executive director shall notify the license holder of the requirements for renewing a license issued under this subsection as specified in §30.24(b)(1) of this title (relating to License and Registration Applications for Renewal).

(4) The executive director shall issue a license to an individual who meets the requirements in paragraph (1) of this subsection within 30 days of receipt of application unless:

(A) the application is deficient; or

(B) the executive director has not received verification from the out-of-state jurisdiction.

(g) In lieu of the standard method(s) of demonstrating competency for a particular license, and based on the applicant's circumstances, the alternative methods for demonstrating competency may

include, but not be limited to, any combination of the following as determined by the executive director:

(1) education;

(2) continuing education;

(3) examinations (written, practical, or a combination of written and practical);

(4) letters of good standing;

(5) letters of recommendation;

(6) work experience; or

(7) other methods or options as determined by the executive director.

(h) Military service members or military veterans. The executive director shall credit verified military service, training, or education toward the licensing requirements.

(1) Verified military service, training, or education shall not be credited toward an examination requirement.

(2) The executive director may not apply this credit provision to an applicant who:

(A) holds a restricted license issued by another jurisdiction; or

(B) has an unacceptable criminal history.

§30.28. Approval of Training.

(a) The executive director shall approve training that provides the knowledge or skills necessary to obtain or maintain licenses or registrations that are issued by the commission. This training shall be directly related to tasks performed by persons whose duties require a license or registration in a program that is administered by the commission.

(b) The executive director may approve specific training events [~~delivery methods~~], to include:

(1) classroom training;

(2) conferences;

(3) prerecorded training [~~technology-based training~~];

(4) correspondence training [~~courses or similar distance training~~];

(5) association meetings that include training sessions containing subject matter related to the particular license; or

(6) other professional activities, such as the publication of articles.

(c) The executive director may approve specific training delivery methods to include:

(1) in-person;

(2) live-online; or

(3) self-paced training.

(d) [~~(c)~~] The executive director shall award training credit for successful completion of approved training used for obtaining or renewing a license.

(e) [~~(d)~~] The executive director shall determine the occupational program(s) and number of hours of training credit that will be granted for approved training. The executive director may:

(1) use the provider's subject matter experts' qualifications to determine the program(s); and

(2) request field testing data from training providers to validate the hours requested.

(f) [~~(e)~~] Training providers who submit applications for approval must:

(1) utilize a standard form and method provided by the executive director;

(2) include the applicable fee found in the chart contained in subsection (g) of this section;

(3) include supplemental information and materials according to the specific requirements for each method of training as approved by the executive director;

(4) include supplemental materials and information edited by subject matter experts;

(5) include samples of certificates of completion, including information as required by the executive director;

(6) document approval from the publisher to reprint text, pictures, graphics, tables, data, and any other information that is copyrighted or obtained from a source that is not an original creation of the training provider. The training materials submitted shall include appropriate references; and

(7) resolve [~~respond~~] any deficiencies and notify the executive director when deficiencies have been resolved, within 60 days of the notification provided by the executive director or the application will become void and the fee forfeited.

(g) [~~(f)~~] The executive director shall determine whether a provider meets the requirements of this subchapter.

(h) [~~(g)~~] Fees for training applications will be calculated based on the number of requested training credit hours, number of core courses for instructor qualifications, or type of association meetings using the following table. If the requested hours are significantly different than the actual hours of training awarded, the executive director may request an adjustment in the fee from the applicant. If the applicant does not provide the adjusted fee, the application will not be processed, resulting in denial of training approval. Fees are nonrefundable whether the training is approved or not approved.
Figure: 30 TAC §30.28(h)
[~~Figure: 30 TAC §30.28(g)~~]

(i) [~~(h)~~] Training delivered to meet the requirements for obtaining or renewing a license must:

(1) be approved by the executive director before the training begins;

(2) provide the knowledge or skills necessary to perform one or more of the occupation's critical job tasks as determined by a job analysis or training needs assessment;

(3) not promote or endorse the products, product lines, or services of a manufacturer, distributor, or service provider or used as an opportunity for advertisement;

(4) provide the means to accomplish the learning objectives identified for the training;

(5) contain learning aids, such as visual aids and graphics. Training must be interactive in order to enhance learning and attain learning objectives;

(6) include regular monitoring of student comprehension throughout the training and provide feedback from the training provider, instructor, or subject matter expert to the student;

(7) verify student's identity;

(8) [(7)] be monitored for successful student completion;

(9) [(8)] track student time and progress toward completing learning objectives; and

(10) [(9)] utilize, at a minimum, subject matter experts and instructional design experts or effective qualified instructors to develop training materials for approval. Additionally, development of self-paced [technology-based] training must also utilize qualified subject matter experts in self-paced [technology] delivery methods.

(j) [(i)] Training shall not be advertised as approved until notice of approval is received from the executive director.

(k) [(j)] Training may not be held in a place of business of a product manufacturer, distributor, or service provider directly related to the occupational license for which the training provider seeks approval.

(l) [(k)] Once training is approved, training providers may offer the training without notification to the executive director.

(m) [(l)] Training is considered approved until the content changes, or until the executive director notifies the training provider that changes in the content or delivery of the training are required.

(n) [(m)] If a training provider changes the delivery method of the training, the training must be submitted for review and approval by the executive director.

(o) [(n)] The executive director may:

(1) deny applications for training courses that contain extensive errors or do not meet the requirements of this section;

(2) conduct an administrative review for application completeness and a technical review for compliance with applicable agency rules;

(3) monitor, recall, reevaluate, and/or rescind approval of topics or training materials;

(4) require training providers to update training delivery methods or training materials to ensure that the content reflects current technology and practices;

(5) deny an application after determination that another delivery method is more conducive for the training material; and

(6) recall training for reevaluation which may result in rescinding any previous approval.

(p) [(o)] The executive director's grounds for recalling, rescinding, suspending, or denying approval include, but are not limited to:

(1) the training does not conform to current accepted industry standard practices or agency rules;

(2) the training does not conform to the materials or method as approved;

(3) the subject matter is not related to critical job tasks performed by licensees;

(4) an instructor is not qualified to teach the subject matter;

(5) an instructor is ineffective in the delivery of the subject matter;

(6) the training promotes or endorses products, product lines, or services from a manufacturer, distributor, or service provider;

(7) the training credits for successfully completed training are not electronically submitted within 14 business days of course completion;

(8) the records, rosters, or application materials have been falsified;

(9) the training provider does not comply with a training recall;

(10) the training provider is not active or training has not been conducted for three or more years; or

(11) the training environment is not conducive to learning.

(q) [(p)] The following types of training will not be approved or awarded training credit:

(1) self-paced [distance] training [or webinars] that is [are] repeated during the renewal period; or

(2) self-paced and live-online training [distance training] that is intended to teach required manual skills.[; or]

[(3) webinar training that is submitted to qualify an applicant for an initial license.]

(r) [(q)] Approved training providers shall:

(1) ensure the executive director has the most current electronic edition of training materials;

(2) keep manuals and training content updated to reflect rule changes;

(3) submit approved training material that references rules for reapproval within 180 days of any new rule adoption that pertains to that training;

(4) submit material with substantial changes, including a summary, list, or other indication of changes, for review and reapproval by the executive director;

(5) allow the executive director staff or their agents access to training in order to audit training content, manner of delivery, and the effectiveness and qualifications of instructors and subject matter experts;

(6) be responsible for the content and delivery of the training;

(7) retain accurate training records for a minimum of five years;

(8) maintain records of training approval throughout the entire period the training provider actively delivers training;

(9) ensure that instructors and subject matter experts are qualified and provide the executive director with qualifications when requested;

(10) notify students of all fees associated with completing the training and obtaining credit for training before and during the training;

(11) accurately present to students the approved training credit along with any other criteria for obtaining full or partial training credit;

(12) provide students with approved copies of texts, manuals, or other training materials to use during the training and for future

reference required by the delivery method and as approved by the executive director;

(13) verify participation;

(14) provide acceptable procedures for student identity verification;

(15) maintain procedures to protect student identity and personal information;

(16) provide students access to subject matter experts to answer technology-related and content-related questions within one business day from the time of request; and

(17) electronically report the students' successfully completed training credit hours per procedures provided and approved by the executive director, not to exceed approved training credit hours, within 14 business days of training completion.

(s) [(r)] Printed training material must be presented in an original manner and must be relevant to the critical job tasks and knowledge for the occupational licensees.

(t) [(s)] Public information copied from websites or other sources is not acceptable as training materials unless modified to be applicable to the target audience and the method of delivery.

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

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SUBCHAPTER E. LEAKING PETROLEUM STORAGE TANK CORRECTIVE ACTION PROJECT MANAGERS AND SPECIALISTS

30 TAC §30.185

Statutory Authority

These amendments are proposed under the authority granted to the commission in Texas Water Code (TWC), §5.012, which provides that the commission is the agency responsible for implementing the constitution and laws of the state relating to conservation of natural resources and protection of the environment; and §5.103 and §5.105, which establish the commission's general authority to adopt rules.

These proposed rules incorporate additional recommended changes to 30 TAC 30.

§30.185. Qualifications for License Renewal.

(a) To renew a license, an individual must:

(1) meet the requirements in Subchapter A of this chapter (relating to Administration of Occupational Licenses and Registrations); and

(2) complete 20 [32] hours of approved continuing education.

(b) With the exception of professional engineers and professional geoscientist, an application for renewal of a corrective action project manager license is complete when the executive director has received an application for renewal on a form provided by the executive director, completed in a manner acceptable to the executive director, and is accompanied with the required training certificate indicating 20 [32] hours of continuing education; and payment of applicable fees specified in §30.30 of this title (relating to Terms and Fees for Licenses and Registrations).

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SUBCHAPTER J. WASTEWATER OPERATORS AND OPERATIONS COMPANIES

30 TAC §§30.340, 30.342, 30.344, 30.350

Statutory Authority

These amendments are proposed under the authority granted to the commission in Texas Water Code (TWC), §5.012, which provides that the commission is the agency responsible for implementing the constitution and laws of the state relating to conservation of natural resources and protection of the environment; and §5.103 and §5.105, which establish the commission's general authority to adopt rules.

The proposed rules implement TWC, §37.0045 as added by HB 1845.

§30.340. Qualifications for Initial License.

(a) To obtain a license, an individual must have met the requirements of Subchapter A of this chapter (relating to Administration of Occupational Licenses and Registrations), the following requirements for each class of license, and pass an examination.
Figure: 30 TAC §30.340(a)
[Figure: 30 TAC §30.340(a)]

(b) At least one-half of the total experience required for a wastewater treatment license must be in actual domestic wastewater treatment facility operation or maintenance duties. Related experience, which involves tasks similar to those required for operation of wastewater treatment facilities, will count at a rate of 50% toward meeting the total experience requirement. For laboratory experience to be applicable, the laboratory must be owned and operated by the permittee and the laboratory technician must consult daily with operational personnel.

(c) Wastewater collection system experience must be in actual wastewater collection system operation or maintenance duties. Credit for wastewater experience that is not directly connected with collection system operation or maintenance shall be approved if the experience involves tasks that are similar to that required for the operation and maintenance of collection systems. Each year of related experience shall count as 1/2 year of experience. Each year of experience in

collection system operation and maintenance shall only count as 1/2 year of experience toward a wastewater treatment facility operator license.

(d) Individuals who request to substitute a bachelor's or master's degree for experience at the Class A, Class B, or Class III level must have a major in chemistry, biology, engineering, microbiology, bacteriology, or another similar discipline approved by the executive director.

(e) For each license, applicants may substitute either college hours or training credit hours to meet the experience requirement:

(1) 16 semester hours or an additional 20 hours of training credits are equal to six months of the required work experience;

(2) Class C and Class II applicants may only substitute up to one year of the required work experience; and

(3) Class A, Class B, and Class III applicants may only substitute up to two years of the required work experience.

(f) The hours of training credit required for a license must be in approved courses, which include the following or their equivalents.
Figure: 30 TAC §30.340(f)
[~~Figure: 30 TAC §30.340(f)~~]

(g) An individual who previously held a Class D license or higher may not apply for a new Class D license if the individual currently operates any activated sludge type facilities, any trickling filter or rotating biological contractor facilities with a permitted daily average flow of 100,000 gallons per day or greater, or any facility that uses a subsurface area drip dispersal system as defined in §222.5 of this title (relating to Definitions) for disposal of its effluent. A trickling filter or rotating biological contractor is a secondary aerobic process that uses microbiological organisms attached to a fixed substrate.

§30.342. Qualifications for License Renewal.

(a) To renew a license, an individual must have[~~:~~]

[~~(1)~~] met the requirements of Subchapter A of this chapter (relating to Administration of Occupational Licenses and Registrations) and completed a total amount of approved continuing education equal to that of ten hours per year the license is valid. [~~; or~~]

[~~(2) met the requirements of Subchapter A of this chapter and passed the examination for the license.~~]

(b) The basic wastewater operation course may not be used to renew a Class B or A license.

(c) Class D licenses are not renewable for operators of:

(1) any activated sludge type facilities;

(2) any trickling filter or rotating biological contractor (RBC) facilities with a permitted daily average flow of 100,000 gallons per day or greater. A trickling filter or RBC facility is a facility that uses secondary aerobic biological processes for treatment of sewage;

(3) any facility that uses a subsurface area drip dispersal system as defined in §222.5 of this title (relating to Definitions) for disposal of its effluent.

(d) To renew an active converted perpetual license, an individual must have met the requirements of this section, with the exception of the renewal fee.

§30.344. Provisional Licenses

(a) A provisional license for a Class D license may be issued to an individual that does not possess a high school diploma or equivalent and who:

(1) has completed the required training;

(2) passed the applicable examination; and

(3) acts under the direct supervision of a license holder.

(b) A provisional license shall have:

(1) a validity period of two years; and

(2) an application fee of $74.00.

(c) Provisional licenses are not renewable and not reobtainable.

(d) To continue to work as a licensed operator the provisional license holder must, before the expiration date of the provisional license:

(1) submit proof of a high school diploma or equivalent; and

(2) apply for a Class D license or higher.

§30.350. Classification of Wastewater Treatment Facilities, Wastewater Collection Systems, and Licenses Required.

(a) Operators of remote or mobile sludge processing facilities are required to hold a valid Class D or higher license.

(b) Operators of domestic wastewater treatment facilities owned and located on industrial sites that are regulated by industrial-type wastewater disposal permits are required to be licensed, only if the point of discharge is separate from any other industrial outfalls and the domestic wastewater is not mixed with other industrial wastewater before discharge.

(c) An individual first entering the field of wastewater treatment or collection may be employed as an operator-in-training for a period up to one year. An operator-in-training must perform all process control tasks in the presence of a licensed operator.

(d) Each holder of a wastewater disposal permit for a wastewater treatment facility shall employ or contract with one or more licensed wastewater treatment facility operators holding the appropriate level of license or wastewater system operations companies holding a valid registration and employing licensed wastewater treatment facility operators holding the appropriate level of license.

(e) Domestic wastewater treatment facilities will be classified in accordance with the following criteria.
Figure: 30 TAC §30.350(e)
[~~Figure: 30 TAC §30.350(e)~~]

(f) Category D wastewater treatment facilities shall be reclassified as Category C facilities if any of the following conditions exist:

(1) a Category D facility incorporating anaerobic sludge digestion, except Imhoff tanks with sludge drawn off to drying beds;

(2) a Category D facility whose permit requires nutrient reduction; or

(3) a Category D facility whose permit requires the final effluent to meet a daily average biochemical oxygen demand$_5$ or total suspended solids concentration less than ten milligrams per liter.

(g) A wastewater treatment facility having a combination of treatment processes that are in different categories shall be assigned the higher category.

(h) The executive director may increase the treatment facility classification for facilities which include unusually complex processes or present unusual operation or maintenance conditions.

(i) The chief operator of each wastewater treatment facility must possess a license equal to or higher than that of the category of treatment facility.

(j) Each category of facility must be operated a minimum of five days per week by the licensed chief operator or an operator holding the required level of license or higher. The licensed chief operator or operator holding the required level of license or higher must be available by telephone or pager seven days per week.

(k) When shift operation of the wastewater treatment facility is necessary, each shift must be operated by an operator in charge who is licensed at not less than one level below the category of the facility.

(l) Either the licensed chief operator or licensed operator in charge must be present for scheduled commission inspections.

(m) A licensed wastewater treatment facility operator may perform all duties relating to the operation and maintenance of both wastewater treatment facilities and wastewater collection systems. It is not necessary to hold both types of licenses. A licensed collection system operator may perform only those duties relating to the operation and maintenance of wastewater collection systems.

(n) Each classified wastewater collection system must employ at least one licensed operator who holds a license class equal to or higher than that category of system. Wastewater collection system operation and maintenance activities shall be supervised and inspected daily by an on-site licensed wastewater operator. Wastewater collection systems shall be classified as follows.
Figure: 30 TAC §30.350(n) (No change.)

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

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SUBCHAPTER K. PUBLIC WATER SYSTEM OPERATORS AND OPERATIONS COMPANIES

30 TAC §§30.387, 30.390, 30.392, 30.394

Statutory Authority

These amendments are proposed under the authority granted to the commission in Texas Water Code (TWC), §5.012, which provides that the commission is the agency responsible for implementing the constitution and laws of the state relating to conservation of natural resources and protection of the environment; and §5.103 and §5.105, which establish the commission's general authority to adopt rules.

The proposed rules implement TWC, §37.0045 as added by HB 1845.

§30.387. Definitions.

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

(1) Chief operator--An individual who has overall responsibility for the operation of a public water system.

(2) Honorary license--License converted from a perpetual license that has been discontinued by the commission. This honorary license does not award the licensee the authority to perform process control duties in production or distribution of drinking water for public water systems.

(3) Military operator-in-training--An individual who is an active duty member of the military of the United States and has successfully completed the Bioenvironmental Engineering Apprentice (BEA) or equivalent military training, as determined by the executive director, and collects microbiological samples and determines disinfection residuals for military facilities' water distribution systems. This individual may not perform any other process control duties in the water distribution or treatment facilities of a military installation.

(4) Operator-in-charge--An individual who has overall responsibility for the operation of a public water system in the absence of the chief operator.

(5) Operator-in-training--An unlicensed individual entering the field of public water system operation for the first time who has less than one year of experience and is in training to perform process control duties in production or distribution of public drinking water.

(6) Public water system operations company--A person or other nongovernmental entity that provides operations services to one or more public water systems on a contractual basis.

(7) Public water system operator--Licensed operator who performs process control duties in production or distribution of drinking water.

(8) Resiliency continuing education training--Training on one or more resiliency topics that is approved by the executive director to count toward the resiliency training required to renew a license.

(9) Resiliency Overview Course--The core training that provides an overview of the resiliency topics outlined by the executive director that can be taken as a stand-alone course or as part of the updated Basic Waterworks Operations core course.

(10) [~~(8)~~] Work experience--The actual performance of job tasks in a public water supply system that are considered essential for the treatment or distribution of drinking water.

§30.390. Qualifications for Initial License.

(a) To obtain a license, an individual must meet the requirements of Subchapter A of this chapter (relating to Administration of Occupational Licenses and Registrations), and the following requirements for each class of license, and pass an examination.
Figure: 30 TAC §30.390(a)
[~~Figure: 30 TAC §30.390(a)~~]

(b) An individual who applies for a Class C, B, or A license, and relies on a bachelor's or master's degree to meet the educational requirements, must have a bachelor's or master's degree with a major in chemistry, biology, engineering, microbiology, bacteriology, or other similar discipline approved by the executive director.

(c) An individual who applies for a Class C or B license must obtain at least one-half of the total work experience requirement in the specific field for the license that is requested:

(1) for Class C and B surface water licenses, the experience must be obtained through operations activities at the production or treatment facilities for surface water or groundwater under the direct influence of surface water;

(2) for Class C and B groundwater licenses, the experience must be obtained through operations activities at the production or treatment facilities for groundwater source or groundwater under the direct influence of surface water; or

(3) for Class C and B distribution licenses, at least one-half of the required experience must be obtained as a result of operations activities at treated water storage, pumping, or distribution facilities; and

(4) once the work experience has been met from paragraphs (1), (2), or (3) of this subsection, the executive director may count any remaining experience to meet up to 50% of the remaining requirement.

(d) For all classes of licenses, laboratory experience must:

(1) be obtained at a laboratory that is owned and operated by the public water system; and

(2) involve daily consultation with individuals who perform process control duties in production or distribution of drinking water for the water system.

(e) For each license, applicants may substitute either college hours or training credits to meet the experience requirement:

(1) 16 semester hours or an additional 20 hours of training credits are equal to six months of the experience;

(2) Class C applicants may only substitute up to one year of the required work experience; and

(3) Class B and Class A applicants may only substitute up to two years of the required work experience.

(f) Training credits must be in approved courses that include the following or equivalent.
Figure: 30 TAC §30.390(f)
[~~Figure: 30 TAC §30.390(f)~~]

(g) An individual who previously held a Class D license or higher shall not apply for a new Class D license if the individual:

(1) currently operates facilities at groundwater treatment systems of 250 connections or more;

(2) currently operates facilities at groundwater treatment systems serving a population of 750 or more;

(3) currently operates facilities at surface water treatment systems;

(4) currently operates facilities at groundwater systems under the influence of surface water;

(5) performs supervisor, crew chief, or foremen duties for distribution systems that have over 250 connections; or

(6) operates multiple groundwater systems and the cumulative number of connections exceeds 250.

§30.392. Qualifications for License Renewal.

(a) To renew a license, an individual must have[~~:~~]

[~~(1)~~] met the requirements of Subchapter A of this chapter (relating to Administration of Occupational Licenses and Registrations) and completed a total amount of approved continuing education equal to that of ten hours per year the license is valid, two of which must qualify as resiliency training for licenses that expire on or after April 1, 2024.[~~; or~~]

[~~(2) met the requirements of Subchapter A of this chapter and passed the examination for the license.~~]

(b) The basic water training course shall not be used to renew a Class B or A license.

(c) Class D licenses are not renewable for licensed operators:

(1) at groundwater treatment systems of 250 connections or more;

(2) at groundwater treatment systems serving a population of 750 or more;

(3) at surface water treatment systems;

(4) at groundwater systems under the influence of surface water;

(5) who are supervisors, crew chiefs, or foremen of distribution systems that have over 250 connections; or

(6) who operate multiple groundwater systems and the cumulative number of connections exceeds 250.

(d) To renew an active converted perpetual license, an individual must have met the requirements of this section, with the exception of the renewal fee.

(e) Individuals with a license that expires on or after April 1, 2024, are required to take the Resiliency Overview Course once as part of the continuing education requirement to renew a license.

§390.394. Provisional Licenses.

(a) A provisional license for a Class D license may be issued to an individual that does not possess a high school diploma or equivalent who:

(1) has completed the required training;

(2) passed the applicable examination; and

(3) acts under the direct supervision of a license holder.

(b) A provisional license shall have:

(1) a validity period of two years; and

(2) an application fee of $74.00.

(c) Provisional licenses are not renewable and not reobtainable.

(d) To continue to work as a licensed operator, the provisional license holder must, before the expiration date of the provisional license:

(1) submit proof of a high school diploma or equivalent; and

(2) apply for a Class D license or higher.

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

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Charmaine Backens
Deputy Director, Environmental Law Division
Texas Commission on Environmental Quality
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For further information, please call: (512) 239-2678

TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER O. STATE AND LOCAL SALES AND USE TAXES

34 TAC §3.330

The Comptroller of Public Accounts proposes amendments to §3.330, concerning data processing services. The comptroller amends this section to clarify existing definitions; to add new definitions; to list examples of services that are included in and excluded from taxable data processing services; to describe data processing that is not taxable; to explain the incidence of the tax; and to update provisions related to the collection of local sales and use taxes on data processing services. The amendments implement language in Senate Bill 153, 87th Legislature, 2021 regarding payment processing. Other revisions improve the clarity and readability of the section.

Subsection (a) provides definitions. The comptroller amends the general definition of "data processing service" in paragraph (1) to list the operative words included as examples of "data processing service" in Tax Code, §151.0035(a)(1) ("Data Processing Service"). The comptroller moves and amends existing language regarding examples to subsection (b). The comptroller deletes existing language regarding internet access services as they are no longer taxable.

The comptroller adds new subparagraph (A) listing services that are specifically included in data processing service under Tax Code, §151.0035.

The comptroller adds new subparagraph (B) listing services that are specifically excluded from data processing service under Tax Code, §151.0035, including services added by Senate Bill 153.

The comptroller adds new subparagraph (C) to exclude some data processing that might otherwise be included in "data processing service" as described in Tax Code, §151.0035. The comptroller adds subparagraph (C) under its exclusive jurisdiction to interpret taxable services, as provided in Tax Code, §151.0101(b) ("Taxable Services").

Subparagraph (C) provides that a data processing service will not be taxable if it is sold for a single charge with another service, the data processing service does not have a separate value, and the data processing service is ancillary to the other service.

New subparagraph (C)(i) provides that if the data processing service is sold for a single charge with another service that does not have a separate value, and the other service is ancillary to the data processing service, the entire charge will be taxable as a data processing service.

New subparagraph (C)(ii) provides that if the data processing service has a separate value and is sold or purchased for a single charge with a nontaxable related service, subsection (e) applies.

New subparagraph (C)(iii) identifies factors that the comptroller may consider in determining whether the data processing service has a "separate value." The "separate value" requirement is drawn from *Rylander v. San Antonio SMSA Ltd. P'ship.* 11 S.W.3d 484, 488 (Tex. App.--Austin 2000, no pet.). The opinion uses the "separate value" concept in evaluating whether services could be segregated for taxation purposes.

The "separate value" requirement of subparagraph (C)(iii) is also consistent with the comptroller's longstanding rule, retained in subsection (e)(3), which provides for the segregation of nontaxable and taxable services sold or purchased for a single charge.

The comptroller explains the "ancillary" requirement in new subparagraph (C)(iv). The requirement is similar to the current provision that excludes data processing service if it "facilitates the performance" of another service. But subparagraph (C)(iv) identifies specific factors, which are not in the current rule.

The test for determining whether a data processing service is "ancillary" to a nontaxable service is not an essence of the transaction test. The essence of the transaction test attempts to determine what the buyer ultimately wants. *Combs v. Chevron, Inc.,* 319 S.W.3d 836, 843 (Tex. App.--Austin 2010, pet. denied) ("underlying goal"). The buyer will never want the manipulation of data for its own sake. The buyer will always want the manipulation of data as the means to achieve an end. Therefore, the identification of the "underlying goal" of the buyer, or the essence of the transaction, is not the appropriate test for data processing services. *See also,* Hellerstein & Hellerstein, State Taxation §12.08 (3rd ed. 2020) (the primary purpose test is "folly").

In determining whether a data processing service is "ancillary" to a nontaxable service, the comptroller will focus on what the seller is doing, and not what the buyer wants. The repetitive or routine manipulation of data by the seller is a factor suggesting that the activity is not ancillary and should be taxable as a data processing service, while the manipulation of data that depends on the external knowledge and discretionary judgment of the service provider suggests that the activity is ancillary and should not be taxable as a data processing service.

For example, the insertion of data into form title or loan documents for a client would ordinarily be a taxable data processing service. The primary service is the compilation, retrieval, and accurate manipulation of the data into the forms, even though there may be an element of independent judgement in correctly entering the data. However, the preparation of a title opinion would not ordinarily be a taxable data processing service. The primary service is the application of legal knowledge and judgement to a set of facts, even though there may be elements of data processing. The "ultimate goal" of the preparation of loan documents and the preparation of title opinions may be the same - to close a real estate deal. But one service is a taxable data processing service because it requires the repeated application of the same process to different data, albeit with skill and expertise; and the other service is not a taxable data processing service because it produces a solitary result based on legal principles. These examples are illustrated in the recent opinion in *Hegar v. Black, Mann, & Graham, L.L.P.,* No. 03-20-00391-CV, 2022 WL 567853 (Tex. App.--Austin Feb. 25, 2022, no pet.).

The comptroller amends current paragraph (2) to delete the definition of "internet" as that term is already defined in Tax Code, §151.00393 (Internet). The comptroller adds a new definition of "downstream payment processor" based on the language in Senate Bill 153 that incorporates the definition in 7 TAC §33.4(c) (Payment Processors) as that provision existed on January 1, 2021.

The comptroller amends paragraph (3) to delete the definition of "internet access services" as the statutory reference to that definition is now listed in subsection (a)(1)(B)(i) and a separate definition is no longer necessary. The comptroller adds a new definition of "point of sale payment processor" based on the lan-

guage in Senate Bill 153 that incorporates the definition in 7 TAC §33.4(d) as that provision existed on January 1, 2021.

The comptroller adds new paragraph (4) to add a definition of "settling of an electronic payment transaction" based on the language in Senate Bill 153.

The comptroller moves the existing text of current subsection (b) to amended subsection (c)(2), with changes. Amended subsection (b) text provides examples that apply the definition of "data processing service."

The comptroller adds new paragraphs (1)-(3) to restate text from current subsection (a)(1) that payroll services, business accounting, and the preparation of financial statements are data processing services.

The comptroller adds new paragraph (4) based on the holding in *Hegar v. Black, Mann, & Graham, L.L.P.,* No. 03-20-00391-CV, 2022 WL 567853 (Tex. App.--Austin Feb. 25, 2022, no pet.), which held the preparation of form title or loan documents is taxable data processing.

The comptroller adds new paragraph (5) to clarify that marketplace providers may provide data processing services to their customers if they enter, retrieve, search, manipulate, and store data or information in the course of their business.

The comptroller adds new paragraph (6) to clarify that internet hosting as defined by Tax Code, §151.108 (Internet Hosting) is taxable data processing.

The comptroller adds new paragraph (7) to clarify that video streaming subscriptions are taxable cable television services under Tax Code, §151.0033 ("Cable Television Service"). See also §3.313 of this title (relating to Cable Television Service and Bundle Cable Service).

The comptroller adds new paragraph (8) to clarify that streaming video gaming subscriptions are taxable amusement services as set forth in Tax Code, §151.0028 ("Amusement Services") and in STAR Accession No. 201405957L (May 28, 2014), and are not taxable data processing services.

The comptroller adds new paragraph (9) to provide that the compilation of nontaxable opinion polls and survey information as described by §3.342 of this title (relating to Information Services), is not taxable data processing if the data processing is ancillary to the acquisition of the information and the service provider's expertise is not managing data, such as in an inventory management service.

The comptroller adds new paragraph (10) to provide that the compilation of nontaxable information derived from laboratory, medical, or exploratory testing or experimentation as described by §3.342 of this title is not taxable data processing if the data processing is ancillary to the provision of the information.

The comptroller adds new paragraphs (11) and (12) to add examples from Comptroller's Decision No. 116,834 (2022) regarding the taxability of computerized three-dimensional rendering, website design, website development, search engine optimization, social media marketing, and lead generation.

The comptroller moves current subsection (c) to amended subsection (d), with changes. New subsection (c) is titled "Imposition of tax, permits."

The comptroller adds new paragraph (1) to provide that the use of data processing service is subject to state sales and use tax and that local sales and use tax may also be imposed.

The comptroller adds new paragraph (2) that contains language moved from current subsection (b) and restates that providers of data processing services must obtain a Texas sales and use tax permit. The paragraph includes the permitting safe harbor for small remote sellers as set forth in §3.286(b)(2) of this title (relating to Seller's and Purchaser's Responsibilities).

The comptroller adds new paragraph (3) that contains language moved from current subsection (a)(1) stating that a data processing service is taxable regardless of the ownership of the computer or whether that data is provided by the customer or the customer's authorized designee.

The comptroller adds new paragraph (4) to restate the language from current subsection (b) which exempts 20% of the amount charged for data processing services from sales and use tax based on Tax Code, §151.351 (Information Services and Data Processing Services).

The comptroller amends relettered subsection (d), formerly subsection (c), to update the storage medium used in the example from a magnetic tape to a Universal Serial Bus (USB) drive.

The comptroller amends relettered subsection (e), formerly subsection (d). The substantive effect of subsection (e) is the same as former subsection (d). However, the term "unrelated service" is replaced by the term "nontaxable related service" to conform to the ordinary usage of the terms. Subsection (e) applies when multiple services are sold or purchased for a single charge. Because the services are sold or purchased for a single charge, the services are in some manner going to be "related," as that term is ordinarily used, even if they are also distinct. When services are related by a common charge, and the services are each also commonly provided on a stand-alone basis, and the performances are distinct and identifiable, then the single charge may be segregated under the conditions described in subsection (e).

The comptroller reletters subsection (f), formerly subsection (e).

The comptroller amends relettered subsection (g), formerly subsection (f) and retitles it "Determining the incidence of the tax (service benefit rule)". The comptroller moves current text in subsection (g) regarding local taxes to relettered subsection (h), with changes.

The comptroller amends paragraph (1) to restate the statutory definition of "use" in Tax Code, §151.011 ("Use" and "Storage"). The comptroller deletes the current presumption language in paragraph (1) regarding a separate, identifiable segment of a customer's business. The current presumption language is replaced by the presumption in paragraph (2) that more closely follows the statutory presumption in Tax Code, §151.104(a) (Sale for Storage, Use, or Consumption Presumed).

The comptroller amends paragraph (2) to restate statutory language in Tax Code, §151.104(a) regarding presumption of use in Texas. The comptroller moves language in current paragraph (2) regarding business conducted both inside and outside the state to amended paragraph (3) and moves language regarding multi-state customers' method of allocation to new paragraph (6).

The comptroller amends paragraph (3) and adds clauses (i)-(ii) to restate statutory language in Tax Code, §151.104 and §151.330 (Interstate Shipments, Common Carriers, and Services Across State Lines). The comptroller moves language in current paragraph (3) regarding a multi-state customer providing an exemption certificate to new paragraph (6).

The comptroller amends paragraph (4) to restate statutory language in Tax Code, §151.101 (Imposition of Use Tax) and to be consistent with the interpretation of statute in Comptroller's Decision No. 116,293 (2022). The comptroller deletes language in current paragraph (4) regarding identifiable segments of a business as the revised subsection follows the statutory guidelines more closely.

The comptroller amends paragraph (5) to restate statutory language in Tax Code, §151.303(c) (Previously Taxed Items: Use Tax Exemption or Credit) and §3.338 of this title (relating to Multistate Tax Credit and Allowance of Credit for Tax Paid to Suppliers). The comptroller deletes language in current paragraph (5) regarding services that cannot be assigned to an identifiable segment of a business, as the revised subsection follows the statutory guidelines more closely.

The comptroller adds new paragraph (6) to restate moved language from current paragraph (3) regarding multi-state customers issuing exemption certificates, with non-substantive changes to improve readability.

The comptroller adds new paragraph (7) to restate language from paragraph (2) regarding a multistate customer's use of any reasonable method for allocation which is supported by business records.

The comptroller adds new clause (i) to restate moved language from current paragraph (2) regarding the method used for business records to allocate a data processing service used both within and outside Texas.

The comptroller adds new clause (ii) to add language regarding the good faith acceptance of an exemption certificate as set forth in §3.287 of this title (relating to Exemption Certificates).

The comptroller amends relettered subsection (h), formerly (g) regarding Local Taxes.

The comptroller amends paragraph (1) to provide general guidance on the consummation of sale for local sales tax and directs taxpayers to §3.334 of this title (relating to Local Sales and Use Taxes) and deletes the existing language.

The comptroller amends paragraph (2) to provide general guidance on determining local use tax and directs taxpayers to §3.334 of this title and to delete language that is now located in §3.334 of this title.

Language in former subparagraph (A) remains as new paragraph (3). The comptroller deletes subparagraph (B) as that language is now located in new subsection (g)(6).

The comptroller adds subsection (i) to restate former subsection (h) and to make minor changes for readability.

The comptroller adds new paragraphs (1) and (2) to clarify when a customer is responsible to report use tax due on the purchase of taxable data processing services under Tax Code, §151.101.

Tetyana Melnyk, Director of Revenue Estimating Division, has determined that during the first five years that the proposed amended rule is in effect, the rule: will not create or eliminate a government program; will not require the creation or elimination of employee positions; will not require an increase or decrease in future legislative appropriations to the agency; will not require an increase or decrease in fees paid to the agency; will not increase or decrease the number of individuals subject to the rule's applicability; and will not positively or adversely affect this state's economy.

Ms. Melnyk also has determined that the proposed amended rule would benefit the public by conforming the rule to current statute and improving readability. This rule is proposed under Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses or rural communities. The proposed amended rule would have no significant fiscal impact on the state government, units of local government, or individuals. There would be no anticipated significant anticipated economic cost to the public.

You may submit comments on the proposal to Jenny Burleson, Director, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711-3528 or to the email address: tp.rule.comments@cpa.texas.gov. The comptroller must receive your comments no later than 30 days from the date of publication of the proposal in the *Texas Register.*

The comptroller proposes the amendments under Tax Code, §111.002 (Comptroller's Rules; Compliance; Forfeiture), which provide the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of provisions of Tax Code, Title 2 (State Taxation), and taxes, fees, or other charges or refunds which the comptroller administers under other law.

The amendments implement Tax Code, §§151.0035 ("Data Processing Services"), 151.0101 (Taxable Services), 151.105 (Importation for Storage, Use, or Consumption Presumed), 151.330 (Interstate Shipments, Common Carriers, and Services Across State Lines), 151.351 (Information Services and Data Processing Services), 321.203 (Consummation of Sale), and 321.205 (Use Tax).

§3.330. Data Processing Services.

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

(1) Data processing service--the computerized entry, retrieval, search, compilation, manipulation, or storage of data or information. [~~services - the processing of information for the purpose of compiling and producing records of transactions, maintaining information, and entering and retrieving information. It specifically includes word processing, payroll and business accounting, and computerized data and information storage or manipulation. The charge for data processing services is taxable regardless of the ownership of the computer. Examples of data processing services include entering inventory control data for a company, maintaining records of employee work time, filing payroll tax returns, preparing W-2 forms, and computing and preparing payroll checks. Data processing does not include the use of a computer by a provider of other services when the computer is used to facilitate the performance of the service or the application of the knowledge of the physical sciences, accounting principles, and tax laws, e.g., the use of a computer to provide interpretive or enhancement geophysical services or the use of a computer by a CPA firm, enrolled agent, or bookkeeping firm to produce a financial report, prepare federal income tax, state franchise or sales tax returns, or charges for temporary secretarial personnel who as part of their function use word processing equipment. Data processing services does not include Internet access services or data processing services provided in conjunction with and incidental to the provision of Internet access service when billed as a single charge.~~]

(A) Data processing service includes:

(i) word processing;

(ii) payroll and business accounting data production;

(iii) the performance of a totalizator service with the use of computational equipment required by Occupations Code, Subtitle A-1, Title 13, (Texas Racing Act); and

(iv) the use of a computer or computer time for data processing whether the processing is performed by the provider of the computer or computer time or by the purchaser or other beneficiary of the service.

(B) Data processing services do not include:

(i) Internet access service as defined by Tax Code, §151.00394 (Internet access service);

(ii) the transcription of medical dictation by a medical transcriptionist;

(iii) the display of a classified advertisement, banner advertisement, vertical advertisement, or link on an Internet website owned by another person;

(iv) services exclusively to encrypt electronic payment information for acceptance onto a payment card network that allows a person to accept a specific brand of debit or credit card by routing information and data to settle an electronic payment transaction, in order to comply with standards set by the Payment Card Industry Security Standards Council; or

(v) settling of an electronic payment transaction by:

(I) a downstream payment processor or point of sale payment processor or point of sale payment processor that routes electronic payment information to an entity described in subclause (II) or (III) of this clause;

(II) a federally insured financial institution, as defined by Finance Code, §201.101 (Definitions), that is organized under the laws of Texas, another state, or the United States, or an affiliate of the institution;

(III) a payment card network that allows a person to accept a specific brand of debit or credit card by routing information and data to settle an electronic payment transaction;

(IV) a person who has entered into a sponsorship agreement with an entity described in subclause (II) for the purpose of processing that entity's electronic payment transactions through a payment card network; or

(V) a person who is engaged in the business of money transmission and required to obtain a license under Finance Code, §152.101 (Money Transmission License Required).

(C) Under its exclusive jurisdiction to interpret taxable services, the comptroller excludes from the definition of "data processing service" data processing that is sold for a single charge with another service if the data processing service does not have a separate value, and the data processing service is ancillary to the other service. The burden is on the taxpayer to demonstrate that the data processing service does not have a separate value and is ancillary to the other service.

(i) If the data processing service is sold for a single charge with another service that does not have a separate value, and the other service is ancillary to the data processing service, the entire charge will be taxable as a data processing service.

(ii) If the data processing service is sold for a single charge with another service that has a separate value, subsection (e) of this section applies.

(iii) In determining whether the data processing service and the other service have separate values, the comptroller will consider whether the services are distinct and identifiable and whether each service is of a type that is commonly provided on a stand-alone basis or commonly provided as an additional service for a greater single charge.

(iv) In determining whether the data processing service is ancillary to another service, or conversely, whether the other service is ancillary to the data processing service, the comptroller may consider the extent to which the service provider exercises discretion or judgment in individual applications of the processed data based on knowledge of the physical sciences, accounting principles, law, or other fields of study. The repetitive or routine manipulation of data by the seller is a factor suggesting that the data processing activity is not ancillary to another service and should be taxable as a data processing service. The manipulation of data that depends on the external knowledge and discretionary judgment of the service provider in individual applications suggests that the data processing activity is ancillary to another service and should not be taxable as a data processing service. The provider's skill, experience, or expertise, in processing data or information is not a factor. Other factors may be considered, and the weight of the factors may vary from case to case. The evaluation is based on what the service provider is doing, not on what the customer wants.

(2) Downstream payment processor--A payment processor that acts as an intermediary between a consumer-facing entity that has incurred an outstanding money transmission obligation to a consumer, and the consumer's designated recipient. [~~Internet - collectively the myriad of computer and telecommunications facilities, including equipment and operating software, that comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocols to the protocol, to communicate information of all kinds by wire or radio.~~]

(3) Point of sale payment processor--A payment processor that receives funds from a consumer on behalf of a consumer-facing entity that either sells goods or services other than money services or accepts charitable donations. [~~Internet access service - a service that enables users to access content, information, electronic mail, or other services offered over the Internet and may also include access to proprietary content, information, and other services as part of a package of services offered to consumers. Internet access service does not include any other taxable service, unless the taxable service is provided in conjunction with and is merely incidental to the provision of Internet access service. Individuals providing Internet access should refer to §3.366 of this title (relating to Internet Access Services).~~]

(4) Settling of an electronic payment transaction--The authorization, clearing, or funding of a payment made by credit card, debit card, gift card, stored value card, electronic check, virtual currency, loyalty program currency such as points or miles, or a similar method. The term does not include charges by a marketplace provider, as that term is defined by Tax Code, §151.0242 (Marketplace Providers and Marketplace Sellers).

(b) Examples of services that are and are not taxable data processing services. [~~Hold permits. All providers of data processing services must obtain Texas sales and use tax permits and collect tax on charges for data processing services, or accept properly completed resale, exemption, or direct pay permit certificates in lieu of collecting tax. See §3.285 of this title (relating to Resale Certificate; Sales for Resale); §3.287 of this title (relating to Exemption Certificates); §3.288 of this title (relating to Direct Payment Procedures and Qualifications). Effective October 1, 1999, 20% of the total amount charged for data~~

processing services is exempted from tax. The exemption applies to services performed on or after October 1, 1999. The exemption does not apply to services performed before the effective date and billed or paid for after the effective date of the exemption.]

(1) Payroll services, such as maintaining records of employee work time, computing and preparing payroll checks, filing payroll tax returns, and completing pre-printed employee-related forms such as W-2s, are taxable data processing because they involve the routine and repeated simultaneous application of the same process to different data. The service provider's skill, experience, or expertise with payroll documents is not determinative.

(2) The production of business accounting data, such as inventory reports, is taxable data processing because it involves the routine and repeated simultaneous application of the same process to different data. The service provider's skill, experience, or expertise with business reports is not determinative.

(3) The preparation of financial statements kept in accordance with generally accepted accounting principles, is not included in taxable data processing, even though it has elements of data processing, because the categorization and characterization of the data is variable and depends upon the discretion and certified opinion of an accounting professional.

(4) The insertion of data into form title or loan documents for a client is taxable data processing because it involves the repeated application of the same process to different data. The service provider's skill or experience with title or loan documents is not determinative. The preparation of a title opinion is not included in taxable data processing, even though it has elements of data processing, because the result is solitary and depends upon the opinion or skills of a legal professional.

(5) Marketplace provider services may be included in taxable data processing services when they involve the computerized entry, retrieval, search, compilation, manipulation, or storage of data or information provided by the purchaser or the purchaser's designee. For example, services to store product listings and photographs, maintain records of transactions, and to compile analytics are taxable data processing services.

(6) Internet hosting, as defined by Tax Code, §151.108 (Internet Hosting), is included in taxable data processing services when the user stores data on the service provider's hardware, or processes data on software that is owned, licensed, or leased by the user or provider. An example is the provision of servers and operating systems that are used by a customer to store software applications and content that can be accessed by the customer's customers.

(7) Streaming video subscriptions are taxable as a cable television service but not as data processing services. See also §3.313 of this title (relating to Cable Television Service and Bundle Cable Service).

(8) Streaming video game subscriptions are taxable as an amusement service but not as data processing services. See also §3.298 of this title (relating to Amusement Services).

(9) The compilation of information that the service provider acquires from unrelated third parties through nontaxable opinion polls and surveys as described by §3.342 of this title (relating to Information Services) is not a taxable data processing service if the data processing is ancillary to the main service of data acquisition and the data processing does not have a separate value. However, if the service provider acquires and compiles data from the customer or the customer's designees, and the service provider's expertise is in managing the data, such as in inventory management, the main service is data processing and the service is taxable.

(10) The compilation of nontaxable information primarily derived from the service provider's laboratory, medical, or exploratory testing or experimentation or any similar method of direct scientific observation of physical phenomena as described by §3.342 of this title (relating to Information Services) is not a taxable data processing service if the data processing is ancillary to the main service and the data processing does not have a separate value. Examples may be geophysical surveys, polygraph tests, and the recording and tracking of vital signs in a medical treatment.

(11) Computerized three-dimensional rendering that is created using customer provided data is taxable data processing as it requires the computerized entry, retrieval, search, compilation, manipulation, or storage of data or information.

(12) Website design, website development, search engine optimization, social media marketing, and lead generation are taxable data processing when they involve the storage, manipulation, compilation, and entry of data.

(c) Imposition of tax, permits.

(1) State sales and use tax and any applicable local sales and use tax are imposed on each sale or use of a data processing service in Texas.

(2) Except for small remote sellers described in §3.286(b)(2)(B) of this title (relating to Seller's and Purchaser's Responsibilities), a seller of data processing services must obtain a Texas sales and use tax permit and collect and remit tax on charges for data processing services, or accept properly completed resale, exemption, or direct pay permit certificates in lieu of collecting tax. See §3.285 of this title (relating to Resale Certificate; Sales for Resale); §3.287 of this title (relating to Exemption Certificates); §3.288 of this title (relating to Direct Payment Procedures and Qualifications).

(3) A charge for data processing services is taxable regardless of the ownership of the computer or whether the data is provided by the customer or the customer's authorized designee.

(4) Twenty percent of the total amount charged for data processing services is exempted from tax. If the data processing service is also taxable as another type of taxable service other than an information service, the twenty percent exemption does not apply.

(d) [(c)] Resale certificates.

(1) Providers of data processing services may issue a resale certificate in lieu of tax to suppliers of tangible personal property only if care, custody, and control of the property is transferred to the client. For example, a service provider purchases a Universal Serial Bus (USB) drive [magnetic tape] to transfer the results of data processing services to customers. The USB drive [tape] is transferred to the customer, and the customer owns and uses the USB drive [tape] to review the results of the data processing service. The service provider may purchase the USB drive [tape] tax free by issuing a resale certificate. Tax is due on the total amount charged the customer, including amounts for the USB drive [tape] and for the services.

(2) A resale certificate may be issued for a service if the buyer intends to transfer the service as an integral part of taxable services. A service will be considered an integral part of a taxable service if the service purchased is essential to the performance of the taxable service and without which the taxable service could not be rendered.

(3) A resale certificate may be issued for a taxable service if the buyer intends to incorporate the service into tangible personal

property which will be resold. If the entire service is not incorporated into the tangible personal property, it will be presumed the service is subject to tax and the service will only be exempt to the extent the buyer can establish the portion of the service actually incorporated into the tangible personal property. If the buyer does not intend to incorporate the entire service into the tangible personal property, no resale certificate may be issued, but credit may be claimed at the time of sale of the tangible personal property to the extent the service was actually incorporated into the tangible personal property.

(e) [(d)] Nontaxable related [Unrelated] services.

(1) A service will be considered as a nontaxable related service [unrelated] if:

(A) it is neither a data processing service, nor a service taxed under other provisions of the Tax Code, Chapter 151;

(B) each of the services provided are [it is] of a type which are [is] commonly provided on a stand-alone basis; and

(C) the performance of the service is distinct and identifiable. Examples of such a service would be consultation, development of and preparation of feasibility studies, design and development, or training.

(2) Where nontaxable related [unrelated] services and taxable services are sold or purchased for a single charge and the portion relating to taxable services represents more than 5.0% of the total charge, the total charge is presumed to be taxable. The presumption may be overcome by the data processing service provider at the time the transaction occurs by separately stating to the customer a reasonable charge for the taxable services. However, if the charge for the taxable portion of the services is not separately stated at the time of the transaction, the service provider or the purchaser may later establish for the comptroller, through documentary evidence, the percentage of the total charge that relates to nontaxable related [unrelated] services. The service provider's books must support the apportionment between exempt and nonexempt activities based on the cost of providing the service or on a comparison to the normal charge for each service when [if] provided alone. If the charge for exempt services is unreasonable when the overall transaction is reviewed considering the cost of providing the service or a comparable charge made in the industry for each service, the comptroller will adjust the charges and assess additional tax, penalty, and interest on the taxable services.

(3) Charges for services or expenses directly related to and incurred while providing the taxable service are taxable and may not be separated for the purpose of excluding these charges from the tax base. Examples would be charges for meals, telephone calls, hotel rooms, or airplane tickets.

(f) [(e) Service benefit location.] If both the data processing service provider and the customer are located in Texas, Texas tax is due.

[(f) Service benefit location--multi-state customer.]

(g) Determining the incidence of the tax.

(1) With respect to a taxable service, "use" means the derivation in Texas of direct or indirect benefit from the service. [To the extent a data processing service is used to support a separate, identifiable segment of a customer's business (other than general administration or operation of the business) the service is presumed to be used at the location where that part of the business is conducted.]

(2) The sale of a data processing service that is delivered in Texas is presumed to be a sale for storage, use, or consumption in Texas until the contrary is established. [If that part of the business is conducted at locations both within and outside the state, the service is not taxable to the extent it is used outside Texas. A multi-state customer may use any reasonable method for allocation which is supported by business records.]

(3) A data processing service performed in Texas is subject to Texas sales tax unless an exemption applies. [A multi-state customer purchasing data processing services for the benefit of both in-state and out-of-state locations is responsible for issuing to the data processing service provider an exemption certificate asserting a multi-state benefit, and for reporting and paying the tax on that portion of the data processing charge which will benefit the Texas location. A data processing service provider that accepts such a certificate in good faith is relieved of responsibility for collecting and remitting tax on transactions to which the certificate relates.]

(A) A data processing service performed in Texas for use entirely outside of Texas is exempt from sales tax.

(B) A data processing service performed in Texas for use both within and outside of Texas is exempt to the extent that the service is used outside Texas.

(4) A data processing service performed outside of Texas is subject to Texas use tax to the extent that the service is for use in Texas, unless an exemption applies. [The customer's books must support the assignment of the service to an identifiable segment of the business, the determination of the location or locations of the use of the service, and the allocation of the taxable charge to Texas.]

(5) A purchaser of a data processing service performed outside of Texas for use in Texas may claim a credit for a similar tax paid in another state if that state provides a similar credit for a taxpayer in Texas. [To the extent the use of the service cannot be assigned to an identifiable segment of a customer's business, the service is presumed to be used to support the administration or operation of the customer's business generally. The service is presumed to be used at the customer's principal place of business. The principal place of business means the place from which the trade or business is directed or managed.]

(6) A purchaser asserting the use of a data processing service at business locations in multiple states may issue to the service provider a form promulgated by the comptroller, or a substantially similar document that asserts a concurrent multi-state business use and represents that the purchaser will report and pay the state and local tax on the portion that is taxable and is not exempt.

(A) The multi-state purchaser may use a reasonable and consistent method supported by its business records to allocate the service between jurisdictions.

(B) A service provider that accepts a multi-state use certificate in good faith is relieved of responsibility for collecting and remitting Texas state and local sales and use taxes on transactions subject to the certificate.

(h) [(g)] Local taxes.

(1) Local sales tax is due in a local jurisdiction where the sale is consummated. The sale may be consummated at a place of business of the seller where the order is received, a place of business of the seller where the order is fulfilled, or at the location to which the service is delivered. See §3.334 of this title (relating to Local Sales and Use Taxes). [For local sales tax purposes, city, county, transit authority, and/or special purpose district sales taxes are due if the data processing service provider has only one place of business (the location where clients request service) within the boundaries of a local taxing entity. Local sales tax must be collected based upon the tax rate at that location, except that no MTA or CTD sales tax is due on services provided

~~at a location outside the boundaries of the transit area. In the case of multiple locations, if an order for service is placed at one location but the service is provided at another location, the place of business from which the service is provided will determine to which local taxing entity the tax is allocated.~~]

(2) Local use tax may also be due in a local jurisdiction where a direct or indirect benefit from the service is derived if the 2.0% local tax cap has not been exceeded. See also §3.334 of this title. [~~For the purposes of the local use tax, if a place of business is outside the boundaries of a local taxing entity, the data processing service provider will be required to collect local use tax if the client is within the local taxing entity and the service provider has representation in the local taxing entity as outlined in §3.286 of this title (relating to Seller's and Purchaser's Responsibilities). Even if the service provider is not required to collect local use tax, the client is still liable for the tax if the service is performed or a benefit is derived from the service within the boundaries of a local taxing entity.~~]

(3) [~~(A)~~] An in-state customer purchasing data processing services for the benefit of locations in more than one local taxing entity is responsible for issuing to the data processing service provider an exemption certificate claiming a multi-city benefit and for determining the extent of benefit for each entity. The local use tax for each entity must be reported, allocated, and paid by the customer. A data processing service provider that accepts in good faith an exemption certificate claiming a multi-city benefit is relieved of responsibility for collecting and remitting local tax on transactions to which the certificate relates.

[~~(B) A multi-state customer purchasing data processing services for the benefit of both in-state and out-of-state locations is responsible for issuing an exemption certificate and for reporting and paying local tax as provided by subsection (f)(3) and (4) of this section.~~]

(i) [~~(h)~~] Use tax. The customer is responsible to report and pay use tax if the service provider: [~~If a provider of a data processing service is not doing business in Texas or in a specific local taxing jurisdiction and is not required to collect Texas tax, it is the Texas customer's responsibility to report and pay the state and local use tax directly to this office.~~]

(1) is not required to collect and remit the sales or use tax; or

(2) does not collect the correct amount of sales or use tax.

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

Filed with the Office of the Secretary of State on August 30, 2024.

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Jenny Burleson
Director, Tax Policy
Comptroller of Public Accounts
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For further information, please call: (512) 475-2220

TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 11. TEXAS JUVENILE JUSTICE DEPARTMENT

CHAPTER 380. RULES FOR STATE-OPERATED PROGRAMS AND FACILITIES
SUBCHAPTER B. TREATMENT
DIVISION 1. PROGRAM PLANNING

37 TAC §380.8703

The Texas Juvenile Justice Department (TJJD) proposes amendments to §380.8703, Rehabilitation Program Stage Requirements and Assessment.

SUMMARY OF CHANGES

Amendments to the section will include: 1) adding that a youth's stage in the rehabilitation program may be lowered when the youth has been unresponsive to intervention attempts over an extended period of time and the youth's current stage does not reflect the youth's current progress; 2) for Stage 1, adding that youth are expected to review their own unique vulnerabilities with the case manager; 3) for Stage 2, clarified that the goal is for youth to become *interpersonally* successful in the future; 4) for Stage 2, adding that youth are expected to identify a long-term success plan; 5) for Stage 2, clarifying that youth are expected to explore patterns in thoughts, feelings, attitudes, beliefs and *vulnerabilities* (rather than values); 6) for Stage 2, removing requirements for youth to make progress toward personalized goals, to present and discuss progress with the treatment team, and to complete case plan objectives; 7) for Stage 4, adding that completing case plan objectives includes the ability to articulate plans for successful community reentry; 8) for all stages, clarifying that youth are expected to participate *safely,* (rather than just participate) in various areas of programming; 9) removing the requirement for youth to receive a stage assessment based on current behavior and progress upon being returned to a high- or medium-restriction facility for disciplinary reasons or upon receiving an additional commitment, and adding that such youth will be placed on the most appropriate stage as specified by written procedure manual; and 10) clarifying that one of the situations in which a youth's stage may be lowered is when the youth *receives an additional commitment* (rather than being recommitted).

FISCAL NOTE

Emily Anderson, Deputy Executive Director: Support Operations and Finance, has determined that, for each year of the first five years the new section is in effect, there will be no significant fiscal impact for state government or local governments as a result of enforcing or administering the section.

PUBLIC BENEFITS/COSTS

Evan Norton, Senior Director of Integrated Treatment and Intervention Services, has determined that for each year of the first five years the revised section is in effect, the public benefit anticipated as a result of administering the section will be improvements to the rehabilitative stage system to more appropriately indicate a youth's motivation and readiness to change patterns of behavior and thinking, to more clearly articulate expectations of each stage in the program to youth and staff, and to more accurately capture a youth's readiness for parole in order to enhance public safety.

Ms. Anderson has also determined that there will be no effect on small businesses, micro-businesses, or rural communities. There is no anticipated economic cost to persons who are re-

quired to comply with the new section as proposed. No private real property rights are affected by adoption of this section.

GOVERNMENT GROWTH IMPACT

TJJD has determined that, during the first five years the new section is in effect, the section will have the following impacts.

(1) The proposed section does not create or eliminate a government program.

(2) The proposed section does not require the creation or elimination of employee positions at TJJD.

(3) The proposed section does not require an increase or decrease in future legislative appropriations to TJJD.

(4) The proposed section does not impact fees paid to TJJD.

(5) The proposed section does not create a new regulation.

(6) The proposed section does not expand, limit, or repeal an existing regulation.

(7) The proposed section does not increase or decrease the number of individuals subject to the section's applicability.

(8) The proposed section will not positively or adversely affect this state's economy.

PUBLIC COMMENTS

Comments on the proposal may be submitted within 30 days after publication of this notice to Texas Juvenile Justice Department, Policy and Standards Section, P.O. Box 12757, Austin, Texas 78711, or via email to policy.proposals@tjjd.texas.gov.

STATUTORY AUTHORITY

The revised section is proposed under §242.003, Human Resources Code, which requires TJJD to adopt rules appropriate to the proper accomplishment of TJJD's functions and to adopt rules for governing TJJD schools, facilities, and programs.

No other statute, code, or article is affected by this proposal.

§380.8703. Rehabilitation Program Stage Requirements and Assessment.

(a) Purpose. Youth earn the ability to move to less restrictive placements by progressing through a stage system that measures progress in the rehabilitation program. The purpose of this rule is to provide a general outline of the areas in which a youth must demonstrate progress and to describe the process for assessing progress.

(b) Applicability. This rule applies to all residential facilities operated by the Texas Juvenile Justice Department (TJJD). This rule does not apply to youth in contract-care programs that are not required to provide the TJJD rehabilitation program. This rule does not apply to youth on parole status.

(c) Definitions. See §380.8501 of this chapter for definitions of terms used in this rule.

(d) General Themes in the Rehabilitation Program.

(1) TJJD's rehabilitation program is composed of a set of stages with objectives related to each youth's rehabilitative needs. Expectations generally increase as youth progress through the stages.

(2) Progress is measured through an assessment of the youth's demonstration of skills in areas such as:

(A) appropriate participation in education/vocational and treatment/intervention activities;

(B) understanding and use of therapeutic tools;

(C) ability to develop, discuss, and work toward individual goals;

(D) application of regulation tools to maintain safe behavior; and

(E) reducing risk factors and increasing protective factors.

(3) The objectives for each youth shall be in writing and provided to the youth.

(4) Each youth is provided an equal opportunity, as the youth's behavior warrants, to participate in the scheduled activities needed to progress.

(e) Stage Assessment.

(1) A stage assessment shall be conducted when the youth completes the required objectives for the stage or within 90 days from the previous stage assessment, whichever occurs first.

(2) Each stage assessment includes a comprehensive assessment of the youth's progress in the rehabilitation program.

(3) The parent/guardian must be given an opportunity to provide input to be considered at each stage assessment.

(4) As a result of a stage assessment, the youth is assigned to the most appropriate stage. Youth may be assigned to a stage that is more than one level higher than the current stage, if appropriate.

(5) Each youth's specific needs and responsivity must be considered when assessing a youth's stage. If a youth fails to progress through the stages, staff must conduct a review for responsivity needs and, if appropriate, implement individualized interventions.

(6) Youth may not be assigned to a lower stage, except:

(A) when it is determined that behavior proven at a Level II due process hearing held in accordance with §380.9555 of this chapter indicates the youth no longer meets the requirements of the current stage assignment; [~~or~~]

(B) when it has been determined that the youth has been unresponsive to intervention attempts for an extended period of time and the youth's current stage does not reflect the youth's current progress; or

(C) [~~(B)~~] in accordance with subsection (g) of this section.

(7) If a youth loses release eligibility under §380.8555 or §380.8559 of this chapter, the youth is no longer designated as having completed the rehabilitative program under this rule and is assigned to stage 4.

(8) The youth and the youth's parent/guardian are notified of the results of the stage assessment.

(f) Requirements for Stage Promotion.

(1) Stage 1--this stage focuses on building a foundation of safety and regulation. During this stage, the youth will gain basic knowledge of the TJJD stage objectives and requirements for program completion. The youth attends the foundational skills development groups and participates in individual sessions with the case manager to develop an assessment of risk and protective factors. To determine whether youth have completed this stage, youth are assessed on factors including:

(A) reviewing the youth's own unique vulnerabilities and risk and protective factors with the case manager;

(B) discussing the youth's progress toward goals with staff;

(C) working on case plan objectives with the case manager; and

(D) participating safely in the following other areas of programming:

(i) treatment and intervention activities;

(ii) academic and workforce development programs; and

(iii) application of learned skills in daily behavior.

(2) Stage 2--this stage focuses on healthy connection and the ability to make repairs after relational harm. Youth on this stage are moving beyond the pre-contemplation stage of change to accept that changes are needed to improve their ability to be interpersonally successful in the future. To determine whether youth have completed this stage, youth are assessed on factors including:

(A) exploring personal risk and protective factors, including those related to TJJD commitment;

(B) identifying a long-term success plan and sharing plans for community reintegration with the youth's family, community supports, or adult mentor;

(C) exploring patterns in thoughts, feelings, attitudes, beliefs, and vulnerabilities [~~values~~]; and

[~~(D) making progress towards personalized goals;~~]

[~~(E) presenting and discussing the youth's progress with the youth's treatment team;~~]

[~~(F) completing case plan objectives; and~~]

(D) [~~(G)~~] safely participating in other areas of programming as described in paragraph (1)(D) of this subsection.

(3) Stage 3--this stage focuses on taking responsibility and making prosocial decisions. Youth on this stage are preparing to move into the action stage of change through continued acknowledgment of the need to change and planning for their future. To determine whether youth have completed this stage, youth are assessed on factors including:

(A) demonstrating a reduction in risk factors and an increase in protective factors;

(B) taking responsibility for behaviors leading to commitment;

(C) completing case plan objectives; and

(D) safely participating in other areas of programming as described in paragraph (1)(D) of this subsection.

(4) Stage 4--this stage focuses on demonstrating and practicing learned skills for youth. The purpose of this stage is demonstrating independence through application of treatment concepts and skills learned in earlier stages. This stage is considered the second-highest stage for purposes of eligibility for transition under §380.8545 of this chapter. To determine whether youth have completed this stage, youth are assessed on factors including:

(A) demonstrating continued reduction in risk factors and increase in protective factors;

(B) identifying new thoughts, feelings, attitudes, beliefs, and values that might increase success in the community;

(C) completing case plan objectives, including the ability to articulate plans for successful community reentry; and

(D) safely participating in other areas of programming as described in paragraph (1)(D) of this subsection.

(5) Rehabilitative stages completion status--this designation indicates that a youth has completed stage 4 and is considered the highest stage for purposes of program completion under §380.8555 and §380.8559 of this chapter. Youth are in the maintenance stage of change and will be given the opportunity to demonstrate and apply learned skills. Youth are expected to safely participate in other areas of programming as described in paragraph (1)(D) of this subsection.

(g) Stage Assignment [~~Assessment~~] upon Return to a High- or Medium-Restriction Facility or upon Additional [~~New~~] Commitment. A youth is [~~reassessed and~~] placed on the most appropriate stage, as specified by written procedure manual, [~~for the youth's current behavior and progress in the rehabilitation program~~] when the youth [~~is~~]:

(1) is returned to a high-restriction facility for disciplinary reasons through a Level II due process hearing;

(2) is returned to a high- or medium-restriction facility for disciplinary reasons through a Level I due process hearing; or

(3) receives an additional commitment [~~recommitted~~] to TJJD for a new offense.

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

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Jana L. Jones
General Counsel
Texas Juvenile Justice Department
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